BRISTOL SAFEGUARDING ADULTS BOARD

Serious Case Review

Following the murder of a young adult, ‘Melissa’, 18 years old, in October 2014

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1. Introduction

1.1 On 12th October 2014 YA2 strangled Melissa at Care Home 1 and she died from her injuries on 16th October 2014. On 1st October 2015 YA2 was convicted of her murder at Bristol Crown Court and sentenced to life imprisonment.

1.2 At the time of the incident both YA2 and Melissa were living at Care Home 1, a privately run care home. Care Home 1 provides residential care for adults with a diagnosis of Autism Spectrum Disorder or Asperger's Syndrome. Melissa was an eighteen year old and YA2 a nineteen year old, both of whom had recently been placed at Care Home 1 by their home local authorities. In the case of YA2, he had been placed at Care Home 1 by YA2's home authority. Melissa had been placed by another local authority. Both YA2 and Melissa were former Looked After Children (LAC) although their lives had been very different. YA2 had lived in residential placements in England since the age of 7 whilst Melissa had spent her childhood living with her family until the 11 months prior to her death.

1.3 During the criminal trial it was established that YA2 had strangled Melissa with the intention of having sexual intercourse with her dead body. He had tried and failed to drag her apparently lifeless body back to his room at Care Home 1 for that purpose.

1.4 In November 2014 Bristol Safeguarding Adults Board agreed to undertake a Serious Case Review (SCR). The SCR Panel was established and an independent author was commissioned. He had no previous connection to services in Bristol, Melissa's home authority or YA2's home authority.

1.5 All of the agencies which have contributed to this SCR wish to express their sincere condolences to the family and friends of Melissa.

Scope and Terms of Reference

1.6 Bristol Safeguarding Adults Board agreed the following terms of reference for this SCR following consultation with Melissa's parents:

Scope (or period covered) of the Serious Case Review

1.7 From the point at which both YA2 and Melissa first came into contact with Children's Services until her death on 16th October 2014. Any support provided by any agency to the parents of Melissa following her death is also within the scope of this SCR. This is up to the 15th April 2015, the date that police family liaison with Melissa's family became less significant.

Terms of reference

- How were the risks posed by YA2 assessed and managed prior to and during his placement in Care Home 1? How were the risks posed by YA2 communicated to the Provider?
- How were the risks to Melissa arising from her placement in Care Home 1 assessed and what measures were put in place to safeguard her?
- How were the decisions taken to place YA2 and Melissa in Care Home 1?
- In making the placement decisions, how effective was communication between commissioners and providers, and placing and host authorities?
- Were the parents of Melissa appropriately consulted on the decision to place her in Care Home 1 and were their wishes taken into account?
- The SCR will also examine the journey through childhood into adulthood of both YA2 and Melissa, and in particular the transition from Children's to Adults' services.

Post incident – see appendix 3

- How effectively did the provider, the placing authority in respect of YA2 and the host authority work together following the incident?
- How appropriately was Melissa's family supported after the incident? In particular, how effectively were the needs of Melissa and her family addressed whilst she was being treated in intensive care at NHS trust 2 following the incident?

Process by which the Serious Case Review was completed

1.8 BSAB decided to adopt an "investigative" or "traditional" methodology for this SCR. Individual Management Reports (IMRs) were requested from all agencies which had had relevant contact with Melissa and YA2. All of these were completed to a satisfactory or better standard with the exception of the Care Home 1, YA2's home authority and NHS Trust 1 IMRs. Whilst the Care Home 1 IMR contained much detail, it lacked analysis of the key issues, challenge and failed to identify learning. YA2's home authority's IMRs were generally satisfactory but some key information provided to the SCR was inaccurate. The NHS Trust 1 IMR was brief and provided little insight into their assessment of YA2. Some conversations were also undertaken with key individuals in order to enable a more systemic exploration of some elements in the case.

1.9 Melissa's parents fully contributed to this review and were also consulted by the independent authors of the home authority IMR and the NHS Trust 3 report. Melissa's

paternal grandmother also contributed to this review. Prior to Melissa's mother's death in December 2015, a brief summary of the draft findings from this SCR were shared with her. YA2's mother has also contributed to this review.

1.10 Following the completion of a draft of the report that had been approved by the SCR Panel it became clear that through no fault of the author, the methodology adopted did not enable the report to be written in a way that could easily and clearly capture the learning required from the case. It was not possible for the Safeguarding Adults Review sub group and the author to agree the best way to achieve this and it was therefore decided that the Board would receive the draft report and that the Joint Business Unit Manager of the Board would produce a final report using the very valuable information, findings and recommendations of the draft report. No new findings or recommendations have been made.

1.11 The purpose of a serious case review is to identify lessons learnt from the case under review with respect to multi-agency practice. Serious Case Reviews should be open and transparent and present the learning identified in an effective and accessible way.

Family Engagement

Melissa

1.12 Melissa's parents and maternal grandmother contributed to this review. Her parents felt they had received insufficient support to bring up two children with ASC and other needs. They felt that their home authority Children's Services had labelled them as "*useless parents*."

1.13 Melissa's parents said she had never had an advocate. Her paternal grandmother said that one of the improvements she would really like to see is that no-one with any mental health issues should have decisions made about their treatment without having someone totally unbiased to advocate for them.

1.14 Melissa's parents expressed concern that their daughter was placed with other young people who experienced issues such as self-harm and eating disorders. They worried that she may have learned behaviours from service users she was with (the NHS Trust 3 IMR accepts that this was a risk).

1.15 Melissa's parents said that they didn't want their daughter to go to Bristol. They said they had been told that there would be a choice of three places but in the end there was only Bristol. They thought that the risks to Melissa increased if she was further away from her home and family support network. Her parents described her as vulnerable, not "*streetwise*" and lacking the ability to make friends. They felt that, whilst she may have had mental capacity, she lacked maturity and experience.

YA2

1.16 YA2's mother contributed to this review with information regarding her son. YA2's father has not been involved in his life since he was a toddler. Consequently, the SCR Panel took the view that there was little merit in attempting to engage YA2's father in this review. YA2's mother however remains an important figure in his life and it was considered important to offer her the opportunity to contribute to this review.

1.17 YA2's mother said that she had kept in as close contact with her son as she could do after he left his home authority at the age of 7. Wherever he was placed in England, she would visit him, but had not visited him at Care Home 1 as he was there for such a short period prior to the attack on Melissa.

1.18 His mother described YA2 as a kind and loving boy; although she also said he had tried to kill her on two occasions. She said she didn't think he meant to do harm but did not understand the consequences of what he was doing. She said he had apologised after he had tried to harm her. She added that she had tried to warn people about his behaviour. She felt he should have been in a setting which was male only, adding that she did not think he could ever be trusted around women.

1.19 She said YA2 was currently obsessed with "Marvel Comic Book" characters and "Star Wars". She said he was happy when he had the space to run around and act out science fiction characters.

2. Key events

YA2's life prior to his placement at Care Home 1

2.1 YA2 was known to his home authority (an off-shore crown dependency) Children's Services from a very young age. His early childhood was characterised by unexplained injuries and his aggressive and sexualised behaviour. One incident involved him wrapping his arms around his mother's neck and squeezing tightly. In 2003 an Interim Fit Person Order (equivalent to a UK Care Order) was granted and YA2 was placed off island at Residential School 1 in South West of England.

2.2 YA2 remained at Residential School 1 for three years. Concerns that the placement was not meeting his care and educational needs led to a decision to seek a foster placement. In 2006 YA2 began a placement with foster carers in the South West of England. Difficulties arose when YA2 was provided with respite. YA2 jumped on his respite carer grabbing a knife, shouting he was going to kill her, her daughter and then himself. The difficulty in providing respite care led to the foster care placement ending in 2007 and YA2 moved to Residential School 2 in the same geographical area.

2.3 At Residential School 2, YA2 displayed "*extreme sexualised behaviour*". He appeared to have become fixated with a young female member of staff and regularly presented

with aggressive and challenging behaviour whilst she was on duty. On one occasion he attempted to strangle her with a dressing gown belt. It is stated that he had reportedly said that he wanted to kill her and have sex with her dead body.

2.4 In May 2009 YA2 twice tried to strangle another female staff member whilst she was driving him and other pupils back from a day trip. This incident was reported to the police and YA2 was arrested however the member of staff did not support a prosecution. Therefore, the police took no further action and the school dealt with the matter "*in house*".

2.5 This and subsequent placements broke down before YA2 was placed at Residential school 4 in the Midlands which is an independent school that provides education for boys and girls aged 8 to 19 years who have Autistic Spectrum conditions, associated complex needs and challenging behaviours. The school is registered for 20 students.

2.6 YA2 appeared to settle well at Residential school 4, responding well to the strategies that were implemented. However, a number of incidents occurred which gave cause for concern: In March 2012 YA2's mother visited him and spent time alone with him in his bedroom. YA2 tried to smother her with a duvet and staff had to intervene. She told staff that YA2 had said that he wanted to kill her and have sex with her. It was agreed that future contact with his mother would be supervised on a 1:1 basis at all times. YA2's mother, although shaken, did not wish to report the matter to the police.

2.7 In May 2012 he approached a female Residential school 4 staff member from behind and put his exposed penis on her back. He then stood in front of the door to prevent her leaving, before eventually jumping out of the window.

2.8 In December 2012 YA2 made a visit to his mother in YA2's home authority, during which an incident took place at a hotel where YA2 and Residential school 4 staff members stayed. YA2 became fixated upon a petite young woman and made efforts to locate her bedroom. He was later ushered back into his bedroom by Residential school 4 staff after being found in a hotel corridor in his pyjamas and in a state of arousal.

2.9 On 15 March 2013 YA2 attacked a Residential school 4 staff member. YA2 was completing his morning routine with other children and supported by members of staff. When the other children were ready to leave the area and go to the classroom, they did so, accompanied by members of staff, leaving the staff member alone with YA2. After around 3 minutes, another member of staff returned to the area in which the staff member had been alone with YA2. He discovered her in a distressed state with YA2 standing a few feet away from her. She reported that YA2 had tried to touch her inappropriately whilst he was sexually aroused. When she had told YA2 that she was leaving and attempted to exit the area he attacked her from behind, put his

forearm around her neck and squeezed until she lost consciousness. When she regained consciousness YA2 was close to her.

2.10 Residential school 4 did not report the incident to the police and the victim decided that she did not wish to involve the police either. The school's Head of Service met with YA2 to emphasise the seriousness of his actions, adding that the police could have been called. 2:1 supervision of YA2 was implemented and YA2's home authority was informed. In a subsequent multi-disciplinary team (MDT) meeting in YA2's home authority, it was agreed that Residential school 4 remained a suitable placement.

2.11 Two days after the attack Residential school 4 Educational Psychologist raised concerns that the attack bore some similarity to the incident with YA2's mother in January 2012 and suggested that the school might be dealing with potential sexual offending behaviour.

2.12 In July 2013 Residential school 4 commissioned an independent forensic assessment of YA2. In September 2013 a Child and Adolescent Mental Health Services (CAMHS) Consultant Psychiatrist and a CAMHS Social Worker assessed YA2 at Residential school 4, during which he shared information he had not previously shared about the March 2013 attack. He explained that he had wanted to have sex with the Residential school 4 staff member but knew that this was against the rules. He had therefore tried to kill her because then she would no longer be a member of staff and so he could have sex with her without breaking the rules.

2.13 In September 2013, Residential school 4 reported the March 2013 attack to a Constable from local police who erroneously advised them that it was now too late to report this incident retrospectively, but that in future any similar incidents should be reported to the police.

2.14 On 24th October 2013 Residential school 4 received the Forensic Assessment report which confirmed the severity of the March 2013 attack. YA2 had stated that he strangled the staff member until she was unconscious for a few seconds and when she became conscious and tried to leave the room he again tried to strangle her as he wanted to kill her and have sex with her. When asked what stopped him from harming her further, he stated that a male member of staff came into the room and intervened.

2.15 The Forensic Assessment report stated that *"due to his complex range of difficulties, YA2 has difficulties in social interaction and social communication. He has difficulty in generating non-aggressive solutions to difficulties, has an inability to experience empathy or remorse for victims, an inability to delay gratification and has a concrete and over literal understanding"*.

2.16 The report concluded that YA2 presented a *"high risk of future physical and sexually*

harmful behaviour" adding that it was "*imperative*" that a robust risk management strategy was adopted within current and future placements, which should include:

- YA2 should be highly supervised at all times; particular attention should be paid to the "*recognised victim profile*" of young, petite women who he feels he can easily overpower;
- staffing rotas should not be shared with YA2 as he has shown an interest in identifying times at which staff members might be vulnerable;
- morning times were considered to be higher risk as YA2 appeared to be particularly sexually aroused at that time of day;
- it was imperative that violent and sexually harmful behaviour was reported to the police immediately;
- staff should cease engaging in fantasy play with YA2 in which they play subordinate roles as this could reinforce his perceived position of power over staff; consideration needed to be given to material that YA2 accesses on the internet or through other media;
- any future placement needed to be highly structured and supervised with a high staff to young people ratio; there needed to be extreme care exercised with regard to YA2's access to the wider community and this needed to be supervised, particularly in high risk areas such as swimming pools, changing rooms, hotels etc.;
- If charged or if involved with the police in respect of the March 2013 attack, discussion of his current risk assessment and sexually harmful behaviour with the local MAPPA[1] co-ordinator should be considered.

2.17 Therefore, in November 2013 Residential school 4 immediately adopted a robust management plan but ultimately concluded that it was no longer able to fully meet YA2's needs as they did not specialise in addressing sexually violent behaviour. YA2's home authority agreed to search for an appropriate adult placement with April 2014 as the target departure date.

2.18 The same month a Multi-Disciplinary Team (MDT) meeting in YA2's home authority decided to commission a further assessment of YA2 and explore the possibility of referring him to MAPPA (No MAPPA referral was subsequently considered possible

[1] Multi-Agency Public Protection Arrangements

because YA2 was judged not to meet the threshold for referral[2]).

2.19 During December 2013 YA2's home authority Adult Mental Health services assumed responsibility for YA2. YA2 was discharged from YA2's home authority Children's Services on his 18th birthday at this time. YA2's home authority Adult Learning Disability Services had engaged in YA2's case from January 2011 to manage his transition from Children's to Adult services. However, the YA2's home authority Adult Social Worker who had been allocated to YA2 left her post in December 2012 and this post remained unfilled for 11 months. From that point there was no further involvement from YA2's home authority Adult Learning Disability Services, leaving the Children's Services entirely responsible for his immediate care needs and without a transition plan in place.

2.20 Subsequently during January 2014 Learning Disability (Forensic) Consultant Psychiatrist from NHS Trust 1 was commissioned by YA2's home authority to carry out an assessment of YA2's needs in order to inform the decision over his future placement. A conclusion of the assessment was that YA2 was *"probably detainable under Section 3 of the Mental Health Act".* However, this was not considered to be the most appropriate option as YA2 had become "*considerably institutionalised*" and he stated that "*one wonders […] whether a more appropriate autism specific risk management approach might not have yielded better overall results*". Two residential placements for people with autism were suggested as suitable. This included Care Home 1 which the psychiatrist said had managed two discharges from inpatient services with "*remarkable success, both of whom posed significant challenges and risks*". A note of caution was also raised, that if Care Home 1 "*were to feel that they could not manage him, then the only reasonable alternative would be a hospital inpatient placement*".

2.21 YA2's home authority approved an approach to Care Home 1 and on 21st February 2014 Residential school 4 wrote to Care Home 1's General Manager enclosing a number of documents to assist with their forthcoming assessment of YA2. Amongst the documents listed as enclosed was the Forensic Assessment report. Care Home 1 acknowledges that they received the report but that they do not know when it was received. Also, that on receipt, it was not "appropriately circulated". The letter stated that YA2 came to Residential school 4 in January 2012, that he had settled well, that it had been a successful placement for him and that he was now ready to move to an adult service.

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[2] YA2 had not been charged with or convicted of a relevant offence. Use of the 'Potentially Dangerous Persons protocol' would have been available however the risk management plan adopted by Residential School 4 was suitably robust.

2.22 During April 2014 the YA2's home authority Adult Disability Panel met and expressed concerns about YA2's proposed placement at Care Home 1 because

- it was in a city centre location,
- no consultant care was provided so this would need to be sourced separately,
- no immediate bed was available and
- YA2's home authority had not used this type of facility before.

2.23 As a result, a manager was requested to examine a low secure unit as an alternative. A further assessment of YA2 was commissioned from another potential provider which concluded that YA2 *"fits the criteria for detention under the Mental Health Act 1983".* However, YA2's home authority decided to continue with the Care Home 1 placement "*due to the personal knowledge of the home by Learning Disability (Forensic) Consultant Psychiatrist at NHS Trust 1*".

2.24 On 29th and 30th April 2014 the General Manager and a Programme Manager from Care Home 1 visited Residential school 4 to assess YA2's needs. In the assessment report, the Care Home 1 General Manager wrote that "*staff explained that there was an incident whereby YA2 strangled a staff member but staff at the school explained that at the time YA2 had difficulty in interpreting the difference between what is real and what isn't real*". Later it is written that "*staff explained that they had less concerns for YA2's behaviour than his team in YA2's home authority. They felt that in YA2's home authority they are likely unused to challenging behaviour and therefore would be more cautious. For this reason, the staff and YA2's home authority had agreed that 2:1 could mean that he needed 1:1 staff support but another staff should be close by or within eyesight in case of emergency*". The assessment report further states "*staff explained that YA2 has a tendency to act out stuff that he sees in movies or in games and therefore he is currently not able to watch or play 18+ games. Staff stated that their rule was "<u>don't let YA2 watch anything that you don't want to happen to you</u>"*. The Care Home 1 General Manager made no reference to the Forensic Assessment report in the assessment report.

2.25 In June 2014 the Care Home 1 General Manager e-mailed YA2's home authority a copy of the support plans and risk assessments prepared for YA2 following the above assessment.

2.26 The **"staff support"** support plan/risk assessment stated "*currently at Residential school 4 YA2 has 2:1 staff. The way that this is arranged is that one staff member works directly with him and one staff member must have YA2 and the other staff member in line of sight at all times. The reason for this is because of the incident whereby YA2 put his arm around a staff members [] until she passed out*" (It is assumed the word "neck" or "throat" was accidentally omitted.) The support plan/risk

assessment went on to state that "*YA2 will have a staff member allocated to him at all times. When in the house, due to staffing levels at Care Home 1 and due to the layout of the building, there will be sufficient staff around for YA2 not to have specifically allocated to him two staff members*". The plan concluded with the following information; "*please note that at any one time between the hours of 8am and 10pm there are 13 staff on duty. In addition to this, there are two programme managers and one general manager*". No information was given about staffing levels between 10pm and 8am.

2.27 YA2's home authority expressed themselves satisfied at a pre discharge planning meeting on 5 August 2014 with these support plans/ risk assessments and YA2 was formally offered a placement at Care Home 1 later the same month.

2.28 During August 2014 an 'off island review' took place at Residential school 4 at which it was acknowledged that the school's risk management plan had been successful in preventing a repeat of YA2's sexually harmful behaviour. It was agreed that this plan should be carried forward to his new placement, including no female working directly or lone working with YA2, 2:1 support "*all the time*", with the second worker in close proximity and within earshot. Care Home 1 was represented at this meeting.

2.29 YA2 was noted to be "*fully capacitious [sic] regarding the move hence a capacity assessment is not required*". A section of the report entitled "*crisis plan for the first month*" included a plan "*to increase staff numbers for the first month of YA2's placement and involve senior staff at the earliest sign of difficulty*". A member of the Residential school 4 staff stated that historically YA2 began to exhibit challenging behaviour after moves have been made and he anticipated that YA2 may start to display difficult behaviour around six weeks into this placement.

YA2: Placement at Care Home 1

2.30 YA2's placement began on 26th August 2014. On 9th September 2014 YA2's home authority Adult Mental Health Social Worker conducted a post-discharge visit and reported that YA2 was settling in well and that his behaviour had been appropriate both in the placement and at college. She highlighted one reported incident in which YA2 went into the room of "*a recently arrived female resident*" to prompt her regarding breakfast. Night staff had apparently seen and followed him and advised not to enter the room without invitation.

2.31 At 12.45am on Thursday 9th October 2014 YA2 appeared on the landing by Melissa's bedroom where staff were supporting her. YA2 appeared anxious and agitated.

2.32 On Friday 10th October 2014 YA2's home authority Adult Mental Health Social Worker attended a review meeting for YA2 at Care Home 1 which was also attended by the Consultant Psychiatrist contracted by YA2's home authority to oversee YA2's care at

Care Home 1. Care Home 1 referred to the Forensic Assessment report which was circulated at this meeting. The Consultant Psychiatrist had not previously seen the report and asked for a copy to be emailed to him so that he could review the contents.

2.33 YA2's home authority Adult Mental Health Social Worker prepared an email update report in which YA2's placement was described as going well. The update report made no reference to the circulation of the Forensic Assessment report.

Melissa's life prior to her placement at Care Home 1

2.34 Melissa lived at home with her parents and older 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). Melissa's sibling also had a disability.

2.35 Melissa's difficulties impacted on her relationship with her family. She was assessed as a Child in Need (CIN) and the home authority Children's Services provided support to Melissa and her family in an effort to help her and her parents better manage family conflicts. However, tension between her parents and the home authority Children's Services complicated these interventions. When Melissa was 16, the home authority closed her case, following a risk assessment, having concluded that whilst concerns about Melissa remained, she did not meet the threshold for child protection intervention.

2.36 Melissa's Home Authority and NHS Trust 3 also accept that the appointment of an advocate may have been helpful, given her complex needs, the impact of ASD upon her ability to process information and the sometimes conflicting views between family and professionals. The NHS Trust 3 IMR records that Melissa's paternal grandparents wrote to the Home Authority to request an advocate for Melissa on 2nd October 2013, but it appears that this was not actioned. Four months later Melissa made the same request at the Adolescent Unit. Attempts were made to identify an advocate without success. It was understood that the NHS Trust 3 advocacy service only applied to adults detained under the MHA. Melissa's Home Authority service was understood not to be appropriate. Young Minds was approached who suggested a voluntary sector service in South London who declined as they were too far away. In the event no advocate was appointed.

2.37 In July 2013 Melissa was admitted to a CAMHS Adolescent Unit (AU1) in a neighbouring authority for a period of in-patient assessment and treatment after she had expressed delusional beliefs and had had thoughts of wishing to be dead. She said she did not wish to return home. A transfer to another CAMHS Adolescent Unit (AU2) eventually took place, although this entailed spending weekends at home, after consultation with the family.

2.38 Although Melissa absconded from the adolescent unit several times initially, she was considered to have settled and established positive relationships there. In December 2013 she was referred to the local ASD Service for Adults at the Community Mental Health Trust (CMHT) where her case was allocated to a senior social worker. From that point the latter co-worked Melissa's case with the home authority Children's Services and was tasked with finding the right support for Melissa once she reached 18 years of age.

2.39 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.

2.40 In May 2014, Melissa made an allegation of historical abuse which occurred when she was 13 years old. An emergency placement was found for her. She was later interviewed by the police. The alleged perpetrator denied the allegations, and in the absence of corroboration, the police decided to take no further action.

2.41 After expressing suicidal thoughts and being taken to A&E in July 2014, CAMHS assessed Melissa. The consultant psychiatrist concluded that her diagnosis remained ASD with emotional regulation difficulties, adding that it was "*very clear that her difficulties are as a result of her ASD and how these affect her interpretation of the world*", adding that admissions to psychiatric units were not appropriate. The consultant advised that Melissa "*requires ongoing support whilst she is in a stable environment with appropriate and most likely supervised contact with her family*".

Melissa: Decision to place at Care Home 1

2.42 A risk assessment completed by her senior social worker concluded that Melissa "*needs constant reminders about the dangers and risks attached to being over friendly and over affectionate. She is at risk of being exploited and she is vulnerable in most situations*". She went on to add that Melissa "*is very vulnerable to abuse by other[s] as she is very trusting*".

2.43 This risk assessment was shared with Care Home 1 which offered Melissa a place. Apparently no local placement was available. The average age of people living in Care Home 1 was 33 years with the youngest being 23 (apart from Melissa and YA2 who were aged 18 at the time of their placement) and the oldest 56 years old. Melissa agreed to the placement but her parents continued to feel that a residential placement out of the local area was inappropriate.

Melissa's placement at Care Home 1

2.44 Melissa exhibited considerable distress during her placement which began on 18th August 2014. She was supported by the staff at Care Home 1 and the Bristol Crisis

Team.

The murder of Melissa

2.45 During Sunday 12th October 2014 Melissa mentioned to a member of Care Home 1 staff that YA2 had been looking at her. She said that she was scared. The Care Home 1 IMR states that "*it was common for* Melissa *to say that she was scared about things in life generally and it did not necessarily indicate that there was a particular risk*". However, staff nevertheless reported what she had said to a team manager who told them, as a precaution, to keep an eye on both of them. Specifically, the team manager says she gave instructions to staff to walk with Melissa upstairs, that night staff were to ensure that YA2 locked his door and to carry out checks to ensure that both Melissa and YA2 were in their rooms.

2.46 After Melissa and YA2 had gone to their bedrooms, YA2 came to his door without a top on. He was asked to go back into his bedroom and lock his door. A member of staff monitored his bedroom from the stairs for approximately 10 minutes and at 10.30pm another member of staff carried out a sweep of the building and closed all fire doors. All residents were noted to be in their rooms.

2.47 At 11.20pm staff heard footsteps on the stairs and a loud bang which sounded like a door slamming. When they went to investigate they noticed that YA2's bedroom door was ajar and that he was not inside. They opened a fire door and found Melissa lying on the floor at the bottom of the stairs. One of the members of staff called Melissa's name and shook her but there was no response. The staff members then noticed YA2 standing on the opposite stairs. When they asked him what happened he claimed that Melissa had fallen. An ambulance and the police were summoned.

2.48 Melissa's condition was not survivable and on Thursday 16th October 2014, following brain stem tests, her death was confirmed. By this time YA2 had been arrested for the second time and he was later charged with Melissa's murder.

3. Learning, Findings and Recommendations

The risks presented by YA2

3.1 The risks YA2 presented were clearly set out in the Forensic Assessment report completed in October 2013. Within six months of this report being completed, the registered manager of his future placement at Care Home 1 had undertaken an assessment of YA2 and within this assessment formed the view that the March 2013 attack was an incident in which he had taken fantasy play too far and support plans/risk assessments had been drafted which underestimated the risks YA2 presented. How did this happen?

The communication of risk

3.2 The following factors contributed to what was effectively a failure in the communication of risk:

Contributory Factor 1: The withdrawal of YA2's home authority Children's Services as soon as YA2 attained the age of 18. Their records were shared with YA2's home authority Adult Mental Health Services but the accumulated experience and voice of children's services was not retained.

Contributory Factor 2: YA2's home authority Adult Disability Services were unable to work effectively with YA2's home authority Children's Services to ensure that YA2 experienced a smooth transition to adult services and his adult placement post Residential school 4. This appears to have been due to staffing issues when the allocated worker left and their post remained vacant for a significant period due to difficulties in recruiting.

Contributory Factor 3: The delay in planning for YA2's future was only addressed very late in the day by YA2's home authority Adult Mental Health Services. YA2's home authority Children's Services IMR acknowledges that Adult Mental Health Services "*involvement should have happened much earlier if any service was to gain a full understanding of extremely complex needs and issues*".

Contributory Factor 4: The decision taken by YA2's home authority Adult Mental Health services that Residential school 4 should play such a prominent role in the facilitation of YA2's placement at Care Home 1. YA2's home authority say that *"the majority of communications were between [Residential school 4] and [Care Home 1] rather than with the commissioners (YA2's home authority)"* and that "*communications between the provider and commissioners were principally focused on funding or contractual issues in this case*". Clearly Residential school 4 had a vital role to play in YA2's transition to Care Home 1. In allowing them to manage the "*majority of communications*" with Care Home 1 and limiting their own communication to "*funding or contractual issues*", YA2's home authority Adult Mental Health services did not exercise sufficient oversight of the placement process. Crucially, they did not put themselves in a position to assure themselves that information about the risks that YA2 presented was fully and accurately shared with Care Home 1. They mitigated their decision to allow Residential school 4 to play such a prominent role in placing YA2 by employing an off island social worker to manage YA2's case but it is not clear that the Forensic Assessment report was shared with her.

Contributory Factor 5: Residential school 4 appeared to portray the conclusion of YA2's placement at Residential school 4 as a planned event when this was not the case. In the letter to Care Home 1 dated 21st February 2014, Residential school 4

Educational Psychologist wrote that YA2's placement had been "*successful for him*" and that "*he is now ready to move on to an adult service*".

Contributory Factor 6: The most significant contributing factor was the limited risk assessment by Care Home 1 of the risks presented by YA2. The existence of the Forensic Assessment report which they accept was shared with them was not referred to until 10 October 2014. Their assessment erroneously linked the March 2013 attack to YA2's inability to distinguish between 'fantasy and reality', which resulted in a view being formed by Care Home 1's registered manager that the attack had occurred because YA2 had "*over-stepped boundaries in a role play situation"* (the words of the Care Home 1 Registered Manager when interviewed for this review). YA2 was found in the forensic assessment report to "*have difficulty in distinguishing fact from fiction and this can lead to difficult behaviours on his part and when in his fantasy world can find it difficult to revert to the real world"*. There was no suggestion in the Forensic Assessment report, or from any other account, that role play was involved in the March 2013 attack on the Residential school 4 member of staff.

What do we learn from Care Home 1's assessment of YA2?

3.3 The process used by Care Home 1 for assessing potential placements lacked structure. YA2's assessment report consisted of 15 bullet points, described as "*findings*". The methodology adopted was not described nor were there any headings to guide the assessor on which areas to cover in the assessment.

3.4 The 15 bullet points were written in uniformly positive language. Whilst there is much to be gained by adopting a positive approach, this assessment should have been a measured, professional judgement of a complex young man with substantial needs and who presented significant risks. Research suggests that risk perceptions can be influenced by the emotional state of the person perceiving those risks. This is known as valence theory where positive emotions can lead to optimistic risk perceptions[3]. The ethos that informed the practice of Care home 1 could have had a bearing on the perception of risk when the assessment was being undertaken.

3.5 There was a lack of internal scrutiny and quality assurance of the assessment of YA2 and therefore the errors, which included a lack of structure and methodological approach in YA2's assessment, went unnoticed. Alongside this the assessment of Melissa was not documented; Care Home 1 states that *"there is no documentation which details the observations undertaken and any conclusions made about the*

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[3] Lerner, JS; Keltner, D (2000). "Beyond valence: Toward a model of emotion-specific influences on judgment and choice". *Cognition and Emotion* **14**: 473–493

suitability [of Melissa] being placed at Care Home 1.

3.6 Care Home 1 appears to be less familiar in taking service users from special schools and is much more experienced in receiving service users from an inpatient environment. In the case of a prospective placement from a special school such as Residential school 4, YA2's risk history needed to be assembled from a wider range of sources. The Care Home 1 IMR states that information received from the school was comprehensive but downplayed the risk. A clear summary of the risk had also been provided within the forensic assessment report, which was listed as sent by Residential School 4 but the exact date of receipt by Care Home 1 is unclear. Nevertheless they were aware that it existed.

3.7 Their IMR described the assessment of YA2 as "*detailed and extensive*" and that it "*followed its own policies and procedures to great effect*". It also stated that YA2's 'Support Plans/ Risk Assessments' were noted to contain "*appropriate strategies and interventions... which related to YA2's assessed needs".* No justification for these conclusions was provided. The IMR is not written in a way that enabled effective learning to be identified and shared with the review, for example there is no indication that any reflection had taken place as regards the information within the forensic risk assessment report.

Finding for Consideration by BSAB

The Forensic Assessment report was a crucial document in order to appreciate the risks that YA2 presented. Neither referencing nor acting on this document was a serious omission. Care Home 1's IMR stated "*that receipt of that report would not have changed its assessment of YA2's suitability for placement at [Care Home 1] or the care arrangements that it put in place*". There is therefore a clear dissonance between the risk outlined in the forensic assessment and the stated position of Care Home 1 and it is clear that the support provided by Care Home 1 did not meet his needs as far as the risks he posed.

Recommendation 1

That Bristol Safeguarding Adults Board should share the concerns expressed in this SCR about the processes and practices adopted by Care Home 1 with the Care Quality Commission.

Recommendation 2

That Bristol Safeguarding Adults Board seeks assurance that Care Home 1 has fully addressed the deficiencies identified by this SCR. Additionally; this SCR should be shared with all authorities which have service users currently placed in Care Home 1.

Placing YA2 in Care Home 1

3.8 Where to place YA2 was an extremely challenging decision for YA2's home authority. The advice they sought from the Learning Disability (Forensic) Consultant Psychiatrist from NHS Trust 1 proved very influential in their decision to pursue a non-secure option and in ultimately choosing Care Home 1.

3.9 The Forensic Assessment report concluded that YA2 was currently not detainable under the Mental Health Act. The YA2's home authority Adult Mental Health Services IMR stated that this conclusion "*clearly removed at that time, albeit remote to a serious event by a few months, an avenue of considering options with respect to transition that would incorporate the use of the Mental Health Act i.e. any hospital environment with a degree of security*".

3.10 The Learning Disability (Forensic) Consultant Psychiatrist from NHS Trust 1 took the view that "*in terms of admitting him to hospital, I think he is probably detainable under Section 3 of the Mental Health Act*". However, he said that this was not necessarily the most appropriate option, recommending instead a specialist residential placement for people with autism, as he felt that YA2 had become "*considerably institutionalised*". In recommending Care Home 1, a significant caveat was added; "*if they (Care Home 1) were to feel that they could not manage him then the only reasonable alternative would be a hospital inpatient placement*". As this review has identified, Care Home 1's view that they could "*manage*" YA2 was based

on an assessment in which there were errors made. This caveat should have prompted YA2's home authority to check that Care Home 1's confidence that they could "manage" YA2 was well founded. This was not done.

3.11 Ultimately, YA2's home authority arrived at the view that "*this degree of restriction (secure hospital placement) would not be in YA2's best interest at that time. Furthermore, the fact that he had neither been charged with any offence nor accepted as meeting the threshold for MAPPA in the UK meant that there were no grounds to consider a placement that would further restrict his liberty, for example in a secure hospital*".

3.12 Deciding what was in YA2's best interests was a challenging decision to take. Supporting that decision by correctly stating that YA2 had not been charged with any offence was undermined by their knowledge that YA2 was suspected of committing an extremely serious criminal offence which YA2's home authority had encouraged Residential school 4 to report to the police from the outset.

3.13 YA2's mental capacity was assessed four times whilst he was at Residential school 4, most recently in October 2013, when he was deemed not to have capacity in a number of areas including free choice of films and computer games. His behaviour was strongly influenced by what he watched and this had led him to behaving in a manner which put others at risk.

3.14 By the time YA2's placement at Care Home 1 was due to begin, YA2's home authority regarded YA2 as "*fully capacitous regarding the move*" (to Care Home 1). This was on the basis "*that staff from Care Home 1 and Residential school 4 who had known and spent adequate time with YA2, confirmed*" this to be the case. On this basis, YA2's home authority concluded that a capacity assessment was not required. The Forensic Assessment report had recommended consideration of a mental capacity assessment under the Mental Capacity Act and, and should his liberty be restricted in any placement, consideration of Deprivation of Liberty Safeguards. This is an important issue because, as the YA2's home authority Adult Mental Health Services IMR states, having assumed YA2 to be "*fully capacitous*", this ruled out the use of the Deprivation of Liberty Safeguards (DoLS)[4] and represents a missed opportunity to consider the legal framework (MHA, MCA and DoLS) available to them.

3.15 A key placement issue for YA2's home authority to satisfy themselves about was whether the risks that YA2 posed could be safely managed at Care Home 1. YA2's home authority needed to ensure that all relevant information about the risks that YA2 posed was shared with Care Home 1 and that Care Home 1 fully considered this

[4] https://www.gov.uk/government/publications/deprivation-of-liberty-safeguards-forms-and-guidance

information in carrying out their assessment of YA2 and subsequently that they were satisfied about the adequacy of the support plans and risk assessments to care for and safely manage YA2 once his placement began.

3.16 YA2's home authority did not obtain assurance that Care Home 1 could safely manage YA2. They allowed Residential school 4 to play a more prominent role in facilitating YA2's placement move to Care Home 1 than would be reasonably expected. YA2's home authority employed an off-island social worker to manage YA2's case that attended transitional planning and review meetings, but it remains unclear how effective this arrangement was.

3.17 A key opportunity for the placing authority to review the suitability of the Care Home 1 placement was when Care Home 1 sent them the support plans/risk assessments they had prepared for YA2 in June 2014. The SCR panel was advised by the representative of YA2's home authority that the commissioning of the placement by YA2's home authority was on the basis that:

- YA2 would receive 1:1 support over the 24-hour period
- a premium for 24-hour support was being paid for.

3.18 Neither of the assumptions that these arrangements were based upon was correct. They did not exercise oversight and obtain the necessary assurance about the effectiveness of the placement of YA2 at Care Home 1. There was a lack of clarity and assessment as to the appropriate level of supervision of YA2 within the placement at Care Home 1 and that this should have been resolved by all parties prior to his placement there.

Finding for Consideration by BSAB

There are substantial challenges for YA2's home authority in placing and subsequently supporting children and adults they, out of necessity, place on the UK mainland. Because of these substantial challenges and the issues identified in this case it is recommended that YA2's home authority make use of this SCR to reflect on their arrangements for placing children and adult's off-island, taking into consideration the separate jurisdiction and legal framework.

Recommendation 3

That Bristol Safeguarding Adults Board write to YA2's home authority to request that it take the necessary actions to ensure that it is able to independently and effectively manage the process of placing children and adults off-island.

Placing Authority: communication with the host authority

3.19 YA2's home authority Adult Mental Health Service's IMR states that "*no communications took place between the commissioners and host authorities. This represents our normal custom and practice when placing someone in a private establishment. Having secured the services of the private psychiatrist to support this placement we were not advised of any Local Authority material relationships at the time. The placement had agreed to liaise with the local health service to alert them to the possibility of referral in the future*".

Finding for Consideration by BSAB

The possibility of placement breakdown would require a "*material relationship*" with the host authority to be established rapidly. The placing authority seems to have not considered the risk that the Forensic Assessment report on YA2 stated he presented to the wider community. This risk included locations such as swimming pools, changing rooms, hotels described as "*high risk*". There were "*material*" issues to discuss with the host local authority. Consideration of using the Potentially Dangerous Persons protocol would have been relevant in this case in order to ensure that there were multi-agency risk management plans in place.

Recommendation 4

That Bristol Safeguarding Adults Board writes to the Department of Health to advise them of the absence of notification of out of area placements by the placing to the host authority so that the Department can consider what action is necessary

Placing Authority: Ambiguity over the level of support to be provided

3.20 There was a lack of clarity between the placing authority and the provider over what 1:1 support for YA2 actually meant. In YA2's case the level and duration of support provided was an issue of the utmost importance about which the placing authority and the provider needed to have a clear and unambiguous view.

Finding for Consideration by BSAB

This SCR has identified that the placing authority and the provider had a differing understanding of what the phrase "*1:1 staff support*" actually means. It would be helpful to all concerned – service users and their families, providers, placing authorities and regulators - for individual staff support levels to be expressed unambiguously within placement agreements.

Recommendation 5

That Bristol Safeguarding Adults Board brings the importance of expressing individual staff support levels unambiguously to the attention of NHS England and suggest that they write to all potential placing authorities to advise them of this. Given the potential for individuals to be placed in England from elsewhere in the UK, and in this case YA2's home authority; NHS England should also communicate this to other relevant jurisdictions.

Limitation of individual risk assessments of service users

3.21 Care Home 1 did not prepare a separate support plan/ risk assessment in respect of the risks YA2 presented to female service users at Care Home 1, or referenced this risk in any of the other support plans for him. Care Home 1 was aware of Melissa's vulnerability to exploitation and abuse. Given their substantial experience of managing an establishment in which service users presented a range of risks to themselves and others, it is surprising that Care Home 1 considered service user risks in isolation.

Finding for Consideration by BSAB

Care Home 1 has now introduced a "*compatibility assessment*" in order to address this omission. It would be prudent for BSAB to seek assurance that it is operating effectively.

Recommendation 6

That Bristol Safeguarding Adults board seeks assurance that the existing safeguarding arrangements that have been put in place to ensure that the risks posed by and to other service users resident in Care Home 1 are managed are working effectively.

Reporting incidents to the police

3.22 Some incidents involving YA2 were reported to the police but none led to a prosecution. Many incidents were not reported to the police. The March 2013 attack on the Residential school 4 staff member should have been reported to the police. Residential school 4 say the incident was not reported to the police at this time as "*it was seen as linked to YA2's autism and his inability to recognise acceptable social behaviour*". However, they accept that the incident should have been reported to the

police and that this was accepted in a meeting with their local police liaison in September 2013 but add that it is not unusual for incidents to occur which could justify reporting pupil's behaviour to the police.

3.23 When Residential school 4 reported the matter to the police in September 2013, the full seriousness of the incident was apparent including YA2's motivation. Unfortunately, the local community officer that Residential school 4 reported the matter to inaccurately advised them that the offence could not be proceeded with because more than six months had elapsed since it was committed. This time limitation applies to Common Assault and some other summary offences[5]. The March 2013 attack was a much more serious offence. In their IMR the Police say that their officer "*should have recorded the offence retrospectively, commenced an inquiry and seen what could still be done in order to best serve the victim of the attack. This approach would have ensured that safeguarding issues as well as investigative issues were considered*".

Finding for Consideration by BSAB

The reticence in reporting incidents involving YA2 to the police had a number of negative consequences;

- managing incidents 'in-house' sent the wrong message to YA2;
- YA2 might be managed on the basis of allegations presumed to be true but untested by investigation;
- any record of incidents could not be assumed to be completely objective and accurate; and
- failure to report matters to the police prevented referral to MAPPA or the securing of relevant criminal justice disposals.

Recommendation 7

When disseminating the learning from this SCR, Bristol Safeguarding Adults Board, and all the bodies which have contributed to the SCR, should take the opportunity to reinforce the importance of full and accurate recording and reporting of safeguarding concerns.

Recommendation 8

That Bristol Safeguarding Adults Board writes to the Department for Education to advise them of the practice of some independent Schools not to report serious crimes allegedly committed by pupils with challenging behaviours, so that the Department can consider whether any action is necessary.

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[5] Magistrates' Court Act 1980 s 127(1)

Finding for Consideration by BSAB

The reluctance to involve the police in the strangulation incident in March 2013 was explained by Residential School 4 as an action which would have been inconsistent with the therapeutic approach of seeking to avoid punitive consequences for undesirable behaviour. The tension between arriving at the most appropriate therapeutic approaches to meet an individual's needs whilst affording others an appropriate measure of protection from the risks they presented is a theme in this SCR. There is a balance to be struck between the desire not to criminalise some behaviour and to manage this within the therapeutic setting against the need to protect others who may be at risk from this behaviour. Incidents should always be reported to the police. This does not automatically mean that a criminal investigation will occur. It would however assist in the development of a better understanding of risks and enable the effective management of these within a multi-agency framework. Those responsible for YA2's care prioritised his therapeutic needs. This inadvertently resulted in the safety of those caring for him being compromised. There may be much for practitioners and managers to reflect on by exploring the decision making in this case.

Recommendation 9

That Bristol Safeguarding Adult Board shares this SCR Report with the authorities in YA2's home authority, and the relevant Safeguarding Adult and Children Boards in Melissa's home area together with NHS Trust 1 so that the SCR can inform training and development.

Transition from Children's to Adults' services: Melissa

3.24 Melissa's home authority has identified a number of areas for improvement in how her transition from children to adult services was managed:

- Child protection enquiries were never followed by an Initial Child Protection Case Conference which would have brought together Melissa, her family and those professionals involved with her. This would have given an opportunity to analyse her needs, and her parents' capacity to respond to those needs. It would have clarified what future action was required to safeguard Melissa.
- Melissa was allocated six social workers over the last two years of her life which may have impacted upon continuity of care and support.
- Melissa did not receive a Leaving Care Assessment and Pathway Plan outlining how her needs would be met.

- Her referral to adult services was made late, just eight months before she turned 18, and the referral lacked detail for someone with such complex needs.
- As one of the minority of local authorities which follow Government guidance[6] by having a named individual with responsibility for autism, this expertise was not utilised to support Melissa through her transition into adult services.

3.25 It is noted that Melissa's home authority plan to carry out a review of their transition arrangements for young people with disabilities aged 16 or above.

Transition from Children's to Adult Services: YA2

3.26 In 2014 YA2's home authority commissioned a "*service diagnostic report*" in respect of children's social care in YA2's home authority. Of particular relevance to this SCR is the following extract:

> *"There is a lack of placement choice for young people and poor support for care leavers: There are limited fostering options for young people and the size of the island and degree of expertise available means that young people with challenging or specialised needs end up being placed off island. This unfortunately has a high risk of breakdown and compromises the delivery of excellent social work support for children looked after and care leavers (simply because of the practical difficulties of living overseas). Provisions in the law for support to care leavers have not been resourced effectively and the statutory responsibilities to support them into adulthood and independence have not been implemented, resulting in too many young people failing to achieve good outcomes in terms of housing, relationships, employment and mental wellbeing."*

3.27 The high risk of placement breakdown was a feature of YA2's case. Indeed, Residential school 4 was the only placement for YA2 which didn't end in breakdown or disruption of some kind however it did end earlier than originally planned due to the risk identified within the Forensic Assessment report.

3.28 The manner in which YA2's home authority managed YA2's transition from Children's to the Adult Services he would inevitably require, was insufficient. The "*service diagnostic report*" also noted that in YA2's home authority "*the statutory responsibilities to support (looked after children) into adulthood and independence have not been implemented*". This deficiency is apparent in the case of YA2 in:

- the premature withdrawal of Children's Services;

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[6] Govt. guidance – Implementing fulfilling lives, 2010
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216129/dh_122908.pdf

- the lack of Adult Disability Services to co-work YA2's case with Children's Services after initial early engagement; and
- The late entry of YA2's home authority's Adult Mental Health Services into planning YA2's transition to adult services.

3.29 There are elements of good practice in the work of agencies with YA2:

- YA2's home authority Children's Services maintained admirable continuity in that only two social workers managed YA2's case for the eleven years he was placed off-island.
- They also funded and facilitated regular visits by YA2's mother and holiday visits by YA2 to YA2's home authority.
- Residential school 4 provided much valuable support to YA2 who made good progress educationally whilst there.
- Residential school 4 implemented a rigorous risk management regime in respect of YA2 as soon as they became aware of the provisional findings of the Forensic Assessment report.
- YA2's home authority Social Services are unregulated. It could therefore afford providers and host authorities which receive placements from YA2's home authority greater confidence that the prior care of those individuals had been managed effectively if YA2's home authority were to submit their transition arrangements to independent inspection.

Finding for Consideration by BSAB

Placing authorities and providers need to ensure that there is a robust placement failure contingency plan when placements are made.

Recommendation 10

Bristol Safeguarding Adults Board considers how best to disseminate the message that placement breakdown contingency plans for out of area placements are essential.

Recommendation 11

Bristol Safeguarding Adults Board to write to YA2's home authority to request that they submit their transition services to independent inspection.

Transitional support for care leavers

3.30 Transition of Looked After Children to adulthood has been the subject of considerable attention and scrutiny in recent years with the cross departmental Care Leavers Strategy published by the Department for Education in October 2013[7], the publication of the Care Leavers Charter[8], the placing of duties on local authorities to provide assistance to care leavers to 21 years (or 25 years if in education or training) and enabling of care leavers to "*stay put*"[9] wherever possible.

Finding for Consideration by BSAB

Adverse outcomes arising from deficiencies in managing transition from children's services to adult services have been a feature of many SCRs in respect of adults. However, there is as yet no central repository[10] for SCRs (and now Safeguarding Adult Reviews) to enable the widest dissemination of learning and to allow issues which feature prominently or repeatedly in SCRs, such as transition, to be considered as part of the national policy agenda.

Recommendation 12

That Bristol Safeguarding Adults Board write to the Department of Health to propose that a central repository of safeguarding adults review reports is established in order to ensure that learning from such reviews is shared more widely and that arrangements are made to periodically analyse safeguarding adults review reports in order to identify significant issues which could require a national policy response.

Provision of services and placements for people with Autistic Spectrum Condition (ASC) and Asperger Syndrome

3.31 Both Melissa and YA2 were young adults with a diagnosis of Asperger syndrome. Both were placed in Care Home 1 which is a specialist residential placement for adults with Asperger syndrome. However, it is evident that this placement may not have been the most ideal placement for either Melissa or YA2.

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[7] Care Leaver Strategy https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266484/Care_Leaver_Strategy.pdf

[8] Care Leaver's Charter retrieved from https://www.gov.uk/government/publications/care-leavers-charter

[9] "Staying Put" Arrangements for Care Leavers retrieved from https://www.gov.uk/government/publications/staying-put-arrangements-for-care-leavers-aged-18-years-and-above

[10] The NSPCC are commissioned by the DfE to operate a central repository of Serious Case reviews in respect of Children and they also provide thematic reviews of the learning identified within these serious case reviews.

3.32 In Melissa's case the placement was 97 miles away from her family home and 179 miles away from the home of her paternal grandparents who had played a significant part in her upbringing. One might also question whether Melissa had developed the maturity and personal resilience to thrive in a placement in which the majority of service users would be male, older than her and potentially pose risks to her given the vulnerabilities identified prior to the placement. It seems likely that Melissa might not have required an out of area placement had her needs been met by local services.

3.33 In respect of YA2, although Care Home 1 was recommended by Learning Disability (Forensic) Consultant Psychiatrist at NHS Trust 1, the lack of knowledge of the ethos and model of provision Care Home 1 were able to provide led to insufficient commissioning of the supervision that YA2 required. The placement could also have been ruled out on the basis that it was mixed-gender environment. Distance from home was an unavoidable consideration for YA2.

Finding for Consideration by BSAB

The extent to which Care Home 1 was not a suitable placement for both Melissa and YA2 raises the question of whether there is sufficient provision for adults with ASC and Asperger syndrome. It also raises the question of whether there is sufficient knowledge and expertise within placing authorities and the bodies which advise them on these matters, concerning the range of placements qualified to meet the needs of the service user they wish to place. It also raises the question of whether enough priority is being afforded to the development of local services for adults with ASC and Asperger Syndrome.

Recommendation 13

That Bristol Safeguarding Adults Board write to NHS England to advise them of this SCR and the messages which emerge from the SCR which indicate there is a lack of suitable provision for adults with ASC and Asperger Syndrome, insufficient expertise in placing authorities to identify the most suitable placements and a need to develop more local ASC and Asperger Syndrome services.

List of Recommendations

Recommendation 1

That Bristol Safeguarding Adults Board should share the concerns expressed in this SCR about the processes and practices adopted by Care Home 1 with the Care Quality Commission.

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That Bristol Safeguarding Adults Board seeks assurance that Care Home 1 has fully addressed the deficiencies identified by this SCR. Additionally; this SCR should be shared with all authorities which have service users currently placed in Care Home 1.

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That Bristol Safeguarding Adults board seeks assurance that the arrangements they have put in place to ensure that the risks posed by and to, other service users resident in Care Home 1 are working effectively.

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When disseminating the learning from this SCR, Bristol Safeguarding Adults Board and all the bodies which have contributed to the SCR, should take the opportunity to reinforce the importance of full and accurate recording of safeguarding concerns.

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Bristol Safeguarding Adults Board considers how best to disseminate the message that placement breakdown contingency plans for out of area placements are essential.

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Was the death of Melissa predictable?

3.34 In terms of considering whether Melissa's death could have been predicted, it is considered that the death would have been *predictable* if there was evidence from the perpetrators' words, actions or behaviour at the time that could have alerted professionals that they might become imminently violent, even if this evidence had been unnoticed or misunderstood at the time it occurred.

3.35 YA2's attack on the female member of staff at Residential school 4 took place nineteen months prior to the murder of Melissa at Care Home 1. The full severity of the March 2013 attack was revealed by the Forensic Assessment report which discovered that YA2 had strangled the female member of staff with the intention to kill her in order to have sex with her.

3.36 The Forensic Assessment report also brought together the detail of previous incidents involving YA2 from which it was possible to discern a pattern of escalating behaviour over the years which preceded the March 2013 attack.

3.37 The authors of the Forensic Assessment report said that they were of the opinion that YA2 presented "*a high risk of future physical and sexually harmful behaviour*". They stressed that it was "*therefore imperative that a robust risk management strategy is adopted within current and future placements*". They then recommended a number of points which any risk management plan for YA2 should contain.

3.38 Amongst the report's recommendations were:

- Highly structured and supervised with a high staff ratio;
- Staff should be made aware of his victim profile – young petite women who he can easily overpower;
- Staff should be aware that YA2 goes to some lengths to identify potential victims including taking an interest in staff rotas;
- Extreme care should be exercised with regard to YA2's access to the wider community.

3.39 The Forensic Assessment report was received by Residential school 4 in October 2013 and shared with YA2's home authority, which were responsible for securing an appropriate adult placement for YA2 after Residential school 4 advised them that they lacked the expertise to safely manage YA2. The risks that YA2 presented and the steps necessary to manage those risks were clear. Residential school 4 immediately enhanced their support plans/risk assessments for YA2 to reflect the contents of the Forensic Assessment Report when it was received by them.

3.40 However, the "*robust risk management strategy*" recommended by the Forensic Assessment report and implemented by Residential school 4, was not reflected in the

approach adopted in the Care Home 1 Support Plan/Risk Assessments prepared for YA2. The reasons for this are addressed elsewhere in this report. This divergence resulted in opportunities for the "*physical and sexually harmful*" behaviour the Forensic Assessment report warned of.

3.41 It is concluded that without the implementation of robust risk management an attack on any female that fitted his victim profile was therefore probable given YA2's history of violent assaults in his previous placements if not entirely predictable.

Was the death of Melissa preventable?

3.42 In terms of preventability, it is considered that the death would have been *preventable* if there was evidence that professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take the steps to do so.

Care Home 1

3.43 Care Home 1 did not make use of the Forensic Assessment report in determining whether YA2 could be offered a placement with them, or in assessing and managing the risks that YA2 could pose to others, including female members of staff or female service users at Care Home 1. Care Home 1 states that it was not provided with this report during the assessment. Care Home 1 did not change their risk management plans when the report was eventually shown to senior staff members. When Care Home 1 discovered the Forensic Assessment report on 10th October 2014 it was still theoretically possible to address the risks outlined in the report and potentially avert the attack on Melissa which occurred two days later.

3.44 Care Home 1 do not know when they received the Forensic Assessment Report but it was listed as enclosed in documentation about YA2 prior to his placement at Care Home 1. Had they noted and read the document they would have had the knowledge and opportunity to adequately assess YA2 and make a better informed decision over whether or not to offer him a placement at Care Home 1. Had they still decided to offer him a placement, then the recommendations contained in the Forensic Assessment report would have provided Care Home 1 with the knowledge and opportunity to prepare support plans/ risk assessments commensurate with the risks he presented.

3.45 The Forensic Assessment report was not the only key source of knowledge available to Care Home 1. Details of the regime introduced at Residential school 4 to manage the risks presented by YA2, including the bolstered support plan/ risk assessments introduced after Residential school 4 received the Forensic Assessment report, were shared with Care Home 1. In addition, the report commissioned by YA2's home

authority from NHS Trust 1 Learning Disability (Forensic) Consultant Psychiatrist appears not to have been shared with Care Home 1.

Residential School 4

3.46 Residential school 4 accepts that they should have reported YA2's March 2013 attack on their member of staff to the police at the time it occurred. It remains difficult to speculate what the impact of prompt reporting might have been.

3.47 When Residential school 4 reported the March 2013 attack to the police, the officer inaccurately advised them that the offence could not be proceeded with because more than six months had elapsed since it was committed. The failure to investigate this matter was another missed opportunity to intervene in YA2's life.

3.48 Residential school 4 does not appear to have communicated the significance of the Forensic Assessment report to Care Home 1 as unambiguously as they should have. In their initial letter to Care Home 1, Residential school 4 advised that YA2's placement had been "*successful for him*" and that "*he is now ready to move on to an adult service.*" The implication being that YA2's departure from Residential school 4 was planned, when in fact his placement was ending early because Residential school 4 had advised YA2's home authority that they lacked the specialist expertise to manage the risks YA2 presented.

YA2's Home Authority

3.49 YA2's home authority, as the placing authority, did not manage the transition of YA2 from children's to adult's services effectively. They did not exercise an appropriate degree of oversight of the arrangements to place YA2 in Care Home 1.

3.50 As soon as YA2 attained the age of 18 years, YA2's home authority Children's services ended their involvement in his life. Much of the accumulated knowledge of YA2's troubled history was relinquished at a time when key decisions about where he went after Residential school 4 had yet to be made. As a result, a social worker with no previous knowledge of YA2's case assumed responsibility for representing YA2's home authority in the discussions about his future placement. It is not known how well this social worker was briefed or whether there was any handover from YA2's home authority Children's Services. This social worker was employed by Adult Mental Health services which then became the service responsible for placing YA2. They had very little experience of placing adults in placements other than hospital settings and appear to have informally sub-contracted much of the responsibility for facilitating the Care Home 1 placement to Residential school 4. This approach was, given what was known about YA2, fraught with risks, one of which was that they denied themselves the opportunity to exercise oversight of the sharing of information about YA2's risk between Residential school 4 and Care Home 1.

3.51 YA2’s home authority agreed a contract with Care Home 1 which stipulated 1:1 supervision of YA2 without spelling out that in respect of YA2, this meant 1:1 supervision for 24 hours per day. There was a lack of clarity and assessment as to the appropriate level of supervision of YA2 within the placement at Care Home 1.

3.52 ‘YA2’s home authority also did not notice that the Care Home 1 risk assessments did not reference the Forensic Assessment report and that did not reflect the full nature of the risk. In YA2’s home authority's brief to Care Home 1 there was only a reference to YA2 being a threat to female staff. There was no reference to him being a threat to any other categories of female such as female service users or members of the public.

3.53 It is therefore concluded that the death of Melissa could have been prevented. The Forensic Assessment report provided professionals in the placing authority and Care Home 1 with the knowledge and opportunity to implement measures that would have reduced but not necessarily removed the likelihood of the violent incident occurring.

Conclusion

The death of Melissa was a tragedy from which clear lessons have been identified as outlined in detail within this report. It is recommended that copies of this report be provided to the agencies involved in this review to enable them to consider their practice as outlined in this report and to take such further action as the board consider necessary.

Appendix 1

Membership of Serious Case Review Panel

Independent Chair	Hospital Trust
Safeguarding Adults Service Manager	Bristol City Council
Mental Health Service Manager	YA2's home authority
Interim Head of Adult Social Care and Health Partnerships	Melissa's home authority Adult Social Care
Detective Chief Inspector	Avon and Somerset Police
Detective Chief Inspector	West Mercia Police
Support Officer	Bristol Safeguarding Boards
Independent Author	

Appendix 2

Glossary

ADHD - attention deficit hyperactivity disorder is a group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness. Common symptoms of ADHD include: a short attention span or being easily distracted, restlessness, constant fidgeting or over-activity, being impulsive.

Autism - is a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them. It is a spectrum condition, which means that, whilst all people with autism share certain difficulties, their condition will affect them in different ways. Some people with autism are able to live relatively independent lives but others may have accompanying learning disabilities and need a lifetime of specialist support. People with autism may also experience over- or under-sensitivity to sounds, touch, tastes, smells, light or colours.

Asperger Syndrome is a pervasive developmental disorder that falls within the autistic spectrum. It is a life-long condition, which affects about 1 in 200 people, more commonly in men than women. Those with Asperger Syndrome are usually of average or above average intelligence. The condition is characterised by difficulties with social interaction, social communication and flexibility of thinking or imagination. In addition, there may be sensory, motor and organisational difficulties. This condition was first identified over 50 years ago by Hans Asperger, a Viennese paediatrician. A pattern of behaviours and abilities was identified, predominantly amongst boys, including a lack of empathy, impaired imagination, difficulty in making friends, intense absorption in a special interest and often problems with motor co-ordination. Whilst people with Asperger Syndrome will exhibit some or all of these characteristics to a greater or lesser degree, many tend to experience isolation and a lack of understanding in their everyday lives, which often results in frustration, anger, depression and a lack of self-esteem.

Child in Need (CIN) – is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable standard of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled.

Deprivation of Liberty Safeguards (DoLS) aim to ensure that those who lack capacity and are residing in care home, hospital and supported living environments are not subject to overly restrictive measures in their day-to-day lives.

Looked After Children – a child is looked after by a local authority if s/he is in their care by reason of a care order or is being provided with accommodation under Section 20 of the

1989 Children Act for more than 24 hours with the agreement of the parents, or of the child if s/he is aged 16 or over (Section 22(1) and (2) of the 1989 Children Act).

Mental Capacity Act: The Act is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 or over.

Mental Health Act: The 1983 Act (which was substantially amended in 2007) allows people with a mental disorder to be admitted to hospital, detained and treated without their consent – either for their own health and safety, or for the protection of other people.

Multi-Agency Public Protection Arrangements (MAPPA) were established by the Criminal Justice Act 2003 in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders. The core MAPPA members are the Police, Prison service and Probation service in each area.

Appendix 3

Events following the assault on Melissa which led to her death

The terms of reference include a requirement to consider:

- How appropriately was the family of Melissa supported after the incident? In particular, how effectively were the needs of Melissa and her family addressed whilst she was being treated in intensive care and NHS trust 2 following the incident?

In addition the terms of reference also ask:

- How effectively did the provider, the placing authority in respect of YA2 and the host authority work together following the incident?

These matters are of significant importance however they do not contribute to the learning regarding events that precipitated the assault on Melissa by YA2 which led to her death. Therefore these matters are outlined here within an appendix rather than within the main body of the report.

Melissa's Family

Melissa's family said that the way the family was dealt with in NHS Trust 2, where their daughter was being cared for after the attack, was an utter disgrace. They said that when the family member was "*kicked out*" of the hospital he was "*beside himself*" with distress. They asked how what their daughter had said about a family member could be "*treated as gospel*" and relied upon to remove the family member from the hospital ICU in which she died.

Post incident: The exclusion of Melissa's family member from NHS Trust 2 ICU

The decision to ask Melissa's family member to leave the NHS Trust 2's ICU on Wednesday 15th October 2014 caused the family immense distress. There is some dispute over what was said in the phone call between the Bristol Crisis Team intensive practitioner and the staff nurse on the Intensive Care Ward which led to the exclusion of Melissa's family member. The former said she rang to enquire about Melissa's condition and during the call advised the staff nurse of wishes expressed by her whilst she had been receiving care from the Crisis Team. There exists a lack of clarity in the recording of what was stated by both parties. There is a clear need for accurate agreed recording of potentially contentious information.

The staff nurse escalated the matter and during a discussion which also involved the safeguarding team for the NHS Trust, staff wrestled with the dilemma of whether they should respect what they believed to be the expressed wishes of their patient or place greater emphasis on the impact on the grieving family of respecting her wishes. The NHS Trust IMR states that the Trust's safeguarding lead sought verification through two phone

calls to the Intensive Practitioner. However, it is unclear how accurately verification was obtained given the differences which exist between the information the NHS Trust say they received and the information the Intensive Practitioner says they provided.

The Bristol Crisis Team intensive practitioner was apparently unaware of the weight given to the information she shared with the staff nurse or the fact that a significant decision would be based on it. Had she been aware, she believes she would have advised that information be sourced from services which had had longer contact with Melissa.

Events which followed the attack on Melissa at Care Home 1

Melissa was initially taken to the local Emergency Department before being transferred to an acute Hospital as she required specialist neurosurgical assessment and care.

The following morning, Care Home 1 informed YA2's home authority that YA2's placement was being terminated with immediate effect due to the risk to other residents should he return to Care Home 1.

YA2 had been held in police custody since his arrest late the previous evening. Despite this the police had been unable to interview him because of objections from his legal representative. As no evidence could be gathered by interview, and the time limit for detention was approaching, the police released YA2 on police bail.

Due to the nature of the incident and concern over the risk that YA2 might pose to other service users, Bristol City Council declined to offer an emergency placement. The pragmatic solution ultimately arrived at was that YA2 would remain in the police station canteen overnight accompanied by a number of police officers.

The next day YA2 moved to a flat within the estate of the company that owned Care Home 1 in which he was supported by Care Home 1 staff. YA2's home authority funded this arrangement whilst they continued to seek an alternative placement.

Care Home 1 subsequently advised YA2's home authority that supporting YA2 in the flat was having a detrimental effect on their staff and so YA2's home authority agreed to send over a team to manage the situation, with a view to returning YA2 to YA2's home authority whilst a secure placement was obtained. The YA2's home authority team arrived during the afternoon of Wednesday 15th October 2014.

Post Incident: the effectiveness with which the provider, the placing authority and the host authority worked together

After his initial arrest, the police had no legal alternative to granting YA2 bail the day after he attacked Melissa. YA2's home authority had been unable to obtain an alternative placement. Bristol City Council declined YA2 an emergency placement due to the nature of the incident and concern over the risk that he posed to other service users.

The solution ultimately arrived at was that YA2 would remain in a police station canteen overnight supervised by a number of police officers whilst efforts were made by Care Home 1 to prepare a currently vacant flat within their estate to temporarily accommodate YA2 until YA2's home authority could arrange an alternative.

This was a pragmatic solution to which it is understood that YA2 willingly consented. The decision was also endorsed by his appropriate adult. A police officer fitted with a "bodycam" was briefed to remain with YA2 so that any interaction between officers – who had been briefed not to discuss the attack on Melissa with him - and YA2 was recorded.

Supervised by police officers within a police building, the argument could be advanced that YA2 was effectively detained without any legal power. However, YA2 never asked to leave. Had he asked to leave, and been prevented from doing so, this would have been unlawful. Fortunately, this situation did not arise.

Neither Care Home 1 as provider of YA2's placement nor YA2's home authority as placing authority, had agreed any contingencies in the event of placement breakdown. When out of area placements break down, particularly when there is little or no warning of an impending breakdown, considerable difficulties are almost inevitable. The traumatic manner in which Melissa's out of area placement came to an end also left her home authority with a host of very sensitive issues to contend with.

It is therefore incumbent on the placing authority and the provider of out of area placements to jointly agree a placement breakdown contingency plan. Such a contingency plan is unlikely to have generated a "*readymade*" solution to the circumstances of this case. However, it could have provided all parties with a framework with which to approach the situation.

Finding for Consideration by BSAB

Placing authorities and providers need to ensure that there is a robust placement failure contingency plan when placements are made.

Recommendation

Bristol Safeguarding Adults Board considers how best to disseminate the message that placement breakdown contingency plans for out of area placements are essential.