



BRISTOL SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW USING THE

SIGNIFICANT INCIDENT LEARNING PROCESS

OF THE CIRCUMSTANCES CONCERNING

Kamil Ahmad
and
Mr X

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1. Introduction to the Safeguarding Adults Review.

- 1.1 Bristol Safeguarding Adults Board commissioned this Safeguarding Adults Review in response to the murder of Kamil Ahmad, a Kurdish male, by Mr X, a white British male, in 2016. Both men were residents in the same accommodation provided for individuals with mental health needs. Mr X had a significant forensic history and had been detained in secure mental health facilities for a large part of his adult life.
- 1.2 Mr X and Kamil were tenants of Milestones Trust and their flats were in a nine bedroom converted Victorian house with a mixture of self-contained flats and bedsits sharing bathroom and kitchen facilities. Their flats were on different floors, although the layout of the building meant that Kamil would inevitably pass Mr X's flat when entering or leaving the premises, speaking to staff, or using communal facilities.
- 1.3 Milestones Trust seeks to support people who are experiencing a range of mental health difficulties to enable them to develop the skills to live independently.
- 1.4 The building was staffed by a small rota of support workers who provide individual support for tenants for a set number of hours during the working week. There was no staff cover overnight or at weekends.
- 1.5 There was tension between the two men, which had existed for the previous three years. The ill feeling between them was provoked by the resentment Mr X displayed towards Kamil because of his race and status as an asylum seeker. There were periods, particularly when Mr X was unwell, that this dislike escalated to verbal and sometimes physical aggression.
- 1.6 Kamil had arrived in the UK as an asylum seeker. He had diagnoses of PTSD (Post Traumatic Stress Disorder) and Obsessive Compulsive Disorder (OCD). Several of the agencies who worked with Kamil believed he had a level of learning difficulty which affected his ability to benefit from their services. This had not been formally diagnosed earlier and it was not until May 2016 that Kamil was referred by his GP for a clinical diagnosis of a possible learning disability. This assessment was not completed before Kamil's death.
- 1.7 At the time of his death Kamil was seeking a judicial review of the decision not to grant him asylum and the decision by Bristol City Council that he no longer met the criteria for care and support under the Care Act 2014.
- 1.8 The fatal assault occurred soon after Mr X had been discharged from hospital where he had been detained under Section 2 of the Mental Health Act¹. Mr X was subsequently tried and convicted for the murder of Kamil and received a life sentence.

¹ Section 2 of the Mental Health Act (MHA) 1983 is the legal provision which allows a person to be detained for assessment of a mental disorder for up to 28 days.

- 1.9 This Review is concerned with the services provided to both men in an attempt to understand the reasons for decisions made at the time and to improve services in the future.

2 The Decision-Making Process.

- 2.1 The Care Act 2014 states that Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) when an adult with care and support needs dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.² Safeguarding Adult Boards must also arrange a SAR if an adult in its area has not died, but the Board knows or suspects that the adult has experienced serious abuse or neglect.
- 2.2 In addition to the above, Boards might select cases for either of the reasons noted in the statutory guidance:
- Where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults.
 - To explore examples of good practice where this is likely to identify lessons that can be applied to future cases.
- 2.3 The Bristol Safeguarding Adults Board (BSAB) commissioned Review Consulting³ to undertake the Safeguarding Adults Review using the Significant Incident Learning Process (SILP) methodology.

3 The Key Principle of the Significant Incident Learning Process (SILP).

- 3.1 The key principle of the SILP is the engagement of frontline staff and first line managers as active participants in the review process, alongside members of the BSAB Safeguarding Adults Review Sub Group and designated and specialist safeguarding staff. The involvement of frontline staff and first line managers improves the quality of the review and adds important context to written reports and a greater commitment to learning and dissemination of the lessons from the review.
- 3.2 The process focuses on understanding why key decisions were made in a certain way at a particular time. It highlights what factors in the system contributed to their decision making at that time. The SAR process is separate from any potential grievance process or disciplinary action. The fundamental tenets are concerned with

² Kamil was assessed as having Care and Support needs in the period covered by this Review, these needs were re-assessed and had changed before he died. The Bristol Safeguarding Adults Board believed that it would be helpful to learn the lessons from this case and commissioned the SAR on this basis.

³ Review Consulting is an independent company that specialises in undertaking case reviews for Adult and Children Local Safeguarding Boards.

open and transparent learning from practice, to improve inter-agency working. It also highlights what is working well and examples of good practice.

3.3 This engagement comprises:

- Management reviews being commissioned from all the agencies/providers engaged with the subjects of the review during the scoping period,
- A Learning Event involving Practitioners, Managers and Safeguarding Lead professionals coming together for a day,
- All management reviews being shared with participants at two Learning Events,
- A draft Overview Report which critically reflects the management reviews that gives equal weight to the comments and perceptions of the participants in the Learning Event,
- A Recall Day where the first draft of this Overview Report is debated.

4 Agency Involvement.

4.1 Management Reports were received from the agencies working with Kamil and Mr X at the time of the incident and others who had relevant background information to contribute.

- Bristol City Council – Adult Social Care and Support Services (Bristol City Council Adult Social Care Services provided support to Kamil through the Asylum Team and the Care and Support Team. Mr X was referred for an assessment by the Care and Support Team and for a mental health assessment).
- Cygnet Health Care (Kewstoke Psychiatric Hospital where Mr X was an inpatient).
- Avon and Somerset Constabulary (Police force who had contact with Kamil and Mr X).
- Avon & Wiltshire Mental Health Partnership NHS Trust (Health Trust responsible for Mr X's mental health care in the community and inpatient psychiatric care).
- Milestones Trust (Housing Provider for Mr X and Kamil).
- Bristol Clinical Commissioning Group/NHS England (GP services to Mr X and Kamil)
- Stand Against Racism and Inequality (SARI) (Charity supporting victims of hate crime who supported Kamil)
- Bristol Refugee Rights (Charity which provides services to asylum seekers and new refugees in Bristol who worked with Kamil)

- Trauma Foundation South West (Charity providing counselling and psychotherapy to traumatised refugees and asylum seekers who worked with Kamil)
- United Communities (The housing management agency who provided advice on housing issues to Milestones Trust, they had no direct contact with Kamil or Mr X)
- Emergency Duty Team (An emergency social work service for the Unitary Authorities of Bath and North East Somerset, Bristol, North Somerset, and South Gloucestershire which had contact with Mr X).

5 The Learning Event

- 5.1 The Learning Event included 30 staff from agencies working with Mr X and Kamil. Their involvement ranged from front line practitioners who had worked with one or both men on a regular basis, through to managers and management report authors.
- 5.2 All participants contributed to the review with candour and honest reflection on their actions and the services provided by their respective agencies. Accounts of the murder were in the public domain following the conclusion of the trial, and these details were particularly distressing for individuals who had worked on a day-to-day basis with the two men.

6 Key Episodes

- 6.1 The report is structured around the analysis of “key episodes”. A key episode can be a single event or a period where there were significant changes in the circumstances of the case which require further analysis. A key episode can be good or problematic and the use of the word “key” emphasises that this is not a list of every event in a person's life; rather it is intended to shine a light on those events which seem significant in understanding the decisions made at the time.
- 6.2 Inevitably there is some overlap between key episodes due to the complex interface between different services.

7 Engagement with Relatives

- 7.1 Some of Kamil's family members agreed to meet with one of the reviewers and the Bristol Safeguarding Adults Board Business Manager to discuss their view of the services offered to their relative. With the family's permission, an interpreter who had known Kamil for several years also spoke with one of the reviewers and the Bristol Safeguarding Adults Board Business Manager to share his perceptions of Kamil's life and the challenges he faced.

- 7.2 Family members also provided a copy of the victim impact statement they submitted to the court at the trial of Mr X. This is a personal and heartfelt tribute to a much loved family member. The statement also affords an appreciation of Kamil's early life and formative experiences which were unknown to many of the professionals working with him.
- 7.3 Mr X is currently detained in a secure hospital; contact has been made with him but he was not able to participate during the period in which the review was conducted. Subsequently he has expressed a wish to read the Overview Report prior to publication and his perception of the care and support offered to him will be shared with Bristol Safeguarding Adult Board. Mr X's family have declined to contribute to the review process.

8 Key Episode 1- Incidents prior to the scoping period (January 2013 – March 2016)

- 8.1 Mr X had moved into Milestones Trust supported accommodation in 2010. He had been living previously in a registered residential care home with 24 hour staff support. Kamil moved to the same premises in January 2013, his placement was funded by Bristol City Council following an assessment of his care needs. Although this accommodation is recognised as supported accommodation, it is not staffed in the evenings or at weekends.
- 8.2 The first recorded incident between Mr X and Kamil occurred on 23rd June 2013, an altercation which occurred when Mr X tried to enter Kamil's room uninvited. No staff were on duty at the time, but the incident was reported to them the following day.
- 8.3 On 6th October 2013 the Police recorded a racially aggravated common assault where Mr X had repeatedly punched Kamil in the communal area of their accommodation. Kamil had attended the Police station with an interpreter and made a statement. The incidents were further investigated by staff at Milestones Trust and despite concerns about the effect of a Police interview on Mr X, he was interviewed by the Police on 22nd October 2013. Mr X's version of events was that he had punched Kamil who had attacked him first. No further Police action was taken; because of the lack of corroborating evidence meant that the incident did not meet the charging threshold.
- 8.4 Although the Police could have cautioned Mr X for making racist remarks, it was accepted that Mr X's mental health played a part in his behaviour on the day of the incident and it was essential to support and manage this going forward. Mr X apologised for the racist words he had used stating that they were in the heat of the moment.
- 8.5 Milestones Trust issued Mr X with a written warning about his behaviour. At the time, the incident was seen to be relating to Mr X's mental health rather than the beginning of him targeting Kamil.

- 8.6 On 16th December 2013 a further incident occurred when Mr X returned to Milestones Trust following a night out drinking. He banged on Kamil's door until he answered and then punched him in the face twice. Mr X was arrested and again detained under the Mental Health Act.
- 8.7 Kamil was clear that the incidents were racially motivated and in particular aimed at his nationality. A referral to SARI (Stand Against Racism and Inequality) was made on both occasions.⁴
- 8.8 On 14th January 2014, whilst Mr X was in hospital, Milestones approached the courts for an injunction preventing his return to the property as he was in breach of his tenancy. The Judge rejected this because Mr X did not attend court. Milestones Trust issued a final warning to Mr X regarding his behaviour at this point.
- 8.9 On 31st January 2014 a safeguarding meeting took place between Milestones Trust, Police, Bristol City Council (BCC) Adult Social Care and Support Services and the Care Coordinator to discuss the dynamics between Mr X, Kamil and another female resident, and how they could safely be managed at the property. Mr X had been spoken to and agreed to abide by the conditions of his tenancy. He understood he was on a final warning at this point and any further breach could result in eviction.
- 8.10 Kamil was offered a place at a different property, but he did not want to move because the proposed alternative accommodation was a considerable distance from the community and support networks he had established. Social Care produced a protection plan which was shared with all parties/partners.
- 8.11 Milestones Trust recorded six incidents directly between the two men in the period between Kamil starting his tenancy in January 2013 and the scoping period for this review in April 2016. In the same period, they also recorded six incidents where Mr X had behaved in a sexually inappropriate way towards other residents or staff. The incidents are not evenly spread throughout the 3 years; between October 2014 and November 2015, no incidents involving Kamil and Mr X were reported. However, there is evidence of an emerging pattern of an increase in these incidents and changes to Mr X's medication and his abuse of alcohol.

9 Key Practice Episode 2 – Safeguarding Concerns April/May 2016

- 9.1 A safeguarding referral was made in respect of Kamil on 4th April 2016. Milestones Trust cited concerns for Kamil due to the escalation in threatening behaviour from Mr

⁴ SARI is a charity supporting those facing racism & hate. SARI worked with Kamil between May 2014 and April 2015, it was agreed that SARI would support Kamil to get a better response to the assaults by liaising with Milestones Trust and the Police. SARI would report the incidents to the council and request an investigation of the incidents; SARI would also monitor the Police investigation and support Kamil's view that action should be taken against Mr X.

X, although their referral did not identify the incidents as hate crimes. At this time all safeguarding referrals were initially screened by a Triage Team in the City Council. The Triage Team discussed the referral with Milestones Trust and it was agreed that they would undertake their own internal investigation.

- 9.2 The following day (5th April) Kamil attended a local Police station supported by Milestones Trust staff and complained about harassment from Mr X, which had been ongoing for the last 2 weeks. The Police recorded the crime as a hate crime, which gave Kamil status of an "enhanced victim" and he was referred to Lighthouse Victim and Witness Care for support⁵. Unfortunately, Kamil did not respond to Police attempts to contact him and as a result it was not possible for them to complete a risk assessment. Background checks revealed that Kamil had been a repeat victim of racially aggravated assault by Mr X in the past, and they lived at the same address.
- 9.3 Two weeks later the case was reviewed and allocated for further investigation within the Police. The Police liaised with Milestones Trust, who shared the information that Mr X had received a final warning regarding his tenancy. Milestones Trust also informed the Police that Kamil was planning to move from the premises within the next 10 days. This was incorrect, and it seems clear that Kamil never considered moving as a realistic option.
- 9.4 The Police made three attempts between 20th April and 10th June to take a statement from Kamil with an interpreter. The Police formed the opinion that Kamil was either unavailable or unwilling for one reason or another to take up these appointments. On at least one occasion there appears to have been a breakdown in communication with differing accounts provided to the review. Kamil's interpreter said that on one occasion he was waiting with Kamil for the Police who did not arrive. The interpreter said that he called to re-arrange the appointment and was waiting for the Police to call him back with a new time. The Police Call handler reports that they received a call from the interpreter and believed he was cancelling the appointment. A Police officer finally spoke to Kamil directly on 10th June; Kamil informed him that he did not wish to pursue a complaint or make a formal statement, but he wanted Milestones Trust to move Mr X to another address and believed the staff were looking into this.
- 9.5 Social Care contacted Kamil on 5th May in relation to the Safeguarding Referral, the referral had already been in the system for twenty-three days before it was sent to the Social Work Team for allocation on 27th April and allocated to a senior practitioner for further enquiry.

⁵ Lighthouse is the Integrated Victim and Witness Care department within Avon and Somerset Constabulary. Lighthouse offers an enhanced support service to vulnerable, intimidated, or persistently targeted victims of crime and anti-social behaviour, and victims of serious crime. An "enhanced victim" is entitled to support from Lighthouse and an assessment of their needs.

- 9.6 When the allocated worker visited Kamil to discuss the content of the Safeguarding Referral no interpreters were available, despite several attempts to find one.⁶ The interview established that Kamil was aware that the Police were considering further action and considered the incident a hate crime. The Social Worker was made aware that the possibility of moving to a different flat was also discussed with Kamil, but he had declined the offer because the alternative was too far away from his community and the services he used on a regular basis.
- 9.7 The Safeguarding Referral was closed and marked No Further Action (NFA) on 19th May; the explanation given for the closure was that *'Mr Kamil was not a vulnerable adult. He is in the process of being discharged from social services. He is able to call for Police assistance if needed and did so in this case'*.
- 9.8 Kamil was informed that he was no longer eligible for support from the City Council on 9th June 2016. He was given four weeks' notice of this decision, it was later discovered that Milestones Trust required an eight week notice period to end the tenancy and therefore the City Council agreed to extend their support to cover this period. This was an extremely traumatic event for Kamil, and the extent of his distress was not fully appreciated at the time. Further limited supported may have been available, but the loss of his flat and all it represented was very difficult for him to cope with.

10 Key Practice Episode 3 – Mr X's deteriorating mental health April 2016 – June 2016

- 10.1 On 26th April, Mr X refused to have an injection of antipsychotic medication when the nurse came to administer it. Mr X had previously been prescribed Clozapine in 2010. This is a powerful and effective drug in treating schizophrenia. The drug is subject to strict monitoring requirements because it is associated with serious side effects.
- 10.2 Because of adverse indicators Mr X medication was changed in November 2015. He was prescribed a different antipsychotic medication, Risperidone, which required twice monthly intramuscular injection to help ensure his compliance with his treatment. The effects of his medication were also altered by his use of alcohol and cannabis.
- 10.3 Milestones Trust informed the Care Coordinator of their concerns in the changes in Mr X's behaviour. The Care Coordinator visited the home on 27th April and confirmed that Mr X had eventually agreed to take his medication. The Care Coordinator discussed with staff from Milestones Trust about making a referral to BCC Adult Social Care and Support Services for an assessment of Mr X's Care and Support needs.
- 10.4 The Care Coordinator made a referral to BCC Adult Social Care and Support Services on 5th May 2016 for an assessment of Mr X's care and support needs. This had been prompted by the threat of eviction of Mr X from Milestones Trust. Unfortunately, the

⁶ In situations where no interpreter available practitioners have the option of using Language Line a telephone-based translation service. It is not clear why this was not used in this case.

referral was not accepted at the time because the supporting documentation was not attached as required.

- 10.5 On 24th May a support worker at Milestones Trust recorded for the first time Mr X talking about murder and not caring if he spent the rest of his life in jail. The details of the conversation were passed verbally to the Community Mental Health Services Team, but no further action was taken. In hindsight this conversation gains a significance that was not apparent at the time, the context was a general conversation, with passing reference by Mr X to his thoughts and feelings.
- 10.6 On 25th May, in the early hours of the morning Mr X had contacted the Police stating that Kamil should be detained on terrorist charges and that two years previously he had raped a female resident in his flat. Police investigated the allegation; a Supervisor reviewed the crime and requested a Victim Care Strategy to support an identified Enhanced Victim of a serious sexual assault allegation. A Detective Sergeant reviewed the crime and identified the alleged victim (who was in a Mental Health Hospital at the time).
- 10.7 The Police also looked at other reports made by both Mr X and Kamil and identified a pattern of incidents between them. The Police contacted the alleged victims' mental health worker and asked them to hold a letter until such time she was well and released from the Hospital. The letter disclosed a third party allegation of a serious nature and invited the female to contact police if she would like to report any matter. The alleged victim declined, and the investigation ended but the incident is a further example of Mr X's developing obsession and targeting of Kamil.
- 10.8 A more serious series of events commenced on the weekend of the 4th/5th of June. Mr X had admitted to smoking cannabis and displaying an escalating pattern of sexualised behaviour within the accommodation. On 8th June a staff member from Milestones Trust contacted the Police to report an incident of indecent exposure by Mr X. In the context of previous concerns about Mr X's behaviour towards female residents this raised the level of concern that Mr X was becoming unstable and his health deteriorating.
- 10.9 The possibility of a voluntary admission to hospital was discussed with Mr X by his Care Coordinator on 9th June, which he refused. The following day, Friday 10th June Milestones Trust staff found 34 notes which Mr X had pushed under the office door. They included delusional ideas about his abilities, comments on his current state of mind, comments about the mental illness of other tenants living in the property, and one which included threats to kill named tenants (including Kamil) and "everybody else on the street". Some of the notes contain graphic sexual references.
- 10.10 The notes acted as a catalyst which set in train a course of action which would eventually lead to Mr X being detained under the MHA for further assessment. The initial response from Milestones Trust was to raise concerns with the Community Mental Health Service team and inform them of the notes and the threats to kill.

- 10.11 Staff from the Community Mental Health Service Team and Crisis Team met with Mr X at the accommodation later that afternoon on 10th June. Mr X had accepted his antipsychotic medication, but due to a shortage of beds he remained at the property over the weekend. Milestones Trust staff were appropriately concerned about the vulnerability of other tenants and staff. Contingency plans were in place that there would be no lone working to protect staff. Tenants were spoken to by the staff to remind them of the importance of not permitting anyone into their flats unless they expressly invited them in and about how to contact the emergency services. Attempts were made to contact Kamil, but he was not spoken to regarding the increased risk posed by Mr X.
- 10.12 It was not until the early evening of 10th June that Milestones Trust staff were able to review the CCTV footage from the evening of 9th June. It showed Mr X's sexually disinhibited behaviour, including entering a female tenant's room uninvited. Milestones Trust contacted the Police over the content of the CCTV. The Police agreed to attend the property to view the CCTV footage.
- 10.13 The Emergency Duty Team made attempts to contact Mr X over the weekend of the 11th/12th June, it would seem he was either absent or hiding in his flat and it was not possible for them to undertake an assessment. In any event, the same concern about availability of beds remained.
- 10.14 Due to the lack of Milestones Trust staff able to download and copy the CCTV over the weekend, the Police were not able to view the recording and read the notes that Mr X had written until 13th June. Mr X was arrested later that day on suspicion of threats to kill and indecent exposure.
- 10.15 Mr X was assessed by the Mental Health Team whilst in custody and detained under section 2 of the Mental Health Act 1983. The Police and Criminal Evidence Act (PACE) requires the Custody Sergeant to make this decision whether criminal charges will be immediately brought (such as cases where a serious crime has been committed). In this case Mr X was released without charge to a section 2 MHA diversion into the care of an AWP hospital. However, the crime report was still allocated for investigation, and the Officer in the Case (OiC) was trying to establish whether Mr X had capacity for the offences he had been arrested for by contacting various professionals. The Police were still treating it as an open investigation until the decision regarding capacity could be made and reviewed with the OiC's Sergeant.
- 10.16 Where an offence is ended in custody, the case remains allocated and the offender can still be dealt with after their mental health diversion has ended if there is evidence, and they have mental capacity. Once the decision had been made by the Mental Health Tribunal to release Mr X from Kewstoke Hospital, but prior to his actual release a conversation should have taken place between the CPA Co-ordinator and the OiC to allow for a decision to be made about the progression of

the investigation. Once Mr X was released, then he would be deemed mentally well and fit for interview, so the case could have then continued to progress.

11 Key Practice Episode 4 – Mr X detention in Hospital 13th June - 6th July

- 11.1 Mr X was initially placed in an Avon and Wiltshire Mental Health Partnership (AWP) NHS Trust hospital. However, on 20th June 2016, Mr X was transferred to an Out-of-Trust hospital, Kewstoke, as there was pressure to create additional capacity for new admissions to the AWP ward. This is a routine process in the day to day management of bed capacity within AWP. It is not routine practice to involve Community Services in these decisions and they are notified after the transfer has been made. Clinical responsibility was also transferred to the Consultant Psychiatrist at Kewstoke Hospital.
- 11.2 Continuity of care should be maintained through an Out of Area Manager liaising with Kewstoke Hospital and attending ward rounds. However, the Out of Area Manager was on leave and therefore Mr X's Care Coordinator was expected to attend ward rounds in their place although no one informed them of this.
- 11.3 Kewstoke Hospital did not receive historical information regarding previous concerns about Mr X's psychiatric history from AWP, and only became aware of the extent and significance of the deficits in their records during the Mental Health Tribunal. This background knowledge would have been particularly relevant for the Mental Health Tribunal which took place on 28th June 2016.
- 11.4 Mr X made an application for a Mental Health Tribunal to review his detention⁷. The AWP Consultant Psychiatrist was not aware that Mr X had applied for a Mental Health Tribunal, nor were they asked to contribute to the Care Coordinator's report or made aware of the outcome of the Tribunal. Tribunal Reports follow an agreed template that provides guidance on what information should be included and prompts the report author to include "the views of any other person who takes a lead role in the care and support of the patient."
- 11.5 The Tribunal was not satisfied that Mr X was suffering a mental disorder of a nature or degree which warranted his continued detention. The decision of the Review Tribunal panel was that Mr X was to be discharged from his liability to be detained on 6th July 2016 at 4.00 p.m. The Tribunal made its decision without considering the views of Mr X's brother, the Community Psychiatric Consultant, or Milestones Trust. This decision was also contrary to the advice of the Psychiatrist caring for Mr X in hospital.
- 11.6 The decision of the Tribunal was unexpected; Kewstoke Hospital carefully explained to Mr X the implications of the tribunal decision and encouraged him to remain in

⁷ Mental Health Tribunals are independent quasi-judicial bodies that primarily rule on the need to continue to detain a person who has been sectioned. It is outside the scope of this review to challenge the decision of the Tribunal. Tribunal decisions can be appealed against by an appeal to an Upper Tribunal or by Judicial Review.

hospital beyond the date of discharge of the section as a voluntary patient. However, Mr X refused to remain in the Hospital after the date set by the Tribunal. The key agencies who would be affected by Mr X's return to the community, the Police and Milestones Trust, were not informed of the Tribunal decision. As the AWP Care Coordinator was the only representative of community services working with Mr X, communication of the Tribunal decision was dependent on them contacting agencies individually.

- 11.7 It was noted by the Tribunal that accommodation "may be a problem" as Mr X had warnings about this behaviour from his accommodation provider and may have been served a notice to quit. A discharge planning meeting was recommended, and the date of discharge was delayed for this purpose.
- 11.8 The Tribunal was unaware that Milestones Trust had been working with United Communities over the previous 4 months to manage Mr X's behaviour and the incidents in June 2016 had led to the decision to serve a section 21 notice⁸ on Mr X and terminate his tenancy.
- 11.9 AWP did not initiate discharge planning prior to 5th July when the Care Co-ordinator was informed by Kewstoke Hospital that Mr X would be discharged the following day. This was a key event in a chain of events which would eventually lead to Mr X being discharged without adequate plans being made for his return to Bristol. The Care Coordinator had expected that Mr X would be returned to an AWP hospital prior to discharge. This was the usual process in the circumstances. While this has developed as the custom and practice, a return to an AWP hospital is not part of any formal arrangement.
- 11.10 As the day of Mr X's discharge approached it became apparent that there were no grounds to detain Mr X further and there was a strong possibility that he would be homeless because Milestones Trust were seeking an eviction order to prevent his return.
- 11.11 Milestones Trust as the accommodation provider were not contacted until 5th July when the Care Coordinator asked for information about the progress of the eviction. The Care Coordinator did not appreciate the time a legal eviction would take; and would involve a two month notice period followed by a court hearing six weeks after the expiry of the eviction notice.
- 11.12 On the day of discharge 6th July 2016, Kewstoke Hospital faxed a brief discharge summary to the Care Coordinator and reported that Mr X was settled and was not displaying any symptoms of mental illness. There were no grounds to further detain him under the MHA and he was discharged home. Based on the discharge summary,

⁸ A section 21 notice is a 'Notice Requiring Possession (under section 21 of the Housing Act 1988)'.

the Care Coordinator and Crisis Service agreed to visit Mr X for review the following day (7th July).

- 11.13 The Care Coordinator Informed Milestones Trust that Mr X was free to leave hospital and could potentially arrive at the accommodation. Milestones Trust were not informed of the timing of Mr X's discharge from hospital until an hour before it happened and were unhappy about the decision and lack of consultation. Contingency plans were rapidly put in place to advise female tenants (but not Kamil) of his potential return and alert the on-call manager. The Police were not informed and had not received any information regarding Mr X's progress since receiving information from the AWP Hospital on 23rd June.
- 11.14 To respond to the immediate concerns about Mr X's return on 6th July, the decision was made to seek an injunction to prevent Mr X returning to the property. However, there was only the afternoon of 6th July to coordinate this legal application and obtain corroborative information from other agencies. The short notice inevitably meant that the earliest the case could be heard would be 7th July.
- 11.15 Following his formal discharge from hospital Mr X returned to his flat in the Milestones Trust property. He later visited several pubs and consumed a large quantity of alcohol. He returned to his accommodation later that evening.
- 11.16 At 1:30am on 7th July Mr X telephoned the AWP Crisis Team stating that he had drunk a litre of rum and felt like punching an Asian resident who lived in the same accommodation. Mr X became angry when told he would be held responsible for his actions and said that he was 'insane and wasn't responsible' before ending the call. He did not answer when staff tried to call him back. The Crisis Team contacted the Police using the 101 non-emergency number⁹ just after 2:00am, less than 10 minutes later Mr X called the Police stating that he had murdered Kamil.
- 11.17 The details of Kamil's murder are horrific and were widely reported during Mr X's trial. The murder was traumatic for the staff and fellow residents who knew Kamil and Mr X at Milestones Trust. It also deeply affected others who have known and worked with Kamil over many years either in a professional capacity or as a friend.

EMERGING THEMES

Practice Issues

12 Relationship between Kamil and Mr X

- 12.1 The antipathy between the two men has its origins in their respective vulnerabilities. Kamil had been traumatised by his past experiences and this was exacerbated by his

⁹ With hindsight, calling 101 was the wrong decision as a crime was in the process of being committed, the correct course of action would have been to call 999. AWP have subsequently added clear guidance to their website.

mental health needs (he had a diagnosis of Post-Traumatic Stress Disorder and Obsessive Compulsive Disorder) and a level of learning difficulty (this was in the process of being assessed at the time of his death). As an asylum seeker whose claim for asylum had been refused, he lived with a high level of insecurity regarding his future, which was a source of further stress.

- 12.2 From the comments he made to staff and other service users of the Bristol Refugee Rights Service, it would seem that Kamil did not feel particularly accepted by his fellow tenants in his accommodation, which may have led to further social isolation. However, it should be recognised that all the tenants had their own issues and vulnerabilities. The accommodation was not designed to provide a group living experience and all the tenants were private individuals.
- 12.3 Mr X was also struggling to cope with his fluctuating mental and physical health; his stability was highly dependent on taking regular prescribed medication and controlling his use of alcohol and cannabis. Unfortunately, the most effective medication for controlling his schizophrenia and paranoia had serious physical side effects and did not therefore provide a long-term solution.
- 12.4 Mr X held racist opinions, and his attitude towards Kamil was not the result of the deterioration in his mental health; in short, he was a person with racist views who was mentally ill, rather than a mentally ill person whose racism was a manifestation of their illness. These views crystallised into a personal hatred of Kamil that was based on his race and legal status.
- 12.5 Mr X disputes this conclusion and contends that he does not hold racist opinions of Kamil or others.
- 12.6 It was suggested that initially Mr X and Kamil were not getting along because of a female also living in the house who was friendly with Kamil and Mr X. The general feeling was that after she left the property things would improve, and this seemed to be the case for a little while.
- 12.7 While it is undisputed that Mr X was the instigator of the poor relationship between himself and Kamil, it would be inaccurate to portray Kamil as completely passive and unassertive. As a result of the harassment and assaults Kamil received in 2013 he had told Milestones Trust staff he had a knife and would use it to protect himself from Mr X. Kamil was warned by Milestones Trust staff and the Police not to retaliate but raise concerns in the proper way. These comments should not be taken to imply that this review considers Kamil in any way responsible for the violence and harassment he was subjected to. He believed he may need to protect himself because he could not rely on agencies to protect him.
- 12.8 Kamil was clearly frustrated and angry at the behaviour of Mr X and the lack of action by the Police and Milestones Trust to address this. His feelings are evident in his contact with SARI in 2014 where he stated that he felt victimised because he was a

foreigner and not adequately supported (this was also an issue for BCC Adult Social Care and Support Services who funded the 4 hours support from Milestones Trust) in his accommodation.

- 12.9 When the situation between Mr X and Kamil began to deteriorate again some time later, it is documented that this was due to Mr X's mental health relapse. Mr X's racist beliefs became focussed on Kamil which manifested in an obsession with him. Staff at Milestones Trust began to notice Mr X attempting to check Kamil's mail, questioning his right to remain in the UK and behaving in an intimidating way towards him. Recording from both Milestones Trust and AWP refer to Mr X verbalising racist opinions on more than one occasion.
- 12.10 Had the shared living arrangements been risk assessed to take into account all the circumstances, racism being the main reason for the victimisation of Kamil, the outcomes and actions may have been different. Racist views and assumptions are unlikely to change when a person's mental state improves when treated.
- 12.11 These two vulnerable men were supported by different groups of professionals with the only common denominator being the staff team at Milestones Trust, who were not included in case discussions and decision making.

13 Support needs of Kamil

- 13.1 As an asylum seeker Kamil had received some limited personal support from the City Council through the Care and Support Team and the Asylum Team¹⁰. He had initially been supported following a care needs assessment which provided for accommodation and a subsistence allowance. This was in the process of being withdrawn at the time he was murdered. He was under notice to quit his tenancy and would have had to find alternative accommodation through charitable or voluntary sector help.
- 13.2 In addition to the statutory provision, Kamil was supported through various services provided by the Bristol Refugee Rights Service and was a long standing regular attendee at their Centre. This was an important source of personal support and advocacy. Prior to the period under review, Kamil had also received support from other voluntary agencies who work with asylum seekers.

¹⁰ The Care and Support Team were involved to review of Kamil's support. There is a requirement to carry out annual reviews BCC were funding his care and support, including his accommodation. The Asylum Team was involved because Kamil did not have access to public funds due to his immigration status. The Asylum Team's role was to monitor Kamil's asylum application and update Adult Care services on his immigration status (a person's immigration status may determine whether the local authority has a duty to continue support or withdraw it). The Asylum Team also administers weekly subsistence payments, and saw Kamil on a weekly basis

- 13.3 It has become apparent through the process of this review that some of the voluntary agencies held information which would have been relevant to his Social Worker and Milestones Trust about the type of accommodation best suited to his needs. In particular, the Bristol Hospitality Network (the charity that had previously accommodated Kamil) had a clear sense of the level of support he would need. In completing the Care Act Assessment, the social worker could have sought permission to approach the Bristol Refugee Rights Service, SARI and the Trauma Foundation for information which would have improved their understanding of Kamil's situation.
- 13.4 A further important source of support was provided by the Trauma Foundation who had been involved with Kamil for the previous five years. Whilst it was unusual for a psychotherapy service to engage in practical issues, the Trauma Foundation had recognised that Kamil had particular vulnerabilities exacerbated by the language barrier which made it more difficult for him to resolve problems without support.
- 13.5 The Trauma Foundation therapist knew Kamil had been threatened by Mr X and was aware of the rationale for asking Kamil to accept a move to different accommodation. However, the therapist was also sensitive to the fact that such a move could destabilise Kamil and have negative consequences for his mental health. This was in addition to the practical problems of Kamil being further away from sources of support. The location and type of accommodation was important to Kamil, in the literal sense of being a "refuge" and somewhere he felt secure.
- 13.6 The therapist interceded with Milestones Trust on Kamil's behalf and made the point that Mr X as the aggressor should be moved to separate the two men rather than his victim. Kamil was more worried that he would hurt Mr X if Mr X attacked him.
- 13.7 Although there were several agencies involved in supporting Kamil there was no holistic assessment of his needs shared between agencies. In the process of meeting different services and individuals who would offer him specific support, no single agency seems to have developed a comprehensive picture of his personal, social and health needs. The lack of awareness of these issues led to an underestimation of his vulnerability and his need for ongoing support.
- 13.8 A further example of this is demonstrated by the partial awareness amongst agencies of a level of learning difficulty. The possibility that Kamil may have a learning difficulty was raised in the initial referral to Milestones Trust from the City Council when he first became a tenant. There was a recognition by the Trauma Foundation (the agency that had the longest therapeutic relationship with Kamil) that he had a degree of learning need and services needed to be flexible to enable him to benefit from them. The concerns about Kamil's difficulties led to a referral for a formal assessment of Kamil's learning needs being made by his GP on 31st May 2016
- 13.9 Kamil received four hours of support a week from a support worker at Milestones Trust funded by Social Care. In one of his support sessions each week, an interpreter was also funded to help with his communication. Kamil cancelled planned visits fairly

frequently, choosing instead to seek out staff if he had an issue he needed to discuss. He received support with his cooking, with understanding his correspondence, and with practising his English.

- 13.10 Although Kamil had told workers and friends at the Bristol Refugee Rights Service he did not feel accepted by fellow residents in his accommodation, he had a more positive relationship with staff and is described by them as universally liked.

14 Asylum Seeker status

- 14.1 Kamil had lived with the precarious status of Asylum Seeker since 2011, and as result may have been inhibited from seeking formal resolution of his complaint that neither the City Council nor the Police did enough to protect him from Mr X. In the latter part of the period under review, on the 5th May 2016, he was informed that support - both financial and accommodation - would be withdrawn as a result of the re-assessment under the Care Act, and therefore he had other more pressing priorities than pursuing his complaint against Mr X.
- 14.2 The ability to communicate in English was clearly a barrier for Kamil although it is likely that he understood more than he could express. His limited English meant he was inevitably dependent on others interpreting his opinions and decisions. As a person seeking asylum, he was involved in complex court procedures and navigating a range of services provided by a combination of Health, Social Care and voluntary organisations. Within each of those structures there are complex organisational arrangements, which may seem to have (from the perception of a service user) little obvious relationship with the issues they are trying to work with.
- 14.3 Understanding how these services relate to each other, and oneself, is a challenge for anyone, and even more so for a non-English speaker with a possible level of learning difficulty.
- 14.4 In the light of Kamil's experience it is timely for agencies in Bristol to consider whether an unconscious bias affects how they respond to the designation "refused" (or "failed") asylum seeker; and whether it implies an intention to deceive (i.e. they have claimed something to which they are not entitled) and affects how other concerns are judged.
- 14.5 Kamil was vulnerable because of the situation he found himself in as a person from an ethnic minority background. The victimisation Kamil was subjected to was racially motivated which increased the risks to his personal safety, and risk assessments should have considered this.
- 14.6 BCC Adult Social Care and Support Services still had a duty to ensure that Kamil was linked in with the appropriate support and that he had information at his disposal that would help him to make decisions. Adult Social Care and Support Services should have confirmed, rather than making assumptions about what Kamil understood about how to protect himself. It would be reasonable to expect contact with SARI for

example to check the assumption that they were still actively involved, whereas they had not had any contact with Kamil since April 2015.

15 Response to Hate Crime

- 15.1 The fact that Mr X's harassment and abuse of Kamil constituted a succession of racially aggravated hate crimes was acknowledged by the Police in their recording of the incidents from 2013 through to the final fatal assault in 2016. Hate crimes are recognised as often having a disproportionate emotional effect on the victim because they are targeted for an aspect of their personality.
- 15.2 The assaults on Kamil in 2013 could not be prosecuted due to the lack of any corroborating evidence. The option of Mr X being cautioned for racist comments that he had admitted during interview could have been considered. However, concern about further destabilising Mr X's mental health meant that apart from the written warning from Milestones Trust, no further action was taken against him.
- 15.3 An overlooked dimension to this is whether the assaults on Kamil should also have been considered hate crimes because of his perceived learning difficulty.¹¹ This was not dependant on a formal diagnosis and a decision could have been made based on Kamil's presentation. Possibly because of the language barrier and the need to communicate through an interpreter, the possibility of a learning difficulty was not recognised by the Police in their interviews with him.
- 15.4 Kamil's first contact with SARI happened in May 2014, five months after the aggravated assault which prompted the referral. SARI's initial agreement with Kamil centred on advocacy and obtaining answers from the Police and Milestones Trust about their actions to safeguard him in the future. The working agreement with SARI clearly shows that Kamil remained dissatisfied with the response to the assaults, he did not understand why Mr X could not be prosecuted or removed from the property. Kamil was clear that he believed the reason he had been attacked was because he was a foreigner and the assaults were racially motivated.
- 15.5 SARI proved to be a useful source of additional advocacy, while their interventions did not materially change very much in terms of Kamil's day-to-day living arrangements, they did at least provide some answers to his questions and helped him understand the decision making. Unfortunately, the goal of organising a case conference to discuss risks to Kamil with Milestones Trust, the GP, Bristol Refugee Rights Service and SARI was not achieved. There is no stated reason for this, but it is likely that with the passage of time, and because there had been no repetition of the incidents the need for such a meeting decreased.

¹¹ A disability Hate Crime is any criminal offense motivated by hostility or prejudice based on a person's disability or perceived disability. It is recognised as being significantly underreported.

- 15.6 In November 2014 Kamil's therapist contacted SARI with an insightful analysis of his needs and the traumatic impact of the assaults by Mr X. The letter is significant in several ways; firstly, it emphasises that Kamil had been traumatised by the assaults and they had a long-lasting psychological impact. Kamil felt a sense of injustice about how he had been treated and the lack of consequences for Mr X. He reported to his psychotherapist that he did not feel Milestones Trust took his grievances seriously and he wanted to be able to prove that he had been neglected and failed.
- 15.7 The complaint that Kamil made to the Police in early April 2016 of ongoing harassment by Mr X was correctly recognised as racially motivated and escalated from the Police Community Support Officer who took the first complaint from Kamil to a more experienced Police Officer who placed a marker on the address to "Treat as Urgent" in the event of further incidents. Recording the incident as a hate crime also led to the referral to the Lighthouse Victim Care and Support service.
- 15.8 Unfortunately, the problems the Lighthouse officer had in contacting Kamil meant that no subsequent re-referral to SARI was made. This was because the Police require the victim's consent before making a referral to SARI. As they had been unable to obtain this after three attempts the usual practice would be to send a follow-up letter, although that did not happen in this case. Lighthouse do not routinely refer every 'Hate Crime' to SARI without the permission of the victim. Lighthouse were established to support the victim and work with them in their best interest but also to respect their wishes. Other attempts to contact Kamil could have been made, through his support worker or the Asylum Team for example. The provision of written information was unlikely to be successful in re-engaging Kamil.
- 15.9 It would have been helpful if the process for obtaining support through Lighthouse, the possibility of a referral to SARI (which Kamil knew from previous involvement) and the importance of giving consent had been explained to Kamil when he first contacted the Police. Kamil had previously had a positive experience of working with SARI. In any event it was possible for anyone working with Kamil to consult with SARI to discuss the case anonymously for further advice and guidance.
- 15.10 It is apparent in some of the submissions to this review that some agencies believed the Police had the authority to designate future incidents that might occur between Kamil and Mr X as "hate crimes". This is incorrect, and the Police would be unable to categorise incidents which had not taken place. The Police can place a marker on an address to "treat as urgent" to prioritise a response, which is what happened in this case.

16 Support needs of Mr X

- 16.1 Mr X had been discharged from institutional care in 2008 and was reintegrated successfully into the community, with no recorded concerns until incidents began to emerge with Kamil. An important change had occurred in 2010, when a Restriction Order (imposed to limit his alcohol consumption) was lifted. For an individual with a

long-standing problem with alcohol, this was a significant development as it removed all control on his consumption.

- 16.2 Mr X's care in the community was the responsibility of Avon and Wiltshire Mental Health Partnership Trust (AWP). His allocated worker from the Community Mental Health Services Team was a Care Coordinator. Mr X was ultimately under the care of a clinical psychiatrist who was responsible for an annual review of Mr X's health and medication. Other professionals such as the GP and housing provider, feed information into these reviews through the Care Coordinator.
- 16.3 Mr X's management in the community was highly dependent on the effectiveness of his medication. The Clozapine that had been prescribed in 2010 has serious side effects, such as reducing the white blood cell count (reducing the body's ability to fight off bacterial infections), seizures, and heart disease. Patients prescribed Clozapine must have regular full blood count tests. The Clozapine manufacturers use a traffic light system (green, amber, red) for guiding dispensing based on the blood test results. If a patient has a Red result, the clinician must stop Clozapine and monitor full blood count daily until results return to normal.
- 16.4 Mr X was prescribed an alternative treatment, Risperidone in November 2015. His Care Coordinator was responsible for administering his antipsychotic medication as well as other aspects of his welfare. The effectiveness of his medication was also altered by his use of alcohol and cannabis.
- 16.5 Support workers from Milestones Trust provided five hours weekly of targeted support to Mr X. The hours were spread over four days a week and focused on supporting his physical health and advice regarding cooking and completing forms. The support was task orientated and practically based. Milestones Trust staff were not expected to work with the complex issues raised by Mr X's mental health but had a responsibility to pass these on to the Care Coordinator or other relevant professionals. Staff at the Milestones Trust were often the first to recognise the correlation between changes in Mr X's mood and behaviour with changes to his medication.
- 16.6 BCC Adult Social Care and Support Services had little direct involvement with Mr X other than the referral for a care needs assessment in the light of his impending eviction from Milestones Trust made on 5th May 2016. Later, in June 2016, a referral was made to the Emergency Duty Team for a Mental Health Act assessment. This did not take place because Mr X could not be found at the time and was subsequently sectioned after detention by the Police.
- 16.7 There are few occasions where there is evidence of shared planning and analysis in a multi-agency forum (in Mr X's case a Care Programme Approach (CPA), the last CPA took place in November 2015). The deterioration in Mr X's health is almost exclusively ascribed to changes in his medication and changes in his environment do not appear to have been considered in the analysis of risk. His increased alcohol consumption and substance misuse was known to Milestones Trust and to his GP but did not lead to

a reassessment of Mr X's overall state of health. Referral to treatment services is dependent on the consent of the patient and Mr X had no interest in taking up these services.

- 16.8 The effect of Kamil on Mr X should also have been considered in reviewing the changes in his behaviour. This is not to excuse or condone his racism and bullying, but clearly Kamil living in the same accommodation was a source of stress to Mr X and for whatever reason acted as provocation to him.
- 16.9 Milestones Trust staff sought to challenge Mr X's racist beliefs when they heard offensive comments, however they also recognised that Mr X would be careful about airing his views to a critical audience. Mr X's racist behaviour and language directed at Kamil clearly put him in breach of his tenancy agreement and a warning letter had been issued by Milestones Trust in January 2014, but no further action taken after this.

17 Risk of sexual assault

- 17.1 Mr X's sexual history is not documented, but there are reported concerns about Mr X boasting of his sexual prowess, talking about sex with sex workers, making sexual comments to staff, residents and visitors of Milestones Trust, exposure and masturbating in communal areas of his accommodation and alleged sexual assault. These had not been progressed as crimes either because Mr X was mentally ill or the complainants did not wish to proceed.
- 17.2 His preoccupation with sex may also partly explain his allegation that Kamil had raped a fellow resident two years previously (an allegation that was untrue and malicious). He also sought a prescription for Viagra whilst detained as an inpatient in Kewstoke Hospital (this was not prescribed).
- 17.3 With the discovery of the notes written by Mr X in June 2016 the focus moved away from the potential of a racist assault to threats of a sexual nature. There had been several examples of inappropriate sexual behaviour and sexual assault committed by Mr X against other residents. This shift in focus may have occurred accidentally; as it was the Police Controllers' interpretation of the concerns being expressed by the support worker who was reading the notes aloud to her. When Mr X was arrested on 13th June 2016 it was on suspicion of threats to kill (not solely directed against Kamil) and Indecent exposure.
- 17.4 These concerns amount to a significant level of risk, furthermore these incidents were not widely shared across agencies at the time and may have been attributed to drunken boasting on Mr X's part. However, there was evidence that Mr X presented a risk to vulnerable female residents that was possibly escalating.

17.5 At the time of Mr X's detention it was also recorded that he had made reference to "fourteen-year-old girls and paedophilia". These comments were made when Mr X was first detained by the Police prior to being sectioned on 13th June 2016, they were never explored further with him. While they were not actionable from a Police perspective, given concerns about Mr X's sexual behaviour it was important that they were not overlooked.

18 Alcohol and substance misuse

18.1 Mr X's increasing dependence on alcohol and regular binge drinking seriously affected his health. The issue was known to both his psychiatrist and GP practice, although there was no coordinated response to this.

18.2 Mr X had been a habitual drinker from a young age and therefore it is not surprising that he was resistant to tackling this issue and may have underestimated how much he drank in clinical reviews. In addition to the health risk it also threatened the security of his tenancy through the antisocial behaviour he demonstrated whilst under the influence.

18.3 Family members had also had their concerns about Mr X's drinking and avoided socialising with him due to his excessive drinking.

18.4 Concern about Mr X's alcohol consumption, and to a lesser extent, his substance misuse were on-going concerns for his GP, where a pattern of binge drinking, and some signs of alcohol dependency had been identified. Mr X's GP had raised concerns about excessive alcohol use in 2014. At that time, it was a major contributor to his mental health problems, including insomnia, anxiety, aggression, disinhibition, and paranoia.

18.5 As an issue, it may have "fallen between two stools" in the sense that the GP and Mr X's psychiatrist may have thought the other professional was dealing with this. Subsequently Mr X's care plans did not specify any attempts at engaging him in addressing his alcohol use, either as a health risk, or an issue which may affect security of his tenancy. Services need the consent of a service user to refer them for further help. Again, the key issue was Mr X's willingness to engage with other services. The Care Coordinator did not make a referral to Drug and Alcohol services as they did not think there was any realistic prospect that Mr X would engage.

18.6 The challenge of engaging reluctant service users is one that is familiar to all addiction services. There is a view that take-up of services is often linked to crises elsewhere in an individual's life, for example, an individual may be reluctant to engage with services for health reasons, but if it is an option which may preserve their tenancy or avoid legal action this may be sufficient motivation. This is not to say that these approaches would necessarily have been successful with Mr X, but using the

difficulties caused by his alcohol use as a reason for trying to do something about this problem could have been part of the conversation with him.

Multi-Agency Issues

19 Adult Safeguarding

- 19.1 Kamil had been the subject of two Safeguarding Referrals. The first had been made following the assault by Mr X in December 2013. A safeguarding investigation was initiated (this predated the introduction of the Care Act 2014), and a strategy meeting convened on 31st January 2014. A pattern of incidents occurring in the evening and weekends when there were no staff on duty was identified, and that Kamil did not feel he was sufficiently protected from Mr X.
- 19.2 The protection plan following this investigation was comprehensive and included some key undertakings; the installation of CCTV in the accommodation, Milestones Trust to seek eviction of Mr X if he breached the tenancy agreement and an undertaking that the Police would place a marker on the address.
- 19.3 The January 2014 Safeguarding Referral seems to have had a positive outcome, as there were no further incidents between Mr X and Kamil for several months, enhanced security measures were in place within Milestones Trust and there was a plan for proactive police involvement. However, there were some missed opportunities; the strategy meeting had discussed the need to obtain a forensic assessment of Mr X to support staff with strategies to manage his behaviour. There is no record of a forensic opinion being sought until April 2016 (and no record kept of the outcome of that meeting). The issue of either Kamil or Mr X moving to alternative accommodation was raised and not properly explored, it would have been helpful when this issue re-emerged in 2016 to understand why the alternative accommodation was not acceptable to Kamil.
- 19.4 The second Safeguarding Referral in relation to Kamil was made by Milestones Trust on 4th April 2016 because of their concerns about the escalation in Mr X's behaviour and his preoccupation with Kamil. The referral was triaged by Care Direct (this team was responsible for screening safeguarding referrals to see whether the safeguarding threshold was met, the referral was then passed to the appropriate team to undertake the coordination of the Section 42 enquiry). In this case the Triage Team contacted Milestones Trust and discussed an immediate protection plan to be implemented by them to ensure Kamil's safety before passing the referral on to the relevant social work team to undertake the enquiry.
- 19.5 A Social Worker visited Kamil on the 5th May 2016 to discuss the content of the safeguarding referral. There were no interpreters available despite numerous attempts to find one. A support worker from Milestones was also present at this meeting. Kamil had reported the incident to the Police and believed that it was racially motivated.

Mr X was given a final warning by Milestones Trust. It was also documented that the Police investigated the matter as a hate crime.

- 19.6 The referral was closed on 19th May. This decision had been taken prematurely without a full appreciation of the facts. The view that Kamil was able to protect himself from harm because he had demonstrated that he had contacted the police in the past was an unsafe assumption. Even if correct, it implies that the risk of Kamil being further assaulted by Mr X remained and this is not an acceptable conclusion for a safeguarding concern. It was clearly the responsibility of the agencies providing care and support to both individuals to safeguard Kamil.
- 19.7 There is no record that the risks to Kamil because of his ethnicity and background were considered as part of the decision not to proceed with a Section 42 enquiry. The records also indicate that BCC Adult Social Care and Support Services believed that SARI was still involved, which was not the case. In any event there was no attempt to contact them to discuss the referral.
- 19.8 The Safeguarding Referral should have considered Kamil's needs in more detail, the assessment and consideration of his risks and vulnerabilities as an asylum seeker, a vulnerable adult, and victim of racially motivated hate crime over several years. The referral form included a question about hate crime, but this was not explored in the assessment of Kamil.
- 19.9 Apart from factual inaccuracies, the analysis of Kamil's situation shows a lack of understanding of his particular vulnerabilities and the dynamics of hate crime. An assumption was made that Kamil was more assertive and self-sufficient than he actually was. The fact he had contacted the Police in the past was taken as evidence that he would feel able to do so in the future - although Police contact had not resulted in action against Mr X. Based on past experience there was little reason for Kamil to be confident that reporting the incident to the Police would protect him in the future.
- 19.10 Kamil's refusal to move to alternative accommodation may also have been interpreted as an assertive or positive action – perhaps even stubbornness on his part. In reality, the move to the proposed accommodation further away from the City centre and his support networks would have possibly led to him being more vulnerable and isolated. The possibility of a move was a source of great anxiety for Kamil. If these issues had been fully considered as part of the safeguarding referral, it is likely that it would have met the threshold for a section 42 enquiry.

20 Risk Assessments

- 20.1 Risk assessments frequently fail to consider the effect of interpersonal dynamics between non-family members. There are some professional inhibitions in terms of confidentiality and recording, which perhaps make it difficult to honestly reflect on

the effect one person has on another. However, the effect of a dominant and controlling personality, such as Mr X on other residents (not only Kamil) was a factor in creating a secure and safe environment for all tenants. Milestones Trust needed support and information from those with clinical knowledge and background information of Mr X and Kamil in order to properly assess the risk.

- 20.2 With the added complications of Mr X's mental health issues and his varying compliance with his medication, the risk assessment in this case was clearly much more likely to fluctuate and need reassessment and review on a regular basis.
- 20.3 The pre-existing concerns about Kamil (including the reasons why his previous tenancy had ended) and Mr X's circumstances were sufficient to warrant a thorough risk assessment prior to Kamil's placement with Milestones Trust. However, no assessment took place. Good practice would dictate that this would apply to all vulnerable residents but given the history of these two men a lack of risk assessment was a fundamental omission. It is axiomatic that however good a risk assessment is, it is of no value unless it is shared.
- 20.4 With regard to Mr X there were concerns in at least three areas of his presentation; racist behaviour, sexualised behaviour and substance misuse. There was frequent low-level antisocial behaviour which was dealt with on a day-to-day basis by staff at Milestones Trust. These concerns were routinely reported to the Care Coordinator. Unfortunately, when Mr X's outbursts were more extreme and violent they were usually because he had become psychotic because of missing his medication or combining it with alcohol and drugs. He rarely faced the consequences of his behaviour because he was deemed to be too unwell or mentally fragile to be interviewed and assessed.
- 20.5 The Care Programme Approach (CPA) provided the appropriate framework to assess these issues. Although the CPA was originally designed as a multidisciplinary approach, custom and practice over years has meant that it has become increasingly focused on mental health issues.
- 20.6 In the course of this review, it has become apparent that there are no shared risk assessment tools used across agencies. Management reviews from AWP and Kewstoke Hospital refer to various standardised measures that are used to assess risk, but these tools are not used by colleagues working with the same individuals in social care. It would promote a common understanding and multi-agency analysis if the same tools were available to BCC Adult Social Care and Support Services.
- 20.7 A specific example of delayed risk assessment occurred over the weekend of 10th - 13th June. The Bristol Crisis Service continually requested a Mental Health Act assessment for Mr X but the EDT AMHP (Approved Mental Health Professional) service decided not to proceed as there were no beds available in a suitable mental health ward. The timing of this referral was significant; given that Mr X's mental health had

been deteriorating over the previous week, it was unfortunate that the referral was made to EDT 25 minutes after the daytime services had finished on a Friday evening.¹²

- 20.8 It can be a greater risk to assess that a patient needs to be detained when no bed is available than to not assess them at all. To do so may raise the patient's level of anxiety unnecessarily and possibly make them harder to manage.¹³ The multi-agency protocol states that the availability of beds (or other resources) should never be the sole reason for delaying undertaking a mental health assessment. It further states that: "Statute and guidance are clear that assessments cannot be delayed, and beds will always be available. Therefore, when an assessment is required but a suitable bed is not available, the bed escalation protocol should be followed and the search for a bed intensified".
- 20.9 However, the reality in this case was different. The search for a bed began at 4.55 pm on Friday 10th June and was not identified until 31 hours later and not actually available until 39 hours after the initial referral. The decision to delay the MHA assessment was made by the AMHP (and agreed with by 3 subsequent AMHP's) after balancing the risk of assessing Mr X without a bed and the risk that this would pose to himself, the workers involved and other residents. The EDT AMHP was in contact with the AWP bed manager, as per the policy, who agreed that the assessment should not take place until a bed was identified due to the risks. As soon as a bed and transport were available EDT attempted to assess Mr X.
- 20.10 The decision making process to delay a Mental Health Assessment in cases such as Mr X is a complex process requiring coordination between workers and managers in different teams and subject to change at short notice. In this case for example, the AWP Bristol Crisis Service (BCS) who were supporting Mr X on Friday 10th June 2016, contacted Social Services Emergency Duty Team (EDT) and requested a Mental Health Act (MHA) Assessment. EDT told them that they would not arrange the assessment until a bed had been identified by BCS.
- 20.11 BCS then worked to secure a bed with Cygnet Health Care, but Cygnet later withdrew that bed, so they arranged admission to an AWP bed following movement of other service users. On Saturday 11th June, when BCS contacted EDT again, EDT did not conduct the MHA assessment as there was still no bed available. On Sunday 12th June, the EDT attended the home address but were unable to gain access and see Mr X at the property.

¹² Over this weekend EDT were providing all social care services for adults and children for 4 local authorities (a population of in excess of 1 million). They had a maximum of 5 staff on duty during the Saturday and Sunday day shifts, 3 during the evening and 2 overnight.

¹³ AWP has a multi-Agency Protocol covering these situations. Multi-Agency Protocol - Working together when mental health act assessments are requested, including situations where resources are unavailable.

20.12 Later that day, EDT staff noted that BCS had delivered medication to Mr X on 11th June and despite BCS explaining that he had said he would not actually take the medication, the EDT staff member declined to reconvene the MHA assessment until BCS had reassessed Mr X themselves and reconsider whether a MHA assessment was still indicated. The BCS worker did not agree with this and escalated her concerns to the EDT manager, who also declined to take any further action until BCS saw Mr X again.

21 Inter-agency communication

- 21.1 Communication between partner agencies can always be improved. The more important question is whether the gaps in communication avoidably prolonged the time Mr X and Kamil lived in the same shared accommodation and led to the situation where Mr X was discharged without adequate support and safeguards from Hospital. In the context of this review the gaps in communication between Kewstoke Hospital, Care Coordinator and Milestones Trust had the most significant impact.
- 21.2 Prior to the fatal events of 6th July, the most significant deficit was the lack of face-to-face case planning for Mr X. The need for this was recognised by all the relevant parties at different times, who looked to the Care Coordinator to arrange this. However, these meetings did not take place and communication was often through email or leaving requests for follow-up phone calls.
- 21.3 Through a combination of factors, the Care Coordinator effectively lost management oversight of Mr X's case. Once Mr X transferred to Kewstoke Hospital, partly due to overwork and other conflicting workload responsibilities, the Care Coordinator carried on in the assumption that Mr X would be transferred back to an AWP hospital before his discharge into the community. The review has been informed that this procedure was followed in almost all cases, and it was reasonable to believe that this would also happen in this case. If the Care Coordinator had been informed he was expected to attend Ward rounds at Kewstoke Hospital, he would not have made this assumption.
- 21.4 The Care Coordinator expected Mr X to be returned to an AWP hospital in Bristol to enable the CPA process to take place. It was his belief that Milestones Trust would take legal steps to prevent Mr X returning to his accommodation, and that Mr X would remain a voluntary patient until accommodation in the community was available.
- 21.5 Neither of these assumptions were true; Kewstoke Hospital could also have taken more responsibility for effective communication with the Care Coordinator and Milestones Trust. Kewstoke Hospital faxed and emailed information regarding Mr X to the Care Coordinator but did not demonstrate any professional curiosity about the lack of response to their communication. They were aware there needed to be contingency plans for Mr X's discharge from hospital and should have enquired what these plans were.

- 21.6 There is a lack of clarity in the governance arrangements between AWP and private providers. As the hospital with clinical responsibility at the point of discharge Kewstoke should also have taken responsibility for convening a discharge planning meeting at least seven days before the planned discharge date.

22 Discharge Planning

- 22.1 The discharge of Mr X from hospital back to Milestones Trust was seen by them as something of a *fait accompli*. They were given virtually no warning of the impending discharge and thus were unable to take steps to prevent Mr X returning to his flat.
- 22.2 The failure of any effective discharge planning process meant that Mr X was discharged from hospital after 23 days with no meaningful handover between the hospital and those agencies providing support in the community. Even fundamental details such as changes to his medication were not discussed and the crisis of his accommodation was not properly understood by the hospital.
- 22.3 If a CPA meeting had been arranged in the week before Mr X was discharged, this would not, in practice have given Milestones Trust and United Communities enough time to complete the legal process of eviction, it may however have given enough time to seek an injunction preventing Mr X's return. It should also be noted that Kewstoke Hospital is some 25 miles away from Bristol and there are difficulties in arranging a face-to-face meeting. Whilst in the light of the tragic events which followed this may seem a querulous point, addressing these practicalities can make the difference between a meeting taking place or not.
- 22.4 Following the Mental Health Tribunal, the expected course of action was that the Care Coordinator would convene a CPA meeting. Whilst the Care Coordinator had previously acknowledged to Milestones Trust that a CPA meeting needed to be called, no action was taken until 5th July (the day before Mr X's discharge). The Care Coordinator was still working on the assumption that Mr X would be returned to an AWP hospital prior to discharge, and they would take responsibility for arranging a CPA meeting. In accordance with the agreed code of practice Kewstoke Hospital was right to assume that convening a meeting was the responsibility of the Care Coordinator, but they did not question why no plans for such a meeting had been made prior to discharge.
- 22.5 There is little evidence of "real time" communication between Kewstoke Hospital and AWP (Information was shared by fax and email, but there was no discussion). It is striking that Kewstoke Hospital oversaw fundamental changes in Mr X's mental health but failed to liaise with Mr X's community consultant psychiatrist about changes to his medication, the date of the Mental Health Tribunal (which compromised the level of detail the Care Coordinator was able to provide) or its outcome.
- 22.6 Equally, Kewstoke Hospital had little background information about Mr X when he was transferred into their care beyond information about the reasons for his detention.

These issues were not raised as concerns at the time even though they were fundamental to the reasons for his detention. A lack of understanding of the history of violence and sexually aggressive behaviour was a serious omission which must inevitably have affected the validity of future risk assessments.

- 22.7 The Emergency Duty Team did not have full information of the extent of risk posed by Mr X to other residents of the accommodation. They should have been made fully aware of safeguarding concerns as well as mental health issues. Given that a central reason for the need for Mr X to be admitted into hospital was the threatening behaviour at his accommodation, it would seem pertinent that Mr X's return to the same accommodation would be a key element of the risk assessment. However, there is no record of any conversation with Mr X of his presentation and behaviour which led to his hospital admission. There is no record in the risk summary or care plan of how he felt about returning to the accommodation or how he felt about the people he had allegedly made threats to kill. The views of Milestones Trust were not recorded as part of the risk assessment.

23 Interface between Police and Mental Health services

- 23.1 On many occasions, criminal action against Mr X was curtailed because of his mental health problems. The exceptions were the incident reported to the Police on 5th April 2016 when Kamil decided 5 days later that he did not want to make a statement to the Police and the final fatal assault.
- 23.2 Dealing with Mr X by using the Mental Health Act meant that although his offences were designated as "hate crimes"; in that they were racially motivated and explicitly targeted Kamil as a member of an ethnic group, the outcome was often influenced by his mental health. Kamil was offered support by Lighthouse as a victim of 'Hate Crime' but after 3 failed attempts to contact him, their support ended. A leaflet should have been sent and it is unknown whether this happened. Lighthouse are unable to refer a victim or witness for further support (such as SARI) without consent. Kamil's "enhanced status" would also have assisted Milestones Trust in their eviction of Mr X. The treat as urgent warning marker on the address would also have led to a speedier response from the Police to future incidents.¹⁴
- 23.3 Following Mr X's detention in hospital on 13th June 2016 the Police initially remained in regular contact with the AWP hospital to ascertain Mr X's status. However, the transfer to Kewstoke Hospital unfortunately ended this close liaison. The Police were not informed of the move to a new hospital and did not pursue the matter.

¹⁴ A Storm Information Marker was placed on the address on 06/04/2016 and was active until 05/10/2016. This 'Vulnerable Person' marker highlighted to Police Call Handlers that a different response may be required and provided a brief precis relating to Mr X with Kamil as a victim. The marker was active when Milestones Trust reported the Threats to Kill and Indecent Exposure offences in June and also when Mr X was released from Kewstoke Hospital on the night of the fatal incident.

- 23.4 The Police were not informed of the Mental Health Tribunal or contacted as potential contributors, neither were they aware of Mr X's discharge on 6th July 2016. The Police would not routinely be invited to a Tribunal, and this would only happen if the Panel particularly requested their input. However, in this case they had relevant information which would have assisted the Tribunal's decision making.
- 23.5 Avon and Somerset Police had contact with Mr X at Kewstoke Hospital, but only as a victim of an alleged assault. This was investigated by Police from a different area who did not have information about Mr X's previous incidents. This matter was dealt with separately from Mr X's own arrest some weeks earlier. AWP services were unaware of an alleged assault on Mr X by another patient and the subsequent Police contact with him to investigate his complaint.
- 23.6 The breakdown in communication at this point was significant and another potential avenue for influencing the course of Mr X's treatment and raising concerns about his return to the accommodation were lost.
- 23.7 The diversionary powers available to the Police have been a powerful and effective tool in keeping mentally ill people out of custody and ensuring they are dealt with more appropriately. Unfortunately, the Police lost contact with Mr X when he was transferred from AWP to Kewstoke Hospital and were unaware of the outcome of the Mental Health Review Tribunal.
- 23.8 Dealing with an offender who is also suffering from mental health problems is a complicated area of policing. Each case needs to be treated individually assessing the seriousness of the offence against the severity of their mental disorder and their perceived culpability. The options of Mr X being interviewed, charged, bailed or released under investigation in custody could also have been further explored if the Police had been kept informed of the plans to discharge Mr X.
- 23.9 The investigation of the offences of threats to kill and indecent exposure did not end when Mr X was detained in Hospital, but any investigation was inevitably dependent on a medical opinion on his mental capacity. The process was overtaken by events and Mr X had murdered Kamil before the case could be reviewed.

24 Escalation of Concerns

- 24.1 It is apparent from the management reviews that there was often a degree of frustration between agencies over a failure to follow through on agreed plans. There was a degree of consensus about the desired outcome; Mr X would be removed from Milestones Trust and offered alternative accommodation elsewhere. Because this was a shared goal there was less consideration of formally addressing the lack of progress.

- 24.2 Bristol Safeguarding Adults Board introduced an escalation procedure in April 2016¹⁵ which was available to all agencies and may have helped establish face-to-face communication and develop a shared understanding of risk. There is no discussion in any of the management reports that they had considered its use.
- 24.3 Failure to use escalation procedures is a common finding of serious case reviews and the reason for their lack of use should be explored further. It may be due to a simple lack of awareness of the procedure, but it is often more complex than this; status differential between workers can play a part, workers recognise that overworked and under resourced colleagues are doing their best and resist adding to their burden. On occasion, provider agencies can be reluctant to raise issues with services who refer to them.

Organisational Issues

25 Resource issues

- 25.1 A number of agencies struggled to fulfil their commitment to these two men due to resource issues. For the most part, appropriate resources were in place, but the volume of work for practitioners was extremely high, which inevitably led to a delay in responding to the needs of Kamil and Mr X.
- 25.2 Workload pressures also inevitably affect the ability of services to work together. The opportunity for face-to-face meetings where information is shared is restricted, which in turn affects both the quality of assessments and can lead to a silo mentality rather than an openness to share and work collaboratively.
- 25.3 Specific examples of workload pressures include the delay in the Police responding to the complaint made by Kamil in April 2016, and the delays in Police action following the discovery of the notes in June which were in part due to pressures of other work and fitting in with the shift pattern of Milestones Trust staff. Police resources were extremely stretched, and the volume of work undoubtedly contributed to the delay in responding to Kamil.
- 25.4 There was also the ongoing problem of the overdue CPA which should have taken place in April to address the emerging concerns with Mr X's behaviour. While this was primarily a meeting focussed on mental health it would have allowed Milestones Trust staff to feed in their concerns about Mr X.
- 25.5 The AWP Care Coordinator had an excessive workload and additional responsibilities within the workplace. There are agreed protocols for making allowances in workload for additional duties which were not put into place in this case. Other agencies experienced the Care Coordinator as suddenly pushed for time and too busy with other commitments to arrange the necessary multiagency meeting. While the Care

¹⁵ [Escalation Procedure Resolution of Professional Disagreements in work relating to the Safeguarding of Adults at Risk](#)

Coordinator had lead responsibility for the CPA, safeguarding is a shared responsibility and other agencies could have taken the initiative for convening multi-agency meetings.

- 25.6 The provision of a suitable interpreter was also a factor in responding to Kamil's allegations of abuse. It is recognised that there is a tension between using an interpreter which an individual may feel comfortable with but who may also come from the same community as a service user, raising concerns about confidentiality and personal boundaries. However, it should be remembered that language line is a resource available to all professionals and could have been used in this case.
- 25.7 On several occasions the process of booking an interpreter at a set time for a scheduled interview inevitably caused an element of delay.
- 25.8 The lack of mental health beds within AWP to respond to Mr X's needs also caused avoidable delay. Firstly, the postponement of the mental health assessments on 13th June 2016 was because all the suitable resources were full, and the decision was taken not to assess Mr X until his needs could be met. Secondly, the transfer from the AWP hospital to Kewstoke Hospital caused communication problems eventually leading to the failure to plan Mr X's discharge, this is unlikely to have happened if he had remained solely in the care of AWP.

26 Accommodation issues

- 26.1 The accommodation provided to Mr X and Kamil was essentially self-contained flats and bedsits with limited communal living spaces which included a tenant's lounge and laundry facilities. Support is tailored to individual needs and it is not designed to be a group living experience. The autonomy and privacy encouraged independence and the emphasis of the support was in developing self-reliance and coping skills.
- 26.2 The small rota of staff were also supporting other tenants with their issues and had limited time to support Mr X and Kamil. It should be noted that on numerous occasions Milestones staff worked beyond their agreed hours to support tenants and accommodate other professionals.
- 26.3 Kamil had been moved from shared housing in 2012 because of the difficulties he found living in a shared environment and the effect his traumatised behaviour was having on other tenants. This had led to difficulties with fellow tenants in the past, and therefore even without the tension between Kamil and Mr X, there were risks in placing Kamil in a multiple occupancy house, although Milestones Trust was a better option than his previous accommodation.
- 26.4 The previous failed injunction in January 2014 when Mr X had been admitted into Hospital on a section was a missed opportunity to manage the situation which had arisen between the two men. The application was dismissed by the judge as Mr X was not present, although the application had been timed to allow other arrangements to

be made whilst Mr X was still in hospital. It is ironic that an action taken to ultimately protect Mr X and other residents failed because it infringed his legal rights. Milestones Trust were solely responsible for managing this process at this time, which predated the involvement of United Communities.¹⁶

- 26.5 As the housing provider, Milestones Trust with the support of United Communities could have pursued the eviction of Mr X more proactively, the threats and intimidation exhibited towards Kamil would have supported the application for eviction. United Communities provided the specialist legal advice to Milestones Trust, and advised them to collect information from the Police, the Care Coordinator and GP which would have supported this application.
- 26.6 Mr X had received several final warnings prior to the decision to evict him. Eviction is a relatively lengthy process and the delay in initiating these proceedings inevitably extended the period where Mr X would still have a legal right to his tenancy. This may also have increased the risk if Mr X had felt he had "nothing left to lose" in terms of controlling his behaviour in the accommodation. Therefore, although eviction may have been the preferred option, it still had inherent risks which had not been assessed. Seeking an injunction to prevent Mr X's return was a different legal process which could have run in parallel with an eviction.
- 26.7 It is significant that the Milestones Trust were continuing to proceed with the eviction of Mr X even in the knowledge that Kamil would be leaving the accommodation within months following the withdrawal of support from the City Council. Milestones Trust were aware that Mr X not only posed a threat to Kamil but to other residents as well.
- 26.8 Support workers at Milestones Trust were placed in the difficult position of having to manage the tension in the accommodation because of the ongoing poor relationship between Kamil and Mr X. This was clearly outside of their agreed role and they did not have the time or authority to undertake mediation between the two residents.
- 26.9 Support workers sought to escalate their concerns within their line management, and also by passing concerns on to the Care Coordinator for Mr X. Although Kamil was known to Bristol City Council Adult Social Care and Support Services, and a social worker was allocated for the specific purpose of reassessing his care and support needs, they did not intervene in the problems arising in the accommodation.

¹⁶ Since December 2015 United Communities has held a management agreement with Milestones Trust to provide support to the Trust in relation to any breach of the tenancy. This agreement means that United Communities will offer advice and take legal action in respect of any breach of a Tenancy Agreement or to obtain possession of any homes at the request of Milestones Trust.

- 26.10 Given Mr X's history of institutional care, there was an investment in helping him succeed in living in the community. In the recent past he had been described as "a model tenant" and therefore a decision to evict him and the consequent effect on his mental health would not have been taken lightly.
- 26.11 It is apparent that the support workers who work with vulnerable people in supported accommodation do far more than their agreed roles in helping vulnerable people cope on a day-to-day basis. The staff at the accommodation would regularly work beyond their commissioned hours and make themselves available in the evening and at weekends. Their importance was not recognised by other professionals; at crucial times information was not shared with them and their observations were not sought. Their ability to support Kamil and Mr X would have increased if they had been included in planning and their opinions taken on board.
- 26.12 One of the practice findings of this review has been that support workers from housing providers are not routinely included in CPA or other case review processes. They will frequently be the practitioners with the most recent day-to-day information on the welfare of the service user. In this case, Milestones Trust were the only agency who had first-hand experience of both service users and how they interacted with each other.

27 EXAMPLES OF GOOD PRACTICE

- 27.1 An integral part of the SILP review process is to ensure that good practice is acknowledged, and organisations retain the awareness that the acknowledgement of good practice can support the dissemination of learning.
- 27.2 The following examples of good practice were identified:
- The Milestones Trust team communicated well internally and delivered support to both Mr X and Kamil (with the tragic exception of the final failure to notify Kamil of Mr X's impending release from detention) and managed to preserve a working relationship with both men. They have also provided on-going support to residents following the incident.
 - The AWP Bristol Crisis Service demonstrated assertiveness and tenacity in their pursuit of a MHA assessment for Mr X on the 10th/13th June.
 - The Police who attended the incident on 7th July supported residents and staff with professionalism and compassion in the aftermath of a harrowing and traumatic incident.
 - Bristol Refugee Rights provided Kamil with a place of sanctuary and friendship where he felt safe and appreciated.
 - For both Mr X and Kamil their respective GP practices provided care to support them in the community, both in terms of their physical health and referring on to more specialist services. Mr X's GP also played a key role in monitoring the effects of his medication.

- Liaison between the Trauma Foundation and GP to support Kamil following refusal of Asylum status. A same day consultation with an interpreter and further referral to the Crisis Team were arranged at very short notice.
- The Trauma Foundation were able to maintain a therapeutic relationship with Kamil for over three years and provided advocacy outside of its usual remit.
- SARI provided support and advocacy for Kamil working with Milestones and the Police.
- Milestones and SARI worked well together sharing information and documents whenever appropriate.
- The management of the Safeguarding Enquiry in January 2014 was an example of good practice. The multi-agency approach was adopted and there were actions and protection plans created and distributed
- Practitioners from the social care team recognised the importance of Kamil being able to communicate his views and interpreters regularly used when Kamil was consulted.
- The interface between social care team and the asylum team worked well and there was evidence of joint working to ensure that outcomes for Kamil were appropriate and had taken in to account his asylum status.

28 CONCLUSION

- 28.1 Kamil's murder was racially motivated and the culmination of a developing race hate obsession with Kamil by Mr X.
- 28.2 The fatal assault on Kamil on the evening of 6th July could have been avoided. The decision to discharge Mr X by the Mental Health Tribunal was based on incomplete information. As a result, it foreshortened his compulsory treatment and reduced the time available for AWP to seek alternative accommodation for him and for Milestones Trust to commence eviction.
- 28.3 Whilst the decision-making process of the Mental Health Review Tribunal is outside the remit of this review, it is clear that the decision to discharge the section had tragic consequences. It would seem that the Tribunal did not follow the recommendations of the professionals involved and did not fully appreciate the significance of the problems in the accommodation and the inherent risk of Mr X's return.
- 28.4 The lack of preparation for Mr X's return to Milestones Trust was the result of miscommunication between Kewstoke Hospital and AWP and a corresponding failure to plan for this eventuality. Milestones Trust were left in an untenable position without the time or resources to respond to the situation.
- 28.5 There were several opportunities in the scoping period, but also stretching back to 2014 when actions could have been taken to separate Mr X and Kamil. The long-standing tension between them may have varied in its level of seriousness, but

there remained an underlying dislike and resentment from Mr X towards Kamil, which was given full rein when he became mentally ill.

- 28.6 As housing provider, Milestones Trust were slow to act in pursuing the termination of Mr X's tenancy and needed the support of other agencies to achieve this. As a provider dedicated to meeting the housing needs of mentally ill vulnerable people, revoking the tenancy was not a course of action to be entered into lightly. However, Mr X had been given several final warnings and his behaviour put him in breach of his tenancy agreement. Continued sharing of accommodation was clearly detrimental to both parties and had a knock-on effect on other residents of the accommodation.
- 28.7 Other agencies had requested that a Care Programme Approach meeting was arranged, however the care coordination and caseload management system within AWP failed to recognise the evidence of risk towards Kamil.
- 28.8 A review meeting should have taken place, which would have provided a better understanding of the nature of the risk and placed it in context of Mr X's underlying racist attitudes towards asylum seekers and Kamil in particular.
- 28.9 Information sharing between AWP and Cygnet Health Care failed due to the absence of key personnel due to annual leave. The systems should have been robust enough to have contingency plans for when a key professional is absent from work.

RECOMMENDATIONS

MULTI-AGENCY RECOMMENDATIONS

1. The Bristol Safeguarding Adult Board (BSAB) should refresh and re-launch its Adult Safeguarding escalation policy for all partner agencies.
2. The BSAB should arrange an audit of safeguarding alerts, referrals and responses to understand how the vulnerabilities of asylum seekers¹⁷ are explored and assessed.
3. The BSAB should work with voluntary agencies and charities who support refugees to ensure pathways are in place to support individuals who do not meet the thresholds of the Care Act.
4. The BSAB should implement multi-agency training to raise the awareness of hate crime in all its forms (disability, race, religion, sexual orientation and gender

¹⁷ In the context of these recommendations "asylum seeker" should be taken to include asylum seekers, refused asylum seekers and people with refugee status.

identity), including support for victims when reporting hate crime and in identifying appropriate social and therapeutic support.

5. The BSAB should produce multiagency guidance for the management of two or more service users who are not related, or members of the same family group but living in shared accommodation.
6. The BSAB should produce guidance for practitioners on the assessment of need and risk assessment of vulnerable adults (including asylum seekers). This guidance should explicitly address the issue of unconscious bias and how this can affect professional judgements and practice.
7. The BSAB should ensure that assessment guidance recognises the valuable contribution charities and voluntary organisations can make to the assessment process. Protocols for effective information sharing should be devised to overcome difficulties of sharing information where this is in the best interest of the service user.
8. The BSAB should review practice and ensure staff are adequately trained in making interventions and referrals to substance misuse services.
9. Avon and Somerset Constabulary Lighthouse Victim and Witness Support should review how their delivery model of hate crime services could be made more accessible through models such as assertive outreach and improved joint working.
10. AWP should review the procedures for information sharing and decision making when patients are transferred in either direction with all commissioned independent health care providers. The information provided for this review suggests that these crucial elements are dependent on individual practitioners who have knowledge of the requisite systems. However, it fails to consider the possibility of individual error and the need for contingency plans when a key professional is absent from work.

SINGLE AGENCY RECOMMENDATIONS

This review seeks single agency recommendations in four areas. If these are agreed it will not be necessary to raise these areas of practice with the safeguarding board.

1. Discharge planning is a joint responsibility between the hospital and community mental health team. A protocol should be put in place, setting clear standards for discharge planning meetings and arrangements under the Care Programme Approach in the event of a planned discharges, discharges by appeals, and unplanned discharges. This should include clear guidance on the requirements (AWP).

2. Arrangements should be made to ensure that Care Coordinators/case managers receive information about a service user's progress when they are in hospital and are aware of impending discharge and other developments. (AWP).
3. Safeguarding Section 42 enquiries should not be closed down prematurely before there has been a risk analysis based on the available information and key professionals have been consulted, a rationale for the decision made should be evidenced, recorded and communicated to the referrer and individual. If a section 42 enquiry is not undertaken signposting to other agencies, giving advice or information should be considered. (BCC).
4. The AWP bed availability policy¹⁸ should be revised to avoid mentally ill people in crisis remaining in the community where they are a risk to themselves and others. (AWP).
5. Cygnet Health Care should ensure that its discharge procedures require active engagement with referring organisations to ensure the safe handover of responsibility between the Hospital and community services. (Cygnet Health Care).
6. AWP should provide guidance and training for all staff to assist them in deciding when to use the Police 101 (non-emergency service) and when a 999 call is appropriate. (AWP Crisis Service)

¹⁸ Multi-Agency Protocol - Working together when mental health act assessments are requested, including situations where resources are unavailable. Avon and Wiltshire Mental Health partnership NHS Trust

Bristol Safeguarding Adults Board



Case review

Terms of reference

Subjects: Kamil Ahmad & Mr X

Version 4: 25.05.2017

SUMMARISED FOR PUBLICATION

SECTION 6: AREAS FOR CONSIDERATION

- 6.1** The management, response and recording of risk within and between the organisations responsible for the care and treatment of Kamil/Mr X between April 2016 and July 2016. Please comment on the risk assessments used, whether they were reviewed and shared, and how the Care Programme Approach contributed to multi-agency analysis and evaluation of assessments and interventions.
- 6.2** Did risk management plans about Mr X incorporate risks posed to Kamil and to other vulnerable adults? Were they appropriately shared and understood across agencies and professionals involved with both men?
- 6.3** How were transitions managed between and within different services and what was the impact of this? Were there any barriers to communication about both Mr X and Kamil's diagnosis, risk or care needs?
- 6.4** How did the care planning approach for Mr X's detention, treatment and discharge in relation to his hospitalisation on 13/06/2016 (including the tribunal process and outcome) impact on safeguarding both men?
- 6.5** How were the families of Kamil/Mr X involved in the planning and delivery of the care and treatment of Kamil/Mr X?
- 6.6** Was consideration given to issues of culture, language, race, religion or belief? Was protection of Kamil impacted by his race or asylum status?
- 6.7** Was consideration given to the compatibility of Kamil, Mr X and other vulnerable people being housed together as risks changed?
- 6.8** Identify examples of good practice, both single and multi-agency