Lessons Learned

Warwickshire Safeguarding Adults Board

Neil's Story... Neil was placed in temporary residential care following his eviction from his flat due to anti-social behaviour. At the time of his death, he had been in residential care for 20 months, moving on three different occasions as placements broke down due to his behaviour. The last placement was in a neighbouring county as local provision had been exhausted. Records describe Neil as having ADHD, alcohol problems and possible cognitive damage due to a brain tumour. He had a history of drinking heavily and, when intoxicated, his behaviours would be difficult to manage. He assaulted staff and residents on a number of occasions and would also be verbally offensive; police were often called but staff never proceeded with the charges which meant that Neil faced no consequences for his behaviours.

During the national lockdown due to the Covid-19 pandemic and following an incident at the residential unit in April 2020, Neil was evicted from the residential service. Neil had also stated that he wanted to leave. He was given his possessions and some money, was provided with the details of the housing advice service, and he was recommended to present himself there as homeless. Contact was made with the service to advise that Neil would be presenting.

He was seen by Leicestershire police at 1:12 am the following morning and was safe and well. Neil was found unconscious the following day back in Warwickshire and was taken to hospital. He remained unconscious in hospital for several weeks, however his identity was unknown. Sadly, Neil died in May 2020; his identity was only determined following his death.

What we have learned...

A number of agencies were working with Neil. However, what was lacking was a single shared approach to support and planning. Agencies indicated that they were not fully aware of the *'wider picture'* with the support not being joined up.

Learning for Practice: *Where there is multi-agency support for individuals, a single shared approach to support and planning should be developed and reviewed at agreed timescales. It is also essential that any changes and developments are shared with all agencies involved.*

Neil's behaviour was very challenging to manage, especially when he had been drinking. He was often verbally aggressive and physically violent. He was known to threaten staff and residents and was racially abusive at times. It was clear, however, that there had been no discussion between services about the best course of action that should be taken when Neil's behaviours deteriorated.

Learning for Practice: *Where an individual's behaviours continue to impact on the safety of staff and residents, a multi-agency plan and risk assessment would support all agencies to understand the expected course of action. Where people are responsible for their actions, this should include consideration of criminal proceedings. This should also consider consequences and risk planning for a potential breakdown in support.*

Lessons Learned (cont.)

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What we have learned (cont.)...

The police were often called to the setting, however the staff never wished to make a complaint and police were only able to give words of advice to Neil. The residential care staff stated they did not wish to press charges as this would break down the working relationship and they felt that the presence of the Police may help Neil in calming down and understanding his behaviours.

Learning for Practice: *It is not good practice to tolerate violent and aggressive behaviour that people are responsible for and there is no evidence that it works to maintain a relationship with people by tolerating abuse. This is especially true when the behaviour breaks the law or breaches probationary requirements. Agencies need to develop and agree strategies to change the behaviour, reduce it or keep staff and residents safe.*

What do I need to do....

Advice for professionals

- When working with several professionals or agencies, always try to work as a team: work in a structured way; agree clear actions; agree who is doing what; talk about and try to resolve differences; and as far as possible, try to agree a single shared plan. Always involve the individual as much as possible.
- Assess and be clear about risks and what may be required to manage them.
- Never accept violence and aggression towards yourself or others. Where people are responsible for their behaviour, they should expect to face proportionate consequences such as exclusion from a service or being reported to the police. Where this behaviour is the result of serious mental illness, learning disability or other mental disorder, the right assessment and support should be put in place to keep people safe.

Advice for communities

- When an individual is verbally or physically threatening, always seek advice from the police.