Oxfordshire Safeguarding Adults Board

Safeguarding Adult Review

Adult C

Overview Report

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Report published: 11th April 2018

OSAB
Oxfordshire Safeguarding Adults Board

CONTENTS

Section 1 – Introduction

1.1 - Circumstances of Review

1.1.1 This Safeguarding Adults Review (SAR) concerns Adult C, who was a man in his 40s living alone in Osney, Oxford since 2002. He had no partner or children.

1.1.2 Adult C was born in Germany and came to UK while still very young. He was apparently in Care for some time, and also served a number of prison sentences. He had unspecified mental health issues over 20 years ago, and was reportedly admitted to hospital twice for assessment.

1.1.3 While living at Osney, Adult C was involved in a number of disputes with a neighbour about noise, and was arrested on several occasions for aggressive and threatening behaviour. He set fire to his own car in 2010.

1.1.4 On Friday 10th February 2017, Adult C called Police to complain about noise from a neighbour. His speech was bizarre and the call taker thought he may have mental health issues. Police were also called at the same time by another neighbour reporting that Adult C had threatened to set fire to the flat the previous night, and had taken two cans of petrol inside. Police officers visited the property soon afterwards, forced entry and called an Ambulance because of concerns for Adult C's mental state.

1.1.5 A Mental Health Act assessment was convened at the flat that morning, but Adult C had calmed down and the outcome was that he did not require admission to hospital. Community follow-up was arranged via the Step-Up Team, and Adult C had face-to-face and telephone contact with staff over the next two days.

1.1.6 At around 16.40 hrs on 14.2.17, there was an explosion at the block of flats where Adult C lived, resulting in a large fire and total demolition of the two-storey structure. Three flats were completely destroyed, and others suffered fire damage. The body of Adult C was later found in the rubble, and there were no other casualties. An Inquest on 7.2.18 concluded that 'the explosion is likely to be accidental in nature but he was heard to say he was going to cause an explosion about five days before and it cannot be ruled out that it was caused deliberately."

1.1.7 The cause of death was recorded as 'burns and injuries consistent with an explosion'.

1.1.8 A referral was made to the Safeguarding Adults Review (SAR) sub group in March 2017, and the SAR Sub-Committee resolved in April 2017 to commission a Safeguarding Adults Review.

1.1.9 Martin Bradshaw was invited to undertake an Overview report into the circumstances of the case. He is a retired Approved Mental Health Professional with extensive experience of management investigations.

1.2 The purpose of a Safeguarding Adults Review (SAR)

1.2.1 Safeguarding Adult Reviews are undertaken when a vulnerable adult dies or is seriously injured and abuse and/or neglect is known or suspected to be a factor.

1.2.2 The purpose of a SAR is neither to reinvestigate nor to apportion blame, but to establish if there are lessons to be learnt to prevent such an incident happening again. The Association of Directors of Social Services in their document '*Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services*' described the overriding reasons for holding a review as being to learn from past experience, improve future practice and multi-agency working. Safeguarding Adults Reviews have become a Statutory Duty since the Care Act 2014 came into force on 1st April 2015.

1.2.3 In Oxfordshire the SAR subgroup makes recommendations to the Oxfordshire Safeguarding Adults Board (OSAB) chair and manages the SAR process in accordance with the OSAB protocol for Safeguarding Adults Reviews in adult safeguarding. It considers whether a case meets the criteria for a SAR, applying the criteria as laid out in the Care Act 2014 and its accompanying guidance.

1.2.4 Having taken into account a range of factors and after careful consideration (prior to the Inquest), it was determined that this case met the criteria and a SAR was recommended and commissioned following a multi-agency review by the OSAB SAR subgroup.

1.3 Terms of Reference

1.3.1 The SAR had two central objectives. The first was to review and evaluate the context and circumstances leading up to the death. The second was to identify any contributory factors to the death and learn appropriate lessons across organisations. It is important to note that these objectives were established well before the Inquest verdict indicated that the explosion was likely to be accidental.

1.3.2 Two broad scenarios are possible in relation to the cause of the incident. Firstly, that the explosion and fire were accidental, and secondly that they were the result of a deliberate act by Adult C and/or others. These alternative options were acknowledged by the Coroner in his narrative conclusions.

1.3.3 There is some circumstantial evidence that the explosion may have been a deliberate act. Adult C was known to be emotionally unstable in the immediate period before the fire, and had threatened to damage the flats on several occasions. He had a history of setting fire to his own car when angry, and had made a recent threat of arson. In the month prior to the incident he had purchased 60 litres of petrol in jerrycans, and was reported to have taken petrol canisters

into the flat days before the explosion. On the day of the explosion he was observed to be spraying a liquid into several of his cars, which were later found to smell very strongly of petrol.

1.3.4 This SAR report has been written in a form which recognises both the possible causes of the explosion (accidental and deliberate). The purpose of SARs is to learn from incidents, and investigative reports were produced in good faith by TVP and Oxford Health NHS Foundation Trust. The practice and learning points identified in those reports remain valid, even if there was no direct connection between interventions by those agencies and the explosion.

1.3.5 Exclusions

1.3.6 The OSAB recognises that there is strong public interest in the way statutory services responded to the explosion, and how the search, recovery and rehousing issues were managed. These legitimate concerns are outside the scope of the SAR, which is solely related to the way Adult C was dealt with by key agencies immediately prior to his death.

1.3.7 The Safeguarding Panel established the following questions in relation to Adult C, to be addressed in the Review:

- What specific issues or questions does this case raise?
- Are there any unusual factors in this case, what are they?
- Are there any failings which appear obvious at this stage?
- Do there appear to be any gaps in multi–agency working?

1.4 Contributors - Individual Chronologies and Reports

1.4.1 In the light of minimal recent involvement by statutory agencies with Adult C, the Safeguarding Adults sub group did not consider that Individual Management Reports (IMR) from key agencies were necessary or proportionate. However, Thames Valley Police (TVP) produce IMRs as standard practice following incidents of this nature, and their report was circulated on 2.1.18. This SAR report has included findings of the TVP IMR, which was approved by a responsible officer in the organisation.

1.4.2 The Oxford Health NHS Foundation Trust (OHNHSFT) conducted an internal 'Root Cause Analysis Investigation' under the Serious Incident procedures. Their report was completed on 27.4.17, and has been used to inform the SAR.

1.4.3 The six agencies listed below were asked by the subgroup to produce chronologies detailing their respective contact with Adult C. These chronologies were combined and used by the author as the main basis for this report. A copy is held by the SAR Panel Administrator.

1. Adult Social Services, Oxfordshire County Council (re AMHP)
2. Oxford City Council
3. Thames Valley Police

4. A2Dominion
5. Oxford Health NHS Foundation Trust
6. South Central Ambulance Service

1.4.4 Additional information or content was obtained by the author as required. The author was also given access to the file prepared for the Coroner.

1.4.5 The SAR conclusions represent the collective view of the SAR Panel, there have been full discussions of all the significant issues arising from the review, and these have contributed to the shaping of the report.

1.5 Safeguarding Adults Review Panel Members

Martin Bradshaw	Independent Author	Consultant
Steven Turner	Business Manager	OSAB
Matt Bick	SAR Subgroup Chair and TVP rep	Thames Valley Police
Mel Pearce	Safeguarding Manager	Oxfordshire County Council
Moira Gilroy	Safeguarding Manager	Oxford Health NHS Foundation Trust
Daniella Granito	Policy Manager	Oxford City Council
Alison Chapman	Lead Nurse for Safeguarding (GP Representative)	Oxfordshire Clinical Commissioning Group
Diane Collery	Safeguarding Adult Lead Practitioner	Oxford University Hospitals Trust
Tony Heselton	Designated Safeguarding Professional & Prevent Lead	South Central Ambulance Service

1.6 **Responsibilities to Families**

1.6.1 Good practice requires families to be involved in the SAR so that they can contribute as appropriate (SAR Protocol para. 10). The Board is only aware of contact details for two relatives, the mother and one brother of Adult C. The mother was written to in June 2017 offering the opportunity to participate in the review, which was not taken up.

2 Background, Events and Chronology

2.1 **Background Summary**

2.1.1 Relatively little information was available about the life and background of Adult C, who was not well known to statutory agencies. This summary provides a general overview of key

events. It is not exhaustive or independently corroborated, and further detail of specific contact with TVP is contained in their IMR.

2.1.2 Adult C used a number of aliases and several different Dates of Birth, for unknown reasons. This report uses the main name and DOB recorded by Police in relation to the latest incidents. Background checks were made in OCC and NHS Mental Health records against all aliases, but no additional information or activity was discovered.

2.2 **General Background - Birth to November 2016 Inclusive**

2.2.1 The following background is mainly from mother's police statement, and self-reported from psychiatric interviews with Adult C on 13.12.16 and 10.2.17. It has not been independently confirmed. Forensic background is from TVP IMR.

2.2.2 Family and Social History

2.2.3 Adult C was born in Germany and came to UK in the 70s when he was very young. His father was in the Forces, and became a Prison Officer. There were four boys in the family including Adult C. Father is reported to have been violent to his wife and the children. Mother states that Adult C was 'a normal boy, never caused any problems' until his teens. At the age of about 15 he became 'very distant and moody', and was involved in car crime. If challenged, he would be 'angry and argumentative' and mother was frightened of him from that time. Adult C reported going through the child care system, but no details were given. Contact as an adult with his family was rare and strained, although mother states that he was never actually violent towards her. His mother and one brother live in Doncaster, whereabouts of other family is not known. Adult C had recent contact with them about two weeks before the explosion. He arrived for an unannounced visit and subsequently sent his mother a gift in the post.

2.2.4 Adult C worked in many different jobs and was apparently often bullied by colleagues, being called a 'Nazi' because of his German origins. He installed car radios when living in London, and his last known job was driving a forklift at the Mini plant in Oxford, where his back injury (sustained in the 90's) became worse. At the time of his death, Adult C was unemployed, in receipt of incapacity benefit and disability living allowance. Most of his disposable income was apparently spent on repairing cars. He had lived alone in Housing Association property provided by A2 Dominion since 2002. Prior to this he lived in Simon House in Oxford in 2001.

2.2.5 Adult C reported that he had friends in Oxford, and that he got on well with some of his neighbours. Several local people stated that they had occasional contact with Adult C, who would drop occasionally in to use the computer or to have a cup of tea, but these were not

close relationships. One of the neighbours described Adult C as 'reclusive'. Mother was not aware of him ever having a girlfriend.

2.2.6 Physical Health

2.2.7 Adult C had a road traffic accident in 1997, and stated that he had been debilitated by back problems since that time. He reported chronic and severe back pain as a consequence of degenerative disc disease, and also experienced pain in his hip, ankle and knee. He rarely visited his GP, and apparently did not feel 'listened to' by services in relation to his back condition. Adult C took a significant quantity of painkillers each day to help with the back problem, and suffered from constipation which may have been linked to the medication. He reported having very little sleep because of the pain.

2.2.8 Adult C smoked tobacco and occasional cannabis, and was reported to use Ecstasy in the past. He drank brandy 'occasionally' but said that he was 'not a pub person'.

2.2.9 Forensic History

2.2.10 Adult C stated that he had been a car thief from age 11. He was reportedly held on remand after a fight with his brother in 1995. His brother had apparently attacked him with a garden fork and Adult C retaliated by stabbing him twice with a knife. The brothers were reportedly reconciled after this incident.

2.2.11 TVP report that Adult C had a substantial criminal record, mainly for non-recent offences against property, assaulting police and related to driving. He was disqualified from driving in 2001 and served a short prison sentence that year. In total, some 67 offences are recorded, resulting in 21 convictions between 1985 and 2015. In March 2010 he set fire to his own car in an apparent suicide attempt, but changed his mind about killing himself. In November the same year he was arrested after he smashed all the windows in his car with a wrench, filled it with combustible materials and threatened to set it alight. He also slashed the tyres with a carving knife. The medical record from that arrest described him as 'a very angry man', but an Appropriate Adult was not deemed necessary during his detention.

2.2.12 In April 2015 a neighbour reported Adult C to Police for playing very loud music late at night. When Police attended at 01.45 hrs the music was very loud, and Adult C was initially aggressive to Officers. He stated that he was deliberately playing the music to annoy his neighbour, because of the noise from her washing machine. The neighbour told Officers she felt unsafe as this type of incident happened regularly, and he had threatened her and made 'monkey noises'. Although Adult C initially turned down the music, he turned it up again shortly after Officers left. When they returned he was arrested for harassment. While in custody he became abusive and threw water over staff. On 18.11.15, Adult C was found guilty at trial of assault and harassment, and fined.

2.2.13 Anti-Social Behaviour/Noise Complaints by Adult C re Neighbour

2.2.14 Adult C had a long-running dispute with the neighbour who lived upstairs. This may have been going on for over ten years. Adult C regularly called police to complain about the noise from upstairs, usually from a hoover or washing machine. He stated that the building was not well insulated and he had apparently reported the problem to the landlord. Police records indicate that there were ten such complaints between October 2014 and February 2017. Adult C was often rude and abusive to Call Takers, and to officers when they called round to see him.

2.2.15 During some of these investigations Adult C complained that police were biased towards the neighbour because she was black and female. In October 2014 Adult C mentioned to the TVP Call Taker that he felt like *'becoming violent and ripping the flats down'*. There were further noise complaints from Adult C in April, June and August 2016, with Adult C stating that the neighbour had turned on her washing machine really early *'to get back at him'*. During the April incident he asked '*Do I have to do something dramatic*?

2.2.16 Adult C contacted police four times on 11th and 12th February 2017, complaining of noise from upstairs (stamping feet, music, washing machine) and alleged that police were institutionally racist. This was only two days before he died.

2.2.17 It is not clear from reports how far the noise issues were based in reality, or if the concerns were to some extent unreasonable or even based on hallucinations. Either way, the dispute with this neighbour was a central feature of Adult C feeling angry and bitter about his situation at Gibbs Crescent, and may have been a contributory factor in the fire and explosion if it was in fact deliberate.

2.2.18 Mental Health up to November 2016

2.2.19 Adult C told police that he had self-harmed by cutting his wrists in 1991. He also stated that he had been admitted to hospital on two occasions under the Mental Health Act, some 25 years ago. He did not recall any details or formal diagnosis. One of the admissions was to a psychiatric unit in 1993, when he was transferred from High Down prison. He was apparently discharged without any medication, and there are no records of psychiatric assessment or treatment in Oxfordshire prior to 2016. GP records do not indicate any significant mental health issues before 2016.

2.2.20 The Housing Association records indicate (March 2012) that Adult C was barred from attending their offices in future due to his 'aggressive and threatening behaviour' following a recent visit to discuss rent arrears. In December 2013 Adult C was noted as being 'extremely aggressive' towards the Lettings Co-ordinator, and staff from the Association stopped visiting him at home. As a result of this attitude, there had been no inspection of the flat by A2 Dominion for some time prior to the explosion

2.2.21 On 12th June 2015, the mother of Adult C contacted Police to report concern that he wanted to kill himself. Officers attended the flat for a welfare check, but Adult C shouted at them and told them to leave him alone. He said that he did not wish to harm himself, and *'would rather die than see a Doctor'*. An Adult Protection report was created with concerns regarding his mental health. On 18.6.15 a MASH Adult Protection review noted that there was no consent to share information and no apparent significant risk to Adult C. No further referral was made.

2.3 **Events of 1.12.16 to 14.2.17 inclusive**

2.3.1 On 13.12.16 Adult C telephoned his GP at Jericho Health Centre requesting medication for back pain. The request was declined because the GP had not seen the patient since 2015. Adult C then became verbally aggressive, threatened to take his own life and told the GP he had taken an overdose. An ambulance was called, and Adult C began throwing £20 notes at the paramedics before waving a kitchen knife at them. Police were called, who removed the knife and escorted Adult C to JR2 Hospital. Empty packets of pills found at the flat indicated that Adult C could be taking up to 70 x 30 mg codeine tablets per day.

2.3.2 Following his arrival at JR2 (15.15 hrs), Adult C was assessed by the Emergency Department Psychiatric Service (EDPS). He was hostile and irritable towards staff, refused blood tests and repeatedly stated he had not taken an overdose. He said he had lied about the overdose so that his GP would know he was desperate for a letter to DWP about benefits. Adult C said he was constipated, possibly due to the painkillers he was taking. Mental health history was taken, which was later used for the assessment on 10.2.17. Adult C stated he was sleeping very little, due to back pain. There was no pressure of speech, visual or auditory hallucinations. He did have a firm belief that no-one wanted to help him and that NHS staff were out to persecute him.

2.3.3 The EDPS assessment concluded that Adult C had capacity to understand the implications of not seeing his GP, and that there was low risk of harm to himself or others. There was no evidence of risk from others. The assessment ended at 18.40 hrs 13.12.16 and Adult C was discharged home. A letter was sent to GP suggesting a referral to the pain clinic. No follow up by mental health services was indicated, and no referral was made.

2.3.4 On 16.12.16 Adult C called Police 4 times in 8 minutes, shouting at the call taker because he alleged unlawful access to his property by Police on 13.12.16. He had received a bill for boarding up.

2.3.5 Adult C was sent a letter by GP on 4.2.17 inviting him to attend for a review, and to see if anything could be done to help with the back pain.

2.3.6 On 6.2.17 Adult C was sent a letter by the Housing Association inviting him to a meeting on 16.2.17 to discuss alleged antisocial behaviour.

2.3.7 On 8.2.17, Adult C visited his brother, who described him as being on 'good form'.

2.3.8 On the evening of 9.2.17, a neighbour helped Adult C to carry several cans of fuel into the flat. When asked by Police about Adult C's mental health, The neighbour described him as 'pretty switched on, pretty sound'. He had never been frightened of Adult C, and had occasionally helped him to carry shopping up to the flat.

2.3.9 Early in the morning on 8th or 10th February, a partially sighted neighbour saw a man banging on doors in Gibbs Crescent, shouting "I'm going to blow this place up, God sent me to do it". This witness was not sure if the man was Adult C, but it seems reasonably likely.

2.3.10 **Mental Health Act Assessment 10.2.17**

2.3.11 Early in the morning of Friday 10.2.17 (06.46 hrs), Adult C dialled 999 to complain about the noise from Flat no. 7. He shouted down the phone, saying "His Master was awake now and do I have permission to get on with my day now?". Adult C then disconnected the call. At the same time a neighbour called Police saying Adult C was shouting and banging, and reported helping Adult C to carry two canisters of petrol into his flat the previous night. Adult C had told him he was going to set fire to the place, and the caller did not know if he was joking or not. The neighbour thought that Adult C had 'flipped out' and 'snapped' over problems with another neighbour.

2.3.12 Officers were sent to investigate, arriving at 07.05 hrs 10.2.17. Adult C did not answer the door, so entry was forced. Adult C was conscious but did not react to Officers. He was seated at a desk with two knives, which were removed. He said "she is my master, the lord above, Number 7". Adult C lunged at Officers and was thought to be preparing to spit, so was restrained. An ambulance was requested.

2.3.13 The ambulance arrived at 08.09 hrs. Adult C attempted to spit at paramedics, denied being intoxicated. He was very distressed, in handcuffs and leg restraints, shouting at crew and appeared 'extremely paranoid'. The paramedics then contacted the Approved Mental Health Professional (AMHP) Team for advice. There was an initial suggestion that Adult C should be taken to A&E in case he had physical health problems which were causing the behaviour.

2.3.14 Following various discussions with the City Adult Mental Health Team, it was agreed that a full Mental Health Act assessment would be completed at the flat. The staff involved were the Manager of City AMHT (also an AMHP), the Duty S12 Consultant and the Independent S12 Doctor. The Junior FY2 Doctor took notes. All three of the assessing staff were highly experienced in use of the Mental Health Act. There were male admission beds available if

necessary for Adult C on both Acute Wards in Oxford, and also the Psychiatric Intensive Care Unit if required.

2.3.15 The assessment convened at Gibbs Crescent (home of Adult C) at around 11.00 hrs 10.2.17, some four hours after the initial 999 calls. By this time, Adult C was presenting as calm and cooperative, although still under restraint. Police were surprised by this behaviour, noting 'this sudden change was similar to that of flicking a switch'. The assessment team was shown video evidence of Adult C acting in a bizarre and agitated manner earlier in the morning. Police officers briefed the team about the threats to set fire to the flat.

2.3.16 The flat was 'cluttered' with car parts, which were piled up around the main living room. Police and the assessment team considered that there was a risk of accidental fires due to the presence of motor oil and cleaning fluids. Adult C was seated in an armchair in the middle of the room, and spoke normally to staff, becoming more agitated at times when talking about his neighbour. The interview was led by the Duty S12 Consultant, who is an experienced Consultant Psychiatrist (now retired). Notes were taken and later signed off formally by the Duty S12 Consultant.

2.3.17 The assessment found no clear evidence of hallucinations, thought disorder or delusional thinking. However, the Duty S12 Consultant did consider that the noises reported from upstairs 'may have been hallucinatory in nature'. No psychosis was identified. Adult C was preoccupied with housing problems and the situation with his neighbour, which had been going on for many years. It was thought that he was 'quick to agitation and aggression'. Adult C stated that he had been woken early that morning by noises from upstairs and "had a rant [and] made sure everyone knew about it". "Sometimes you have to do stupid things to get people to listen".

2.3.18 <u>Risk Assessment</u>

2.3.19 Adult C was asked repeatedly about any intent to harm others, or to set fire to the flat. His response was "I've said that I can, but does that mean I would?". He denied having set any fires before, although this was not in fact true since he had set his own car on fire in 2010. The team was not aware of this at the time. Adult C denied that he would carry out his threat of burning down the flats. Police carried out a 'proportionate search' which did not find any petrol canisters, or any smell of diesel or petrol fuel. The assessment team also looked round the flat and did not see or smell any evidence of stockpiled fuel. A number of knives were found near to Adult C when approached by police, and he stated that these were for cutting food or his nails.

2.3.20 Throughout the assessment, Adult C repeatedly denied any thoughts of self-harm or suicidal intent, and also denied any intention to harm others including the lady upstairs.

2.3.21 <u>Outcome of Mental Health Act assessment 10.2.17</u>

2.3.22 Adult C was assessed for approximately an hour (reports vary), and the team then moved outside to discuss their findings. The possibility of fluctuating mental state was considered, given the extreme behaviour reported by police earlier that morning. The team considered that the prolonged violent outburst was most likely to be due to anger and resentment at forced entry by police, in the context of a very 'private' man with anti-social personality traits.

2.3.23 The report for HM Coroner by the Manager of the City AMHT states 'it was unanimously agreed that there was no evidence based on the assessment that Adult C was presenting with a mental disorder of a nature or degree requiring admission to hospital under the Mental Health Act 1983. Adult C was presenting with capacity in relation to his mental health care and treatment, and had calmed significantly. His presentation appeared more aligned with his personality and not a psychotic disorder'. This unanimous view was confirmed by the Author from interviews with two members of the assessment team, and from psychiatric and social work notes.

2.3.24 Given that Adult C was a relatively unknown patient, the team did consider that there was still a possibility of mental illness, and that this would be most appropriately assessed in the community. Adult C readily agreed to community follow-up, and this was subsequently arranged. The Manager of the City AMHT confirmed on interview that even if a paranoid illness had been diagnosed or suspected, the management of this case would still have been in the community, since Adult C was co-operative and there was no perceived immediate risk to self or others.

2.3.25 The assessment team discussed their decision with police, who were still on scene. Officers advised that they *could* act on the allegation of threats to cause criminal damage, but that they did not feel it was appropriate to do so. The team and police finally left the premises around 13.30 hrs, over six hours after officers had first arrived. Adult C was calm and co-operative at this point, and confirmed that he would accept home visits from the Step-Up team. He declined the offer of medication to help with management of his agitation.

2.3.26 <u>Action Taken and Events Following MHA Assessment</u>

2.3.27 On returning to the Warneford Hospital, the Manager of the City AMHT arranged with the 'Step-Up' team for home visits to be made to Adult C over the weekend of Saturday 11th and Sunday 12th February. The purpose of these visits was to review the mental state of Adult C, and to give him an opportunity to vent frustration around his social/housing issues if necessary. A home visit was made by two members of the Step-Up team at 14.30 on 11.2.17. Adult C was initially 'cool' towards staff, but appeared settled and relaxed. There was no agitation or pressure of speech. Conversation was appropriate, he talked openly about his historic and current issues with neighbours and police, and forthcoming appointments with Housing Association and GP. This visit lasted about an hour and Adult C 'appeared to enjoy having company'. There was no evidence of psychotic illness, and no identified risk to Adult C or others.

2.3.28 Following the home visit, one of the Step-Up team members concluded that another face-to-face visit was not required the next day, and that a telephone contact would be appropriate. This type of decision is apparently normal practice in that team.

2.3.29 Later that evening (11.2.17) Adult C made phone calls to Step-Up and Police about the neighbour upstairs 'banging around'. The Street Triage team was contacted, but no action was taken in view of the recent MHA assessment.

2.3.30 On 12.2.17, Adult C telephoned the Step-Up team at around 16.30 hrs to complain about his neighbour playing loud music. He had also called the Police. A check call was later made at around 20.00 hrs by Step-Up. Adult C was calm, and said that he was 'alright, nothing changed', but that the neighbour was making a lot of noise. The call was terminated by Adult C. This was the last contact between NHS staff and Adult C before his death. In the view of one of the Step-Up team, 'there was nothing abnormal or predictive of the outcome on 14.2.17'.

2.3.31 The Manager of the City AMHT had intended to refer Adult C for follow-up by the 'Assessment Team' on Monday 13th February. However, there was a keying error in the electronic system, and the referral went to the wrong team. The consequence was that there was initial confusion about which team was responsible, and no contact was therefore made with Adult C on Monday 13th or Tuesday 14th February. The 'Root Cause Analysis Investigation' notes that the level of contact received 12-14.2.17 was lower than planned, but 'it is not clear as to whether contact with clinicians during this time would have predicted or prevented this incident'.

2.3.32 Adult C was removed from the Step-Up team 'FACT' board of current patients on 14.2.17, but there is no indication on the care notes to explain why his name was removed.

2.3.33 On the morning of 14.2.17, a neighbour stated that he saw Adult C spraying an unknown liquid from a white container into several of Adult C's cars (he owned four) outside the flats. The cars were later found to smell very strongly of petrol.

2.3.34 At 2.22 p.m. on 14.2.17 Adult C purchased £23 worth of petrol from a local service station. He was apparently driving a diesel car at the time. In total, he had purchased £60 worth of petrol in the month prior to the explosion.

2.3.35 At around 3.50 p.m. on 14.2.17, Adult C visited a friend in a neighbouring flat. Adult C was distressed and crying, saying that no-one was listening to him about the problems with his neighbour. He had received two letters from his GP and Housing Association which had upset him. Adult C wished that he could be back in prison so he could have an easier life. He left his neighbour at around 4.15 p.m.

2.3.36 The fatal explosion took place in Gibbs Crescent at around 4.40pm on 14.2.17. Police and fire investigators believe it was probably accidental, due to an unknown source of ignition and build-up of petrol vapour while cleaning car parts. The Coroner recorded a narrative conclusion which does not give a firm indication as to the cause of the explosion. He noted that it was 'likely' to be accidental, but that a deliberate action by Adult C could not be ruled out.

3 **Analysis**

3.1 NB: The following analysis assumes that it is *possible* that the explosion and fire were deliberate, and that there *may* have been some link between the visit by Police and Mental Health staff on 10.2.17 and the fatal events of 14.2.17.

3.2 **What specific issues or questions does this case raise?**

3.2.1 Was the multi-agency response to Adult C on 10.2.17 timely, appropriate and proportionate?

3.2.2 The system for convening and undertaking an emergency Mental Health Act assessment appears to have worked well in this case. Officers attended the address within a few minutes of the initial calls, and restrained the patient before calling an Ambulance. While there were subsequent delays in assembling the team due to the complex nature of the referral, a full assessment by experienced staff took place, starting within three hours of the initial request. The assessment appears to have been thorough and to have resulted in a unanimous and reasonable conclusion based on the evidence available. Psychiatric and social work notes of the assessment are consistent, and were confirmed on interview. The overall response of Police and mental health services was sound, and of good professional standard.

3.2.3 Were TVP justified in not arresting Adult C once it was clear that he was not going to be admitted or detained under the MHA? Was the risk of fire-setting assessed properly by police and psychiatric staff?

3.2.4 The primary goal of officers on 14.2.17. was to safeguard Adult C and the public following the emergency call. They knocked on doors of neighbouring flats, and entered flat No. 5 by force to ensure that Adult C was safe and not carrying out his threat. Neither the officers on scene nor the Mental Health team thought that there was any reason to arrest Adult C after the assessment. He had calmed down, and did not appear to present any significant risk to himself or others. No evidence of petrol or diesel fuel was found in the flat, this was confirmed on body-worn video recording.

3.2.5 The officers used their professional judgement on the basis of public interest. They believed in good faith that this was a situation of 'perceived instability' which warranted referral to the mental health services rather than arrest. Their decision was reviewed by a Patrol Sergeant on 12.2.17, a MASH Detective Sergeant on 14.2.17, and later by a Superintendent. None of the

more senior officers considered that an arrest should have been made, and the Superintendent noted that the actions taken were proportionate to the situation presented.

3.2.6 The risk of fire setting was considered carefully by the assessment team. Adult C clearly and repeatedly denied any intention to set a fire, and there was no evidence of stockpiled accelerants in the flat. Adult C was calm, and no clear evidence of psychotic illness was found. There was some history of him making threats to draw attention to himself. Follow-up was arranged in case there was an underlying psychosis. Overall, the risk assessment was appropriate to the circumstances, and the explosion could not have been reasonably predicted on the evidence available at the time.

3.2.7 While the flat was 'cluttered' with car parts and the officers and mental health staff noted the possible risk of accidental fires, this risk did not appear to be imminent and no evidence of large volumes of fuel was found.

3.3 **Are there any unusual factors in this case, what are they?**

3.3.1 The main unusual factor in this case has been that most of the review work was completed before the cause of death was known. Given the fatal outcome, strong public interest and the recent involvement of police and psychiatric services, it was reasonable for the Board to commission a Review, in case evidence later emerged that the explosion was deliberate.

3.3.2 Adult C was not well known to statutory services, and relatively little background information was available to the Review. No clear diagnosis was identified in relation to his psychiatric history. While Adult C lived a fairly isolated existence, he was independent and not excessively 'vulnerable'.

3.4 **Are there any failings which appear obvious at this stage?**

3.4.1 Three separate failures have been identified in the referral and support arrangements which followed the mental health assessment:

- The original plan for a face-to-face review visit on 12.2.17 was changed by the Community Psychiatric Nurse to a telephone contact, but the reasons for this decision were not recorded.
- There was a technical error in referring the case for follow-up W/C 13.2.17. In the confusion, no visit was made to Adult C on 13 or 14.2.17, and no assessment of his mental state was made in that period.
- Adult C was removed from the 'active' list of Step-Up team cases on Tuesday 14.2.17, with no indication in notes as to the clinical reasons why this decision was taken.

3.4.2 The TVP IMR identified a weakness in the Command and Control recording system. There was inconsistency in relation to the location of recorded incidents (i.e. the callers address or

the subject of the complaint). This could theoretically lead to links between calls being missed, and therefore the scale of a problem being underestimated. It is not clear if improved recording would have made any difference to the outcome in this case.

3.4.3 A2 Dominion did not apparently inspect the flat for some time before the explosion, so were unaware that there was so much machinery and car parts inside. If action had been taken on the misuse of the premises, the accidental fire risk may have been reduced.

3.5 **Do there appear to be any gaps in multi–agency working?**

3.5.1 The multi-agency arrangements for safeguarding and assessing Adult C on 13.12.16 and 10.2.17 appear to have worked well. Police, SCAS and mental health staff co-ordinated closely, and reached reasonable conclusions. No significant gaps were identified.

4 Summary and Conclusions

4.1 Adult C appears to have been a relatively isolated individual, who had very limited involvement with statutory services in Oxfordshire. In the months prior to his death, Adult C had two significant contacts with psychiatric services following threats to harm himself or others. On the first occasion (13.12.16) he was taken to hospital by Ambulance following concern that he may have overdosed. He was assessed in a proper manner by experienced staff, and no follow-up action was indicated.

4.2 On the second contact (10.2.17) four days prior to his death, Adult C was assessed promptly and formally under the Mental Health Act by a highly experienced team. The assessment was appropriate, thorough and well-documented. There was a unanimous conclusion that Adult C did not meet the criteria for compulsory admission to hospital, and follow-up support was arranged. No immediate risk to Adult C or the public was identified.

4.3 There were two significant actions by NHS staff which resulted in the planned face-to-face contact with Adult C not taking place in the two days prior to his death. It is not possible to establish with any certainty if the outcome would have been different if correct Step-Up initiation procedures had been followed. Adult C had been assessed as probably not suffering from mental illness, and the face-to-face contact was to have been a precautionary measure. Even if some additional mental disorder had been identified, it is likely that Adult C would have initially been treated at home since the risks had been assessed as low and he was co-operative with community support.

4.4 The overall conclusion of the Author and SAR sub-group is that there was good inter-agency working in relation to the two psychiatric assessments in 2016 and 2017, and that even if the fire was deliberate, this incident was not predictable or preventable by mental health services or TVP.

4.5 In their evidence to Coroner's Court, A2 Dominion stated that they were not aware of the use that was being made of the flat (to repair cars). No visits had apparently been made by their staff to inspect the property for some time. This may have allowed a potential fire risk to build up, and an accidental fire may have been preventable if action had been taken to stop the repair work taking place.

4.6 Given that there was no definitive finding by the Coroner on the cause of the fire and explosion, the author offers two potential main conclusions:

4.6.1 If the fire was accidental, it could not have reasonably been predicted or prevented by TVP or mental health staff. No fuel canisters were found on 10.2.17, and there were then four clear days for Adult C to take fuel into the flat (however unwisely). Action by A2 Dominion to inspect the flat could have reduced the risk of accidental fire, but would not necessarily have prevented Adult C taking fuel indoors.

4.6.2 If the fire was deliberate, there is no clear evidence that it was predictable or preventable. While Adult C clearly had outbursts of anger at times, he was not apparently suffering from mental illness, and denied suicidal intent or any desire to harm others.

4.7 <u>Lessons Learned</u>

4.7.1 NHS Step-Up and management staff need to check entries onto the Excel referral system to ensure accuracy.

4.7.2 Learning in terms of safeguarding awareness from the arson incident in March 2010 has been addressed in the TVP SAVE Safeguarding programme.

4.7.3 There was a missed opportunity for an Adult Protection report to have been completed following the threat of suicide on 13.12.16. This is considered individual learning by the Armed Response officer.

4.7.4 There does not appear to be a standardised process in place to share safeguarding information about fire hazards between TVP and Oxfordshire Fire and Rescue Service. This issue is reviewed in detail in the TVP IMR.

4.7.5 The A2 Dominion visiting policy may need to be reviewed in relation to aggressive or violent tenants, in the light of potentially unassessed fire risks demonstrated in the Adult C tenancy.

4.7.6 The SAR process was rather convoluted in this case, because of the long delay in final Inquest being held. No cause of death was available until late in the process, which made the task of analysing events quite complex and prolonged in relation to interventions prior to the events of 14.2.17.

5 Recommendations

5.1 The NHS 'Root Cause' investigation report makes the following recommendations:

- A full review of the inputting and removal of information onto the Step-Up FACT board
- Any change to a pre-existing Step-Up plan must be documented

5.2 The TVP IMR makes the following recommendations:

- To review current practices and agree a standardised Safeguarding Referral process with Fire and Rescue Services across the TVP area and communicate this to staff and officers. This should include referrals being made both ways.
- The Contact Management Call handling Procedure should be updated to reflect the importance of attaching the correct address to a URN (i.e. the address for officers to attend). Contact management staff should be advised of the change to the policy.

5.3 A2Dominion have identified the following actions:

- All residents who live in homes who are on the cautionary contact list (CCL) will be visited and each of them assessed to understand their circumstances and individual needs, involving relevant agencies where necessary.
- Where there is a known ASB case involving a resident on the CCL, A2Dominion will visit the alleged victim & perpetrator in their own homes rather than calling them to the office.

5.4 The Author wishes to express his condolences to the family of Adult C. He would also like to thank staff of partner organisations who contributed information or advice to the Review.

Martin Bradshaw
Overview Author
12.2.18