Safeguarding Adult Review F

Executive Summary

1) F was a 23-year-old male who was diagnosed with Recurrent Psychosis and Asperger's syndrome. He was taken to Worthing Hospital Accident and Emergency (A&E) department on the 17th January 2016 because his mental health had deteriorated and he was threatening to commit suicide. He was seen and assessed by A&E clinical and mental health professionals, who noted that both F and his father were requesting that F be admitted to an Adult Mental Health Unit as a voluntary patient. On the 18th January at 16.15, whilst waiting for the allocation of a mental health bed, F left Worthing Hospitals Clinical Decision Unit. He was found a short time later in cardiac arrest following a fall from the hospital roof.

2) An inquest held into F's death in February 2017 recorded a narrative conclusion: *'the evidence does not fully explain whether he intended that the outcome would be fatal. F made a deliberate decision to gain access to the roof by means unknown/undetermined. On the balance of probabilities, the act was deliberate but the evidence does not determine the intended outcome.'*

3) At the time of his death F had had contact with and was under the care of several agencies. West Sussex Safeguarding Adults Board commissioned a Safeguarding Adults Review, as it was believed that there might be learning from F's case for the agencies involved. Agencies were asked to complete Individual Management Reviews and to contribute to a Safeguarding Adult Review Panel.

4) West Sussex Safeguarding Adults Board commissioned an Independent Reviewer who was asked to work with the Review Group and prepare a Safeguarding Adult Report and Executive Summary.

5) The Safeguarding Adult Review focused on the support and care extended to F by the agencies involved with him in the 12 months before his death. F's parents were informed of the review shortly after the inquest into their son's death and at that time decided they did not wish to be involved any further. It was agreed with them, however, that they would be further consulted once the review was complete.

6) F was of dual British and Filipino heritage and lived with his parents in rural West Sussex. He was involved with local mental health services following his GP's referral in 2010, after a first episode of psychosis. From 2010 until his death in early 2016 Sussex Partnership Foundation Trust (SPFT), using the Care Programme Approach, managed F's mental health issues.

7) Over the years of SPFT's involvement with F there were frequent admissions to Adult Mental Health Units (AMHU) connected to his diagnosis of Recurrent Psychosis. This period also featured family contact with Sussex Police in the context of F's mental health and associated (sometimes violent) behaviour.

8) In January 2015, F was being cared for by The Dene Hospital where he was detained under Section 2 of the Mental Health Act and later, on expiry of the Section, as a voluntary patient. F remained resident at The Dene until early March 2015. For almost half of that time F was at home in the care of his parents. These periods of extended home leave were agreed between The Dene's lead clinician and F's parents. These arrangements for home leave were not shared with the Care Coordinator from SPFT. This Review has found that communication between The Dene Hospital and the Care Coordinator from SPFT about F's care was poor and with only very limited contact between the agencies evidenced.

9) A discharge meeting involving F, his parents, the lead clinician from The Dene and the new Care Coordinator from SPFT was held in mid-February 2015. Medication was discussed and agreed upon. The Dene requested that the Care Plan included measures to address issues arising from F's diagnosis of Asperger's syndrome. F's father expressed his concern about his son's misuse of illicit drugs and asked for regular drug testing to take place. The lead clinician later rescinded the plan to discharge when F told him of his intention to commit suicide were he to be discharged.

10) F was discharged from The Dene in early March 2015 without a formal discharge meeting taking place. The Care Coordinator made an appropriate follow up home visit within 7 days of discharge. The focus was on ensuring that F received an anti-psychotic depot injection at the required intervals. Other key aspects of the care plan (illicit drug-taking and Asperger's syndrome) that were agreed at the meeting in mid-February were not implemented.

11) There is one care plan on record completed by the SPFT Care Coordinator (CC) in April 2015. This review has found that: -

the plan was limited in its scope and background information about F and his family was lacking. There is no evidence of a carer's assessment, or that F and his parents were involved in drawing up the care plan. A holistic person-centred approach would have been more appropriate. SPFT recognise that the involvement of carers in the Care Planning Approach is an aspect of their service requiring improvement.

12) There was a marked deterioration in F's presentation and behaviour in the months leading up to F's final hospital admissions. F's parents reported that he was not taking prescribed oral medication. In this final period a Community Nurse made regular home visits to administer depot injections (the CC is an Occupational Therapist by training and was not qualified to administer a depot). F showed increasing hostility to the administration of his depots and was noticeably rude to his mother.

13) Contact with the named CC was minimal with no recorded face to face contacts occurring for seven months between April and December 2015. The GP who retained some prescribing responsibility for F, was not routinely updated on the Care Plan despite making *ad hoc* efforts to obtain information from the Care Coordinator over a similar period.

14) In early December 2015 a decision was taken by the CC together with other members of the Mental Health Team to suspend visits to F's home because of concerns about the risk that he posed to their staff. It was agreed that all future contact would take place at the mental health teams base in Horsham and that two male members of staff would be in attendance to administer the depot. A warning was placed on the SPFT electronic record system to this effect. Neither F nor his parents were involved in making this risk decision and F's parents were required to transport F to their practice base. There was no assessment of the potential for increased risk to F's parents. F's risk assessment was not updated.

15) F was admitted to St Richard's Hospital A&E Chichester on 16th January 2016 with a suspected overdose. He was initially assessed and treated by hospital medical staff. Following this, hospital based mental health staff from SPFT made an assessment. A psychiatric assessment found, that although there were indicators clearly present suggesting an increased risk, these could be balanced against protective features: e.g. his parents/carers and that there was a package of support available in the community, with potential for enhancement. Discharge back to his home was agreed with F and his parents, with a planned rapid follow-up by the community based Mental Health Team, responsible for his care.

16) Within hours of his discharge from St Richard's Hospital, F telephoned the Mental Health Helpline and Sussex Police, telling the police 999 controller that he needed to go to hospital as he 'felt unwell and may do something bad to himself'.

a) The MHHL operative was sufficiently concerned to alert A&E departments to F's potential arrival.

b) The Sussex Police Controller failed to follow policy and guidelines that required a response leading to Police attendance or, failing this, transfer for an ambulance to be despatched. The Police have advised that the controller is no longer in their employ.

17) Shortly before midnight on Sunday 17th January 2016 F' father took F to Worthing A&E, Western Sussex Foundation Hospital Trust (WSFHT). F and his father asked that F be admitted to an Adult Mental Health Unit, as he was feeling unwell. F's father told staff that he and his wife felt unable to manage their son's mental health and behaviour without more support.

18) On examination there appeared to hospital staff to be little change since F's earlier presentation at St Richard's Hospital. The psychiatric assessment concluded that F did not meet the admission criteria. However, concerns were sufficient for F to be admitted overnight, pending a further psychiatric assessment to be made later, on the Monday morning. Observation by a Registered Mental Health Nurse on a 1:1 basis was considered, but rejected on the grounds of being too intrusive.

19) F's father was asked - and agreed - to stay with him. Notes made at the time and shared with the review team by SPFT suggest that this was because of the alert on the SPFT record system, and because of their concerns about the staffing levels in the hospital's Clinical Decision Unit (CDU). WSFHT advise that the CDU was fully staffed.

20) By 07:00 that morning there was deterioration in F's mental health, he was moved across into the adjacent A&E area for treatment with anti-psychotic medication. On psychiatric examination the deterioration was noted and at 10:00 the decision was made for voluntary admission (in accordance with F's wishes) to an Adult Mental Health Unit (AMHU).

21) With the decision made to identify a suitable bed, the SPFT Bed Manager was contacted an hour later at 11:00 and a Trust wide bed alert went out a further two hours later, at 13:00. The Bed Manager's focus was on moving patients across units to free up a suitable placement as close as possible to F's home and within the scope of his

local mental health team. Although a bed was identified in an adjacent area (Meadowfield, Worthing) this was not utilised as it was not served by F's local Community Mental Health Team.

22) The decision to admit F to an AMHU was taken at 10:00 on the 18th January. Five and a half hours later at 16:36 F was found in the hospital grounds with life threatening injuries and close to death.

a) Throughout this period there was a lack of information flow between West Sussex Health Trust and SPFT. Hospital staff who were caring for F had no access to the Mental Health Liaison Team notes, were unaware of the alert concerning F's potential for violent behaviour and were not updated on progress in securing a mental health bed. Circumstances that meant that they were unable to offer reassurance, timescales or location to either F or his father.

23) The author understands that SPFT now include the use of a shared information system with Western Hospitals as part of their CPA recording process. The Crisp Report (February 2017), 'Improving Acute Psychiatric Care for Adults' includes the following recommendation:

a) *'A new waiting time pledge included in the NHS Constitution from October 2017 of a maximum four hour wait for admission to an acute psychiatric ward for adults or acceptance for home based treatment following assessment'*.

24) SPFT are mindful of the Crisp recommendation and working with their commissioners to respond to this pledge. This review has found that the criteria and decision making for a placement in an AMHU would benefit from a service review by SPFT.

25) The five themes that were identified as areas of learning from the Safeguarding Adult Review were:

i. the need for a holistic approach to care planning;
ii. exhibiting greater ambition for F;
iii. more proactive engagement;
iv. greater involvement with F's carers, including their needs and
v. more systematic information sharing and better communication with all parties, particularly around processes and decision making.

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