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**Adult F**

**Statement by the Independent Chair of West Sussex Safeguarding Adults Board**

The Review published today is concerned with the death on the 18th January 2016, of Adult F, a 23 year old male, who died following a fall from the roof of Worthing Hospital in Sussex.

Firstly, I would like to pass on my personal condolences to Adult F’s parents and family following his untimely death, at such a young age.

On the 17th January 2016 Adult F was transported to the Accident and Emergency department at Worthing Hospital, where he was assessed to be very anxious and stating that he would ‘jump off a building if not given help’. His parents were also concerned about his safety, following an overdose incident resulting in an overnight hospital admission (at St Richard’s Hospital) the previous day.

On the 18th January at 16.15 hours, whilst in Worthing Hospital Clinical Decision Unit (CDU) awaiting the availability of a psychiatric bed, F absconded from the CDU and a short time later (16.36 hours), following a search of the hospital was found in the hospital ground in a cardiac arrest. His injuries were consistent with a fall, attempts at resuscitation failed and he was pronounced dead at the scene.

A Coroner’s inquest in February 2017 stated that F had made a ‘deliberate decision to gain access to the roof (of the hospital) by means unknown/undetermined. On the balance of probabilities, the act was deliberate but the evidence does not determine the intended outcome’.

It is important at times like these not to lose sight of the person. As the report outlines Adult F was a much loved son and brother. He was of dual heritage, his father being white British and his mother originating from the Philippines. The family retained their links to Filipino family members and Adult F and his parents were planning a trip to the Philippines shortly before his death.

The Safeguarding Adult Review was commissioned in April 2017, and was undertaken by Leighe Rodgers, an Independent Reviewer, in line with Sussex multi agency safeguarding policies and procedures.

The purpose of a Safeguarding Adult Review is not to apportion blame to individuals or organisations; there are other mechanisms for achieving such outcomes, but to understand what happened and importantly for local partner agencies to learn lessons.

It was agreed that the period for the review should be from January 2015 to January 2016, to explore how agencies worked together to support Adult F during the twelve month period prior to his death; agencies could also provide other information where this was thought to be relevant to the Review.

Adult F was well known to, and under the care of a number of local agencies, following a diagnosis of Recurrent Psychosis and Asperger’s Syndrome, and there had been a marked deterioration in his presentation and behaviour in the months leading up to his death; which Adult F’s family had raised on several occasions.

Whilst not apportioning blame, the report does highlight a number weaknesses in the support provided to Adult F and makes a number of key recommendations for learning for individual agencies which are detailed in the report; I would wish to highlight 4 such areas:

* the report highlights deficiencies in the way the Sussex Partnership Foundation Trust (SPFT) Care Plan was prepared and implemented. This is of concern and had been highlighted in a previous SAR in 2013 (Alan published by WSSAB in 2016);
* the report evidences the difficulties both locally and nationally in securing a placement in mental health beds and providing interim support in a safe and secure environment until such a bed becomes available;
* the report outlines the very significant support given to F by his parents, however, there is less evidence that the agencies fully recognised the pressure on Adult F’s parents and the need to provide them with assistance in their own right, and
* disappointingly, the report once again highlights challenges in information sharing between partner agencies.

It will now be for the various agencies to implement the actions arising from the recommendations from the review and provide reports to the Safeguarding Adult Review sub group, who will monitor progress and report to the full Board (WSSAB).

Finally, I know that the members of West Sussex Safeguarding Adults Board would wish to express their condolences to the family of Adult F, and to promise to continue its joint efforts towards safeguarding adults in West Sussex.

**David Cooper**

Independent Chair

West Sussex Safeguarding Adults Board (until November 2017)