ADULT J SAFEGUARDING ADULT REVIEW LEARNING BRIEF

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The Safeguarding Adult Review in relation to Adult J was commissioned in January 2019 in order to identify areas for learning and improvement.

Case Summary

Adult J was found deceased at home in 2018 and is believed to have taken his own life, the cause of death was found to be "Asphyxia by Ligature".

Adult J had involvement with Mental Health Services for a number of years with a diagnosis of 'acute and transient psychosis', and had been discharged to the care of his GP where he continued to be prescribed anti-psychotic medication. Adult J had in place a care plan which acknowledged a history of non-compliance with medication, presenting a high risk of relapse if medication was not taken for a period of approximately 3 weeks. The care plan also set out Adult J's wishes that his ex-partner and mother were involved at the point of relapse.

A total of 16 contacts were made to services in the nine days leading to Adult J's death, raising concerns for his welfare, suspicions of relapse, and reports that he was acting 'bizarrely and odd'. These calls were made by Adult J's ex-partner; mother; and sister.

The review highlighted key themes and areas of learning which are explained below. The full SAR report can be found on the LSAB website.

Key themes and learning

- **Flagging of non-compliance with anti-psychotic medication** – the review found that GP systems in relation to non-compliance with medication were not appropriate for Adult J's needs. The practice had in place a standard procedure for following up on non-compliance with medication when prescriptions were not collected after a period of 3 months. In the case of Adult J, a relapse would occur if medication had not been taken for approximately 3 weeks. This relapse signature was available on case records and should have been flagged on the system to identify a timelier follow up.

- **Barriers to referrals** – despite a number of contacts from concerned family members, a referral was not opened due to the belief that Adult J had not given consent and was not willing to engage. This judgement had been made without any direct contact with the service user. In addition, consideration was not given to the ability to override consent where there is concern for the wellbeing of the individual. In the case of Adult J, the relapse signature and non-compliance with medication should have highlighted the need for a referral.

- **Engagement with family members** – Adult J's family members were provided with inconsistent advice and redirected to other services to gain advice and support regarding a mental health assessment. Staff within these services should have taken the responsibility of contacting partner agencies themselves, rather than placing this back on the family member.

- **Mental Health Act assessments** – due to the concerns raised by family members in relation to Adult J's behaviour and non-compliance with medication, staff should have considered a home visit to check the welfare of the individual before the decision was taken to undertake a Mental Health Act assessment, however this was not the case and the decision was made without any direct contact with the service user. In the event of safety concerns for the staff member, a joint visit with another agency should have been considered.

- **Multi-agency working** – No direct contact was had between professionals and Adult J in the lead up to his death. A professional was responsive to a concerned call from Adult J's ex-partner and agreed to undertake a home visit, however working in isolation meant capacity to do so was limited. Contact and joint working with other professionals may have assisted in this visit occurring sooner, by the most appropriate professional and at the right time.

- **Use of case records** – reviews often present problems where agencies do not have shared access to electronic records. Positively, this review highlighted that this is now possible amongst some agencies, however on this particular occasion, there was an overreliance on written records within the system which could have been overcome if professionals had direct conversation.

  In addition, two case notes had been made to record that Adult J's phone was broken and he was therefore uncontactable via this method, however practitioners did not view this information on recent records and proceeded to attempt contact via telephone.

- **Professional challenge and escalation** – the review highlighted a lack of professional challenge where requests for intervention had been inappropriately passed from one service to another; and where an agency has not responded to an appropriate request for intervention. All professionals should be familiar with their own agency's escalation policy, and in the case of multi-agency challenge, the Lancashire Safeguarding Adult Board procedure for Resolving Professional Disagreements.