Nottinghamshire Safeguarding Adults Board

Safeguarding Adults Review (SAR) – Executive Summary

SUBJECT: NG

Date of birth : 16.05.2000

Date of death : 20.12.2018

SAR Independent author: Richard Proctor

Nottinghamshire Safeguarding Adults Board wishes to place on record its sincere thanks to the Mother and Father of NG who worked closely with the Board and Independent author. They provided valuable information and an insight into the life of NG which was used to help shape and inform this review. This Safeguarding Adult Review would not have been possible to undertake without the co-operation and information supplied to the SAR Panel by those agencies who provided care and support for NG. This contributed significantly in the production of the final report and helped to identify recommendations for improvement.

Executive Summary

This report provides the outcome of a review undertaken, in accordance with Section 44 of the 2014 Care Act, into the death of NG. For the purposes of this report, NG's initials have been used at the request of his family.

The Case Review was conducted using a blended approach of action learning with a more in-depth analysis of agency involvement.

Overview

NG was the youngest of two boys and shared a close relationship with his older brother and was loved dearly by his parents, family and friends. NG attended main stream education and was a gifted pupil. As well as his academic achievements he was also a keen sportsman and athlete holding the county record for the high jump whilst a teenager.

At the age of 10 years (2010) it was believed, though never officially diagnosed, that he had a condition of Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder. At the age of 11 years (2011) NG was officially diagnosed with Autism Spectrum Disorder (ASD).

From the age of 16 his family felt that NG had changed, becoming very variable in mood, at times very positive, learning to drive, studious, making plans and saving for University. He could also be very negative, self-loathing, consuming extremely large amounts of sugary foods to the point of being physically sick, confrontational and displaying risky behaviours.

The information received from agencies highlights that NG's family had become increasingly concerned about him and had been in contact with the GP, Adult Social Care, and the Mental Health Crisis Team in the lead up to his death.

The GP prescribed Diazepam 6 days prior to his death, and had also referred him to community mental health services. His Mother contacted the Crisis Resolution Home Team (CRHT) on the 18th December when she reported that he had a "bad week".

Following this, an allegation was made by his cousin in relation to inappropriate touching dating back approximately 10 years. A Safeguarding referral was made relating to this incident when NG and his cousin were 8 and 5 years old (respectively). The referral was never progressed as his cousin did not wish to pursue the matter further and agencies felt NG's alleged actions were consistent, as described for a child of his age, with healthy sexual behaviour. The National Society for the Prevention of Cruelty to Children (NSPCC) describes healthy sexual behaviour for a child and how, as children mature, the way they express their sexual feelings change https://www.nspcc.org.uk/keeping-children-safe/sexual-behaviour-children/ . NG was particularly troubled by these allegations.
NG was also seeing a counsellor privately which his parents were paying for.

On the 19th December, NG reportedly caused damage to the family home and the Asperger's team advised his Mother to contact the Police or his GP as no emergency resources are available from the Asperger's Team. NG's Mother also contacted CRHT again, who made a referral into the Intensive Community Assessment and Treatment Team.

On the 20th December NG was reported missing. Sadly, he was found deceased the following morning, after taking his own life.

In learning from the tragic death of NG, the following key themes were identified for the review to focus upon:

Transition Arrangements Child to Adult

- In relation to transition arrangements from child to adult, in NG's case it was felt that Community Adolescent Mental Health Services (CAMHS) worked well in providing support following the referral made by NG's General Practitioner, though it was recognised that NG's wishes and feelings not to be referred to Adult Mental Health Services was a barrier.
- It was identified there is a robust CAMHS transitions pathway in existence which would look at an individual's case from the age of 17.5 years of age.

Response to Mental Health Crisis

- In relation to response to the mental health crisis (12/12/18 to 20/12/18), details of the telephone calls made by NG's Mother to Crisis Resolution and Home Team (CRHT) were considered. Transcripts of these calls had been shared with the lead reviewer and author which detailed in full the conversations involving Mother, NG and CRHT.
- Mother explained NG's history in relation to his ASD diagnosis and that he was currently having a "meltdown". She described how he had pulled the Christmas tree over and was throwing rose buds at her. She described how he was punching the wall and tipping furniture over, which the caller could hear taking place in the background of the call. NG, when asked by his Mother during the call if he wanted to hurt anybody, replied "yes", and Mother referenced recent comments he had made that "No human deserves to live". Mother was advised by CRHT that if she felt at risk or threatened by NG, she should contact the Police.
- No information was provided as part of the review to evidence due consideration being given to the severity of the disclosures and actions of NG where the requirement for a more immediate response to support his mental health presentation was needed.
- Despite the concerns raised by Mother and the disturbance that could be overheard in the house when it was alleged NG was turning furniture over, no

rapid response was provided by CRHT or consideration given to making contact with the Police regarding the risks posed to Mother from NG's apparent violent behaviour. CRHT was not aware of the allegation of abuse involving NG's cousin.

- The decision was taken by CRHT not to provide a rapid response so an assessment of NG's mental health could be undertaken. The review deemed this to be a significant omission in relation to safeguarding NG.
- From transcripts of the conversations between NG's Mother and the CRHT, practitioners involved in the review identified phrases and words used by NG which they were unaware of having been used and were not reflected in the information provided to inform the team decision making process following Mother's call on the 19th December 2018. A decision was made based on the information provided at the team meeting that the case would best be managed within the Intensive Community Assessment and Treatment Team (ICATT)
- A review of the decision to allocate the case to ICATT by Nottinghamshire Healthcare NHS Foundation Trust identified that NG would not have met the service criteria, as he was apparently experiencing a mental health problem.
- The consideration that NG may be a perpetrator of Domestic Abuse was perhaps overlooked by practitioners, subsequently the Police were not contacted and potential risks to Mother unaddressed.
- It was found at the practitioner event that the outcome in relation to the historical sexual abuse allegations were never shared by the police with Mental Health Services or NG's Mother. The Victims Code dictates that the Police must keep a victim of crime informed of the progress of the case and the Police adhered to this code by informing the victim of their investigation to date.
- There appeared to be little consideration of the impact of this allegation upon NG's mental health, should that information be made known to him, which unbeknown to the Police occurred following disclosure by the family member to NG's parents.
- Whilst the review does not seek to question the assumption made by NG's GP that NG had mental capacity in relation to the decisions of being referred to

Adult Mental Health Services and the prescribing of diazepam, the cessation of his anti-depressant medication corresponded with a deterioration in NG's condition. It would have been good practice to assess capacity in respect of making this decision and confirm understanding of the potential impact upon NG's wellbeing in not taking the medication, ensuring that the assessment was formally recorded.

Response to Missing Person Episode

- It was found more detailed information held by health in relation to concerns in relation to his ASD and previous ADHD diagnosis may have assisted in assessing risk.
- In Nottinghamshire there is now a dedicated Missing Persons Team which looks at working in partnership with other agencies to investigate the reports of missing people.

Autism Support and Practitioner Awareness (Including Potential Associated Increased Risk of Suicide).

- It was widely acknowledged of the need to increase awareness of Autism and how people with the condition may respond across the Safeguarding Partnership.
- Research work undertaken by a leading Autism research charity Autistica, drawing upon research work undertaken in Sweden, identifies that people with Autism are 7 times more likely to die by suicide than the general population.
- Risk assessments undertaken by Mental Health Services tend to be generic and the Police confirmed no specific consideration of Autism or how an individual may respond would be specifically considered when responding to the report of a missing person.

Support for Bereavement and Family

- Regarding the concerns in relation to support provided for the family following their bereavement, the issues raised by the family were considered by practitioners.
- The view was that the service provided was of concern but that in their experience the commissioned service is usually of a high standard.
- The Police representative volunteered to take the learning from this case and ensure it is shared with the support service so that the lessons are learnt, and that they inform future practice.

In considering the findings and conclusions of this report the following recommendations were made:

Recommendation 1.

- Nottinghamshire Safeguarding Adults Board should seek assurance from Nottinghamshire Healthcare Trust how they ensure the information provided to inform the internal MDT decision making process reflects the level of risk.

Recommendation 2.

- The Nottinghamshire Safeguarding Adults Board should raise awareness across the Safeguarding Partnership as to what constitutes adolescent to parent “Domestic Abuse” together with providing guidance as to the appropriate response.

Recommendation 3.

- Nottinghamshire Safeguarding Adults Board should raise awareness of the “Mental Health Triage” resource operated by Nottinghamshire Police detailing core role and function.

Recommendation 4.

- Nottinghamshire Safeguarding Adults Board should raise awareness of the dedicated “Missing Person Team“ detailing core role and function to promote multi-agency working in relation to safeguarding ”Adults at Risk” who go missing.

Recommendation 5.

- Nottinghamshire Safeguarding Adults Board should share the learning from this case with the Nottinghamshire Health and Wellbeing Board and the Nottingham and Nottinghamshire Suicide Prevention Group, drawing upon the learning to help inform the Autism and Suicide Prevention strategy.

Recommendation 6.

- Nottinghamshire Safeguarding Adults Board should seek assurance that commissioners consider the needs of bereaved relatives.

Recommendation 7.

- Nottinghamshire Safeguarding Adults Board should seek assurance from partner agencies that staff in their organisation are aware of their professional responsibilities to escalate risks appropriately.

Recommendation 8.

- Nottinghamshire Safeguarding Adults Board should seek assurance as to the extent that the Mental Capacity Act 2005 is being applied across the Nottinghamshire Safeguarding Partnership.

Recommendation 9.

- Nottinghamshire Police should use the learning from this case to inform the development of their suicide prevention strategy in relation to suspected offenders.

Recommendation 10.

- The learning from this case should be shared by Adult Social Care with the "Adults with Asperger's Team" so the response to safeguard "Adults at Risk" is considered and prioritised.

Recommendation 11.

- The Nottinghamshire Safeguarding Adults Board should seek assurance from Nottinghamshire Healthcare Trust of the progress of the training delivery plan in relation to Autism.

Recommendation 12.

- Nottinghamshire Safeguarding Adults Board should establish a working relationship with Nottingham City and Nottinghamshire Mental Health Crisis Care Concordat so it may monitor and influence outcomes in relation to the MHCC, together with sharing learning from this case to influence future "crisis response" and commissioning arrangements.

Future

These recommendations will be monitored by Nottinghamshire's Safeguarding Adults Review Sub-Group who will seek assurances from the agencies named in the above report that these recommendations are being acted upon and will inform and improve practise for the future.