CWMPAS 5 2018

Extended Adult Practice Review

1 Background

Adult M was 22 years old when she took her own life in January 2016. She was a third year residential learner at a college in England, funded through a Welsh Government Further Education placement.

Adult M had a diagnosis of Asperger's Syndrome, Raynaud's disease and depressive illness, and was at risk of self-harm and suicide. She had an allocated social worker from the Adults Disability Team and was under the care of a Consultant Psychiatrist based in her home county in Mid and West Wales.

2 Context

Following Adult M's tragic death, her family raised formal complaints against the residential college, the Local Authority, and two Health Boards involved in Adult M's care. One of these complaints was referred to the Ombudsman for Wales. Collectively, these investigations identified lessons to be learned, particularly in respect of sharing information pertaining to previous episodes of self-harm and suicidal ideation, as well as risk assessments not being updated in light of Adult M's deteriorating mental health. It must be noted, however, that nothing identified in the review suggested that alternative action would have prevented Adult M's death.

3 Key Themes: Understanding the Person

A number of the challenges Adult M experienced in relation to her mental health were likely manifestations of her Asperger's, however, they were not identified as such. The review identified a need therefore for a more holistic understanding of the needs of autistic adults. In relation to risk of suicide, Adult M had been previously noted to be at risk as a result of self-harm. However, in the term prior to her death, Adult M expressed suicidal ideation. This change should have led to an updated risk assessment.

An instance of peer-on-peer abuse involving Adult M's friend was noted to have significantly impacted Adult M's emotional well-being. Her parents were not informed of this, despite the impact on Adult M.

4 Key Themes: Transition

Adult M's mother was a proactive and supportive advocate for Adult M, and she welcomed this support. However, transition planning should have occurred with Adult M and her parents prior to her turning 18, to communicate how services would need to engage differently with Adult M as an adult.

A specific shortfall identified was that significant changes in medication were agreed by the psychiatrist without Adult M present. This area was addressed within the investigations which took place and within the Ombudsman's report.

5 Key Themes: Information Sharing and Recording

Whilst the review identified good practice in terms of multi-agency working, instances were identified where Health input should have been obtained to inform decision-making. Specifically, Adult M's deterioration in mental health should have triggered a multi-agency discussion which included Health professionals.

The review also explored the sharing of information between the social worker and the college in relation to the suicidal ideation expressed by Adult M. Unfortunately, detail of this discussion and follow-up thereafter was not comprehensively recorded.

6 Good Practice

- Adult M's educational needs were well met. She was supported to attend her college of choice via a funded placement. Adult M excelled academically, as well as developing independence skills and building relationships with her peers.
- Risk of suicide was identified within the initial risk assessment and appropriately noted to relate to self-harm
- Advocacy services were routinely offered to Adult M.
- Continuity of care was evident in respect of practitioners.
- The timeline identified good practice examples of Adult M's voice being heard and informing her care.

7 Learning and Actions

- Implement the national autism strategy and Code of Practice.
- Arrangements for provision of mental health care should be reviewed in respect of people temporarily living out of the area.
- The ALN Code to be implemented by Education Services.
- Continued implementation of suicide prevention action plans.
- Robust communication to take place with parents pre-transition.
- Information sharing policies and training to reflect the need to communicate effectively in respect of actioning the information.
- FE Colleges to implement recommendations in respect of peer-on-peer abuse highlighted in Estyn's thematic report.
- Identified issue of non-regulation of placements for 18-25 year olds to be raised nationally.

For full report please click here