Lewisham Safeguarding Adults Board

A working partnership to prevent abuse

7 Minute Briefing

SAFEGUARDING ADULTS REVIEW JOSHUA

THE ADULT

Joshua was a 35-year-old Black Caribbean man. He was of Guyanese background and came to the UK as a child.

Joshua was close to his family, especially his mother, who also lived in Lewisham. Joshua was the eldest child and had four siblings.

It was recorded that Joshua identified as both a Christian and a Rastafarian.

Joshua was described as a 'popular' man; 'other residents looked up to him.' He was recognisable and well known in the local area.

BACKGROUND TO THE REVIEW

The period in scope for this review was 01.09.17 to 09.03.18, which is the date Joshua died.

Joshua first came into contact with mental health services in 2002, at the age of 19. He was a patient of Mental Health Forensic Services since 2006 and of the Community Mental Health Team since 2014.

Joshua had nine admissions to hospital under the Mental Health Act (MHA) 1983, and was subject to s.117 aftercare.

Joshua lived in supported accommodation as part of that aftercare.

WHAT HAPPENED

Joshua was seen by supported living staff on the street at different times on 09.03.18. When staff were unable to locate him they escalated their concerns and the police were called, twice, the second time by a member of the public after a man was seen climbing over residential fences and onto school playing fields.

The police attended and requested an ambulance. Upon arrival the London Ambulance Service reported that Joshua was being restrained on the floor and was in the recovery position. It was unknown how long Joshua had been restrained for. On examination, Joshua was in cardiac arrest and cardiopulmonary resuscitation (CPR) was commenced. Joshua's breathing was assisted and he was conveyed to hospital whilst CPR was continued throughout the journey. He was declared deceased at the hospital.

At the Coroner's inquest the jury found system-wide failures contributed to his death. A Regulation 28 Report to prevent future deaths was issued to the Metropolitan Police Service and the London Ambulance Service. The jury recorded the medical cause of death as Acute Behavioural Disturbance (ABD) (in a relapse of schizophrenia) leading to exhaustion and cardiac arrest, contributed by restraint struggle, and being walked.

KEY LEARNING

Joshua's care plan was lacking in the wider context of his identity. The person's mental health issues need to be understood within the context of race, their family, cultural and other relevant factors.

The importance of reviewing the s.136 (MHA) pathway and the care planning process in general which includes a planned approach to managing deterioration of mental health and crisis situations.

KEY THINGS FOR YOU TO CONSIDER

Review training and strengthen guidance at a cross-disciplinary level, in line with the Position Statement published by the Royal College of Psychiatrists on 'Acute Behavioural Disturbance' and 'Excited Delirium'.

Review relevant training and policies to strengthen anti-racist perspectives and to include the involvement of people with lived experience and their families and third sector organisations. Training needs to be part of a wider programme of change, developing multipronged diversity initiatives that tackle structural discrimination.

Training on the application of the Mental Capacity Act in relation to complex mental health cases, should also have an anti-racist perspective.

Respect, compassion, and dignity must be at the heart of person-centred care, taking into consideration the differences and needs of people from black and minoritised ethnic communities.

WHAT YOU CAN DO TO PREVENT A REOCCURRENCE

Ensure there is oversight and regular review of care and support plans, risk assessments and contingency plans. These need to be person-centred, and person led wherever possible.

Always look to use the least restrictive treatment option wherever possible.

Ensure next of kin details are regularly checked and updated, and especially if they are used in conjunction with any advance choice or planning documents.

Consider your inter-agency working arrangements and partnerships, and ensure formal Information Sharing Agreements are up to date and relevant.

s.136 (MHA) is a power of last resort to be used by the police. Agencies should develop their contingency plans and services to support adults at times of mental health crisis.

Use of force training should be focussed on prevention and de-escalation.