SAFEGUARDING ADULT REVIEW
EXECUTIVE SUMMARY INTO THE DEATH OF RICHARD IN FEBRUARY 2024

Parminder Sahota Independent Reviewer
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Preface

The Independent Chair and Review Panel express their sincere condolences to everyone impacted by Richard's death and thank them for their support and contributions.

This report uses real names for Richard and his family members at the family's request.

A Safeguarding Adult Review (SAR) is a multi-agency statutory review designed to determine what the relevant agencies may have done differently to prevent harm or death. It is essential to establish the potential knowledge that can be derived from Richard's death and for agencies to understand the circumstances so that these lessons can be realised and widely distributed to support future safeguarding practices.

The chair thanked the panel and individuals who provided chronologies, material, and reports for their time, patience, and cooperation.

The chair expresses gratitude to the family for supporting the review and helping to ensure that it appropriately portrayed Richard's life.

"As a family we are distraught at the loss of Richard, he was truly loved by us all and was a kind, thoughtful Son, Brother, Uncle, and person who fought bravely against the inner increasingly hostile world inside his head. We were proud of him."

"Richard never complained about anything, and that generosity and kindness of his soul was ridden over rough-shod by some of the very people who should have cared for him."

"Rest in peace Richard you were loved more than your inner thoughts ever allowed you to understand."

1. Introduction

Purpose of the Review:

1.1 This Safeguarding Adult Review (SAR) was commissioned by Keeping Bristol Safe Partnership (KBSP) by Section 44 of the Care Act 2014. This review aims to examine the circumstances leading to Richard's death, assess the effectiveness of multi-agency safeguarding responses, and identify key lessons to improve future practice and prevent similar occurrences.

Scope and Methodology:

1.2 The review covered the period from February 2022 to February 2023 and involved contributions from key agencies, practitioners, and family members where appropriate. The methodology included chronologies, individual management reviews, care plans, and safeguarding enquiry reports. Richard's family provided the reviewer with the material from the coroner's bundle, including Richard's progress notes whilst admitted to the mental health unit and associated paperwork.

2. Case Review

Background

2.1 Richard was 53 years old at the time of his death. He lived in a supported living flat and received four hours of weekly support from Milestones Trust. This organisation assists adults with learning disabilities and mental health conditions to achieve a better quality of life.

2.2 Richard had a history of anxiety, social phobia, and agoraphobia, which contributed to his fear of social situations. He also experienced hallucinations involving false perceptions of sensory experiences (sight, sound, smell, touch, and taste) and suffered from psychotic depression.

2.3 In December 2023, Richard was detained under Section 2 of the Mental Health Act (MHA) 1983 due to auditory hallucinations directing him to take his own life. He was admitted to Avon and Wiltshire Partnership NHS Trust (AWP) but was discharged seven days before his death. His family expressed concerns that he was not ready for discharge.

2.4 In February 2024, Richard's upstairs neighbour reported hearing him shouting and banging the night before his death. The service coordinator at Milestones Trust contacted the mental health crisis team (AWP), 101 (non-emergency police), and 111 (non-emergency medical support). The crisis team advised contacting 999, but the service coordinator was uncertain whether Richard required emergency medical assistance, and no call was made.

2.5 The following day, Milestones Trust support workers discovered Richard deceased.

2.6 The South Western Ambulance Service NHS Foundation Trust (SWAST) informed Avon and Somerset Constabulary of Richard's sudden death.

2.7 The coroner concluded:

> *"The deceased died from self-inflicted wounds to the neck whilst suffering an acute psychotic episode."*

2.8 Richard had multiple diagnoses, including:

1. Schizophrenia – a mental disorder characterised by impairments in social interactions, emotional responsiveness, perceptions, and thought processes.
2. Depression – a common mental illness affecting thoughts, emotions, and behaviours.
3. Agoraphobia – an anxiety disorder causing intense fear in crowded or public spaces where escape may be challenging.
4. Obesity – excessive fat accumulation presenting health risks.
5. Type 2 Diabetes – a chronic condition resulting in elevated blood sugar levels.
6. Hypertension – high blood pressure.

2.9 As of January 2024, Richard's prescribed medication included:

1. Olanzapine – an antipsychotic medication.
2. Paroxetine – an antidepressant.
3. Ramipril – a treatment for hypertension.

2.10 Richard's engagement with AWP spanned from April 2010 to May 2018, with no recorded contact until his admission in December 2023. His involvement with Adult Social Care (ASC) began in 2016 when he underwent a Care Act Assessment, which led to his admission to AWP following a Mental Health Act assessment by an Approved Mental Health Professional (AMHP).

2.11 His penultimate care episode with AWP occurred between December 2016 and May 2018. During this period, he received support from the Bristol Mental Health Community Rehabilitation Service, a collaboration between Second Step, AWP, and Missing Link. He was discharged in May 2018.

2.12 Following this discharge, Richard resumed paid and voluntary work, participated in activity groups through AWP's Bristol Active Life initiative, and returned to independent living. His medication was discussed, and he was signposted to the MIND social anxiety group.

2.13 ASC conducted additional Care Act assessments in 2017, 2021, and 2023, resulting in continued funding for his low-level support—four hours of weekly care provided by Milestones Trust since 2016. However, Milestones Trust had supported Richard since 2012, and this arrangement remained in place at his death.

Key Agencies Involved

Agency	Role
Avon and Somerset Constabulary	Detective Chief Inspector and Head of the Major Crime and Statutory Review Team
Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) Significant provider of specialist mental health services.	Professional Lead Safeguarding Adults
Bristol City Council (BCC) Adult Social Care (ASC)	Head of Service
Integrated Care Board (ICB) Representing the GP Practice	Deputy Designated Nurse All Age Safeguarding
Milestones Trust	Senior Operations Manager
North Bristol NHS Trust (NBT) It provides hospital and community healthcare to Bristol, South Gloucestershire, and North Somerset residents. It is a regional centre for neurosciences, plastics, burns, orthopaedics, and renal.	Safeguarding Lead
South Western Ambulance Service NHS Foundation Trust (SWAST)	Safeguarding Specialist
University Hospitals Bristol and Weston NHS Foundation Trust (UHBW), which includes The Bristol Royal Infirmary (BRI)	Deputy Head of Safeguarding

3. Key Findings

3.1 **Missed Opportunities:** Richard's discharge from AWP seven days before his death, despite ongoing psychotic symptoms and his family's concerns, represented a missed opportunity for further risk assessment and intervention.

3.2 **Multi-Agency Communication:** There were delays and inconsistencies in information sharing between agencies, particularly between mental health services, social care, and Milestones Trust, which affected the coordination of Richard's care.

3.3 **Risk Assessment & Response**: The risk of self-harm was not adequately reassessed following Richard's discharge, and there was a lack of clarity regarding escalation procedures when concerns were raised on the night before his death.

3.4 **Service Gaps & Accessibility:** Limited crisis response options and uncertainty among frontline staff about when to escalate to emergency services contributed to intervention delays. Reliance on non-emergency services (101 and 111) may have impacted the timeliness of care.

3.5 **Involvement of Adult Social Care (ASC):** ASC was expected to be informed of the discharge plan and reassess Richard's care needs, which did not occur.

3.6 **Lack of Person-Centred Care:** The absence of key stakeholders, including ASC and Milestones Trust, hindered shared decision-making and individualised care.

3.7 **Physical Health Considerations:** The impact of medication on physical health was not thoroughly reviewed despite known risks.

3.8 **Carer Support:** Family involvement in Richard's care was inconsistent, and requests for additional support were not adequately addressed.

3.9 **Crisis Planning:** Transitioning from hospital to community care is high-risk, necessitating robust crisis planning and family engagement.

4. Learning and Good Practice

Learning Points:

4.1 Improve risk assessment protocols around discharge planning and crisis escalation.

4.2 Strengthen communication channels between agencies to ensure coordinated support.

4.3 Enhance training for Milestones staff on identifying and responding to mental health crises.

Good Practice Identified:

4.4 Milestones Trust staff demonstrated diligence in attempting to seek help for Richard on the night before his death.

4.5 The coroner's inquest provided detailed insights into Richard's final moments, informing learning for future cases.

5. Recommendations

5.1 Recommendation One: Strengthening Discharge Planning

Avon and Wiltshire Mental Health Trust Partnership NHS Trust

1.1 Develop a structured multi-agency discharge plan incorporating input from relevant agencies, family, and friends (where appropriate) and include a crisis and contingency plan. The plan should specifically address the needs of individuals at risk of deterioration.

1.2 Develop and implement a post-discharge monitoring system that clearly outlines the roles and responsibilities of involved agencies to prevent relapse.

5.2 Recommendation Two: Enhancing Multi-Agency Collaboration

Avon and Wiltshire Mental Health Trust Partnership NHS Trust, Bristol City Council, and Milestones Trust

2.1 Establish explicit protocols for collaborative work among ASC, AWP, and Milestones Trust.

2.2 During scheduled reviews, all key stakeholders should be invited to enhance decision-making and facilitate the exchange of information.

5.3 Recommendation Three: Enhancing Knowledge and Understanding of Mental Health Crisis Support

Milestones Trust

3.1 To provide staff members training on the duties and responsibilities of Mental Health and Adult Social Care, safeguarding, and mental health crisis intervention.

Avon and Wiltshire Mental Health Trust Partnership NHS Trust and Milestones Trust

3.2 Establish a unified protocol or handbook outlining AWP's mental health crisis support referral pathways, limitations, and responsibilities.

5.4 Recommendation Four: Embedding Learning from the Review

Avon and Wiltshire Mental Health Trust Partnership NHS Trust, Bristol City Council, GP Practice and Milestones Trust

4.1 To ensure that the lessons acquired from the review are incorporated into policy and practice through ongoing training and supervision to reflect on cases and discuss best practices in safeguarding.

4.2 Establish a feedback cycle to ensure that recommendations result in measurable improvements.

6. Conclusion

6.1 This review aims to understand the insights agencies can gain regarding supporting individuals experiencing an acute mental health crisis, focusing on identifying opportunities for improvement in the care and discharge processes.

6.2 Between 2018 and 2023, Richard's mental health was effectively managed with the support of his family, Milestones Trust, and a consistent routine. This stability allowed him to maintain his well-being.

6.3 In December 2023, one week before his admission to AWP, Richard faced a series of life events, including the loss of his employment and the inability to drive due to issues with his car. This disruption to his routine, coupled with his inability to take his medication, significantly contributed to a deterioration in his mental health.

6.4 During this period, Richard's auditory hallucinations intensified, leading him to contemplate suicide, further worsening his depression. His ability to care for himself became increasingly inadequate, prompting his detention under the Mental Health Act and subsequent admission to AWP.

6.5 Richard's admission to AWP was approximately thirty miles from his home, making it difficult for his family to visit regularly and provide emotional support during his stay.

6.6 Richard voiced his concerns regarding the potential recurrence of his mental health issues if he was discharged too soon. Despite being a private individual who refrained from engaging with others, the focus of his admission was primarily on medication adjustment. However, upon discharge, there was no corresponding change in his medication.

6.7 Richard had worked closely with Milestones Trust for twelve years. Still, they were not invited to participate in the discharge planning meeting or provide

relevant input to aid his recovery at home. This lack of inclusion hindered the continuity of care.

6.8 Richard did not receive a formal risk assessment from AWP, nor was a crisis or contingency plan implemented. His family was not offered a carer's assessment, and BCC was not informed of their request to increase the community support package.

6.9 It became clear that Richard's situation upon discharge had not significantly changed. The absence of the routine that had previously helped him maintain stability was a key factor in his mental health decline. The review revealed that, despite input from various professionals, AWP operated in isolation without sufficient collaborative effort from other agencies.

6.10 The review considered the six principles of safeguarding adults as a framework for understanding the findings:

1. **Empowerment:** Richard voiced concerns about his discharge, fearing a relapse into his previous state of mental health.
2. **Prevention:** The lessons learned from this case will inform strategies to prevent similar harm in the future.
3. **Proportionality:** Richard was discharged to a less restrictive environment with the support of the crisis team, though this decision did not address the underlying issues.
4. **Protection:** The review's findings aim to enhance protection measures for individuals in similar situations.
5. **Partnership:** There was insufficient collaboration among agencies, which hindered coordinated support for Richard's recovery.
6. **Accountability:** The review stresses the importance of transparency and accountability in safeguarding practices and has outlined recommendations to improve safeguarding responses.