



THE ADULT

Jake was a young man dearly loved by his parents, sister, family and friends.

Despite the challenges Jake faced he was a highly gifted talented individual,

performing well at his studies, gaining employment as an apprentice welder and working at a local cafe.

He studied engineering at college and achieved the Duke of Edinburgh Gold award with support from a local youth group. His parents describe that Jake always shouldered more than his fair share of life's burdens, he felt other peoples pains keenly and would try to fix things for them.

BACKGROUND TO THE REVIEW

At 6 years old, following the identification of behaviours believed to be associated with Asperger's Syndrome Jake was referred to CAMHS (Child Adolescent Mental Health Services) which continued for several years. He was discharged from their care aged 16 years.

Jake moved into his own flat when tensions in the family home became difficult.

He developed anxiety and depression, which at times overwhelmed him. His actions were impulsive and during his adolescent years he had episodes of self-harm and had made suicide attempts.

Jake's family worked tirelessly to keep him safe and to try to help him to navigate a world that he struggled to understand and fit into.

WHAT HAPPENED

On the 25th February 2018 North Yorkshire Police (NYP) responded to an emergency call made by a friend of Jake, who reported Jake was attempting to jump from a bridge. Jake was escorted to hospital by police. He was assessed by adult mental health services and agreed to support at home from the Intensive Home Treatment Team. Jake also self-referred to a young person's counselling service and Jake's General Practitioner (GP) was closely involved in his care. Jake wanted help to feel better but continued to struggle. He was signed off work and college and displayed variable moods both 'up and down'. He continued to express suicidal ideation, and had feelings of hopelessness. Jake expressed his frustration at having to repeat his case history and felt that he wasn't being provided with any coping strategies. Jake disclosed a further suicide attempt at his assessment for the counselling service; with an ongoing risk of suicide the counselling service conveyed to Jake that their service was not suitable for him at the current time. Jake was found dead at his own address on 28th May 2018, he had taken his own life. Services had tried to work together to provide care and treatment for Jake but the level of risk for Jake was not always recognised, assumptions were made about his understanding, and information sharing was not always done in a timely way.



KEY LEARNING



People with Autism Spectrum Conditions are at higher risk of suicidal thoughts and suicide than the general population

www.autism.org.uk/advice-and-guidance/topics/mental-health/suicide

Autism Spectrum Conditions are life-long. Consideration needs to be given to support at the point of transition from child to adult services and the impact of adolescence on the person and their family.

QUESTIONS FOR YOU TO CONSIDER

How accessible are your services for someone living with Autism Spectrum Condition?

What steps do you take to help people to understand the information you provide? (This is part of Making Safeguarding Personal - MSP)

How informed is your practice in application of the Mental Capacity Act?

If a person acts in a way that could cause them harm, are these actions summarised and a plan developed with the person (and family) to manage any risks to themselves?

Does your organisation share information in line with the joint safeguarding adults policy and procedures?

WHAT YOU CAN DO TO PREVENT A REOCCURRENCE

Listen to and support families, offer a carer's assessment if this is applicable.

Seek safeguarding advice or raise a safeguarding concern if you are worried about someone - preferably with consent but also consider when it is appropriate without consent.

Make sure that people understand the information you provide and that you have understood the information given by them. Summarise risks and actions and check back on what's been said, avoid making assumptions.

Ensure that practitioners have appropriate training to ensure they are able to meet their duties in relation to safeguarding, the mental capacity act and information sharing.