



North Yorkshire Safeguarding Adults Board

Safeguarding Adult Review (SAR)

Ian

Final draft

Overview Report

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1. Introduction, background & circumstances leading to the review

- 1.1. It is a statutory responsibility (Care Act 2014) for each Local Authority to establish a Safeguarding Adults Board to help and protect adults with care and support needs, from abuse and neglect in its area.

Section 44 Care Act 2014

“A Safeguarding Adults Board must arrange for a review of a case involving an adult in its area with care and support needs if:

- (a) There is reasonable cause for concern about how the SAB or its members worked together to safeguard the adult AND*
 - (b) The adult has died AND*
 - (c) The SAB suspects the death may have resulted from abuse or neglect*
- 1.2. On 12th April 2017 an adult male was found dead at his flat in Harrogate. This male was living in supported accommodation and was receiving care and support under the ‘Care Programme Approach’ (CPA) within the provisions of Section 117 aftercare requirements (Mental Health Act 1983).
- 1.3. The North Yorkshire Safeguarding Adults Board (NYSAB) is one of seven SAB signatories to the ‘Safeguarding Adults, West and North Yorkshire and York multi-agency policy and procedure 2015.’ This policy (revised in 2018) sets out examples when a SAR may be required:
- Paragraph 1.3.8 (Neglect and acts of omission): “Examples include: ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services. Neglect and acts of omission concern the failure of any person who has responsibility for the care of an adult at risk to provide the amount and type of care that a reasonable person would be expected to provide. Neglect and acts of omission can be intentional or unintentional.”
- 1.4. A SAR referral was submitted on 10th October 2017 by one of the agencies of the North Yorkshire Safeguarding Adults Board (Tees, Esk and Wear Valleys NHS Foundation Trust).
- 1.5. The referral was subsequently considered by the North Yorkshire Safeguarding Adults Board. In January 2018 the Board decided the referral met the criteria for a Safeguarding Adults Review (SAR) and measures were then taken to commence a SAR.
- 1.6. The North Yorkshire Safeguarding Adults Board and members of all agencies involved in this process extend their sympathy and condolences to the family of the deceased.

2. Methodology

2.1 The agreed methodology for the review was the collation of facts by way of chronologies for all agencies who had contact with the deceased male. Each agency would then appoint an Individual Management Review (IMR) author to scrutinise incidents and decision-making within their organisation and between agencies. In addition, panel members accessed minutes of previous safeguarding strategy meetings and discussions.

2.2 The Board sought an Independent Chair and Author for the SAR who would be responsible for producing the final overview report. The Board were satisfied that this reviewer was independent of organisations involved and had the necessary skills and experience to conduct a thorough and insightful Safeguarding Adults Review:

The appointed Independent Reviewer is Mr Mike Cane of MJC Safeguarding Consultancy Ltd. He is completely independent of the North Yorkshire Safeguarding Adults Board and has no connection to any of the organisations involved in the review. He is a former senior police officer where his responsibilities included homicide investigation, safeguarding and mental health. He has extensive experience as a chair, author and panel member for Safeguarding Adult Reviews, Child Safeguarding Practice Reviews and Domestic Homicide Reviews. He is a former member of Teesside's Safeguarding Adults Board, the Domestic Abuse Strategic Partnerships and the Local Safeguarding Children Boards. During his police career he was Force lead for protecting vulnerable adults, child protection and domestic abuse. As a Senior Investigating Officer (SIO), he has led many investigations into serious crimes including deaths in secure mental health facilities, deaths of vulnerable adults in residential settings and wilful neglect cases.

The Independent Chair and Author was supported during the review by facilitated discussions with an appointed expert in the treatment of mental health (a consultant psychiatrist who had no involvement with this case). These discussions related both to the effects of medication and the expectations of mental health professionals regarding planning, reviews and escalation.

2.3 The SAR will consider the key questions set by the North Yorkshire Safeguarding Adults Board:

- Was the multi-agency response adequate to work and respond to the needs of the individual?
- Did the agencies know enough about the individual in order to support him?
- Could his death have been prevented?

- 2.4 A SAR panel was established made up of the Independent Reviewer (Chair of the panel) plus representatives from all organisations who had involvement with the deceased male. Panel members had no direct involvement or management of any professionals who had involvement with the deceased. The panel agreed individual, systemic and other contributory factors, practice and procedural issues would be considered to establish key learning from this untimely death.
- 2.5 Family involvement was established at an early stage and the views of the family are reflected in this report.

3. Process and Scope

- 3.1. The first meeting of the established SAR panel convened on 26th June 2019. The panel agreed the scope of the review including date parameters plus considered the terms of reference.
- 3.2. The agreed parameters were from 1st June 2014 through to the date of his death. This was to enable scrutiny of the key incidents as far back as his last known 'crisis' episode in 2014.
- 3.3. The panel acknowledged that North Yorkshire County Council (NYCC) had already carried out a safeguarding enquiry and that Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) had conducted a 'Serious Incident' report.
- 3.4. The panel membership comprised:
 - Independent Chair and Author
 - Designated Nurse for Safeguarding Adults, NHS Scarborough & Ryedale Clinical Commissioning Group
 - Assistant Director, Care and Support, NYCC
 - Head of Engagement and Governance, NYCC
 - Team Manager, Mental Health, Hambleton Locality NYCC
 - Named Nurse, Adult Safeguarding, Harrogate and District NHS Foundation Trust
 - Head of Safeguarding, North Yorkshire Police
 - Associate Director of Nursing, (Safeguarding), TEWV
 - Head of Care and Support, Craven, NYCC
 - Governance Manager, NYCC
- 3.5 The SAR panel recognised there had been a delay of two years from the death to the establishment of the panel. The independent chair confirmed therefore that there was no requirement for IMR authors to conduct interviews with individual members of staff. Many professionals has already taken part in the NYCC and TEWV internal reviews.

- 3.6 All panel members agreed the focus of the SAR would be on learning and not about blame. IMR authors would be encouraged to avoid any hindsight bias. Agency representatives were asked to be open and transparent throughout the process in order to achieve the goal of identifying learning that could be taken forward and improve the services to vulnerable people and their families within North Yorkshire.
- 3.7 It is important to see life through the experiences of the person involved but also to protect their identity and respect confidentiality. Following consultation with the deceased's family, the SAR panel agreed to use a pseudonym for the person involved rather than initials. The agreed pseudonym for this review is **Ian**. Throughout this report, the person involved will be referred to as Ian.
- 3.8 The protected characteristic affecting Ian was disability i.e. potential learning difficulty and mental health. The panel did not identify any other protected characteristics relating to Ian's care, i.e. age, race, religion, sexual orientation, gender or gender reassignment.
- 3.9 There are also several premises referred to within this report. These are residential premises that support vulnerable people. Again, in order to maintain confidentiality, the names of these premises have been changed and pseudonyms used instead.

4. Terms of Reference

4.1. The terms of reference were established at the first meeting of the SAR panel. These TOR provided the focus to establish facts, analyse events, review existing policies and scrutinise actions and decision-making. They also provided the framework to consider any 'missed opportunities' or to identify any good or effective practice.

4.2. Terms of Reference:

GENERAL

- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which professionals and agencies work together to safeguard adults at risk.
- To inform and improve local inter-agency practice.
- To improve practice by acting on findings and learning.

- To produce an overview report which analyses the findings of individual reports from agencies and makes recommendations for future action.

SPECIFIC TO THIS CASE

- What were the systems for risk assessment of harm and how were reviews of risk conducted and managed? Did any review take account of any change(s) in the person's circumstances?
- How effective was the person's care plan? Did the plan operate within the policies and procedures for each agency? Did the plan meet his identified needs? How was the plan implemented?
- To what extent was the service user, his family or other advocate involved in the planning of his care?
- How effective was information sharing and liaison both within single agencies (intra) and between multi-agency partners (inter)? Did the information exchange adhere to agreed protocols?
- What were the missed opportunities for intervention to protect him?
- What was the mechanism for escalating concerns to senior managers?
- What was the organisational context? (for example were teams co-located or use different IT systems? Were there cultural issues that impacted on decision-making or actions?)

5. Synopsis

- 5.1 NOTE: All references to main hospitals and wards remain in place. These are the real titles as they are large medical facilities and do not require anonymising.

There are four other premises referenced within the report. One is a rehabilitation and recovery unit managed by Tees, Esk & Wear Valleys NHS Foundation Trust (TEWV). The other three were all considered as potential options for Ian's longer term (outpatient) residential stay. These have been anonymised to protect current or future vulnerable residents. The premises have been given pseudonyms:

- (a) Moordale House -a specialised rehabilitation and recovery service with 24/7 support from trained mental health professionals. Ian stayed here as an inpatient following his move on from acute services on a ward at the hospital.
- (b) Hill Street (a residential property divided into flats with minimal support).
- (c) Larkwood House – a premises with several rooms and communal areas located near the centre of Harrogate but with no staff based within the building. Staff attend from premises elsewhere in the locality, but the service does not operate at weekends or after 8.00pm.
- (d) The Woodlands – a premises for adult supported living with 24/7 assistance provided by housing support staff.

Ian was one of five brothers. During his early life he lived with his biological parents and siblings. However, when he was 4 years old he was placed in foster care. Ian's mother died when he was 24 years old. It is not believed that Ian was ever in a long term intimate relationship and he remained single throughout his life.

- 5.1 Ian suffered adverse childhood experiences. Exact details cannot be ascertained but in any event, no further comment is made in order to protect Ian's privacy.
- 5.2 Ian had a number of episodes of care going back to 1995. He was admitted as a mental health 'in-patient' on at least five occasions between 1995 and 2014. This was due to suicidal thoughts, chaotic behaviour, sexual disinhibition and increased aggression.
- 5.3 He had a history of suicide attempts. These were determined efforts to end his own life and methods included carbon monoxide poisoning, driving into a barrier, hanging and electrocution. Prior to the agreed timeframe for this review, Ian's last episode of care was in 2009.
- 5.4 In June 2014, Ian had been living with one of his brothers. However, due to several issues, he left and became homeless. He came to the attention of the Homeless Project in Harrogate.

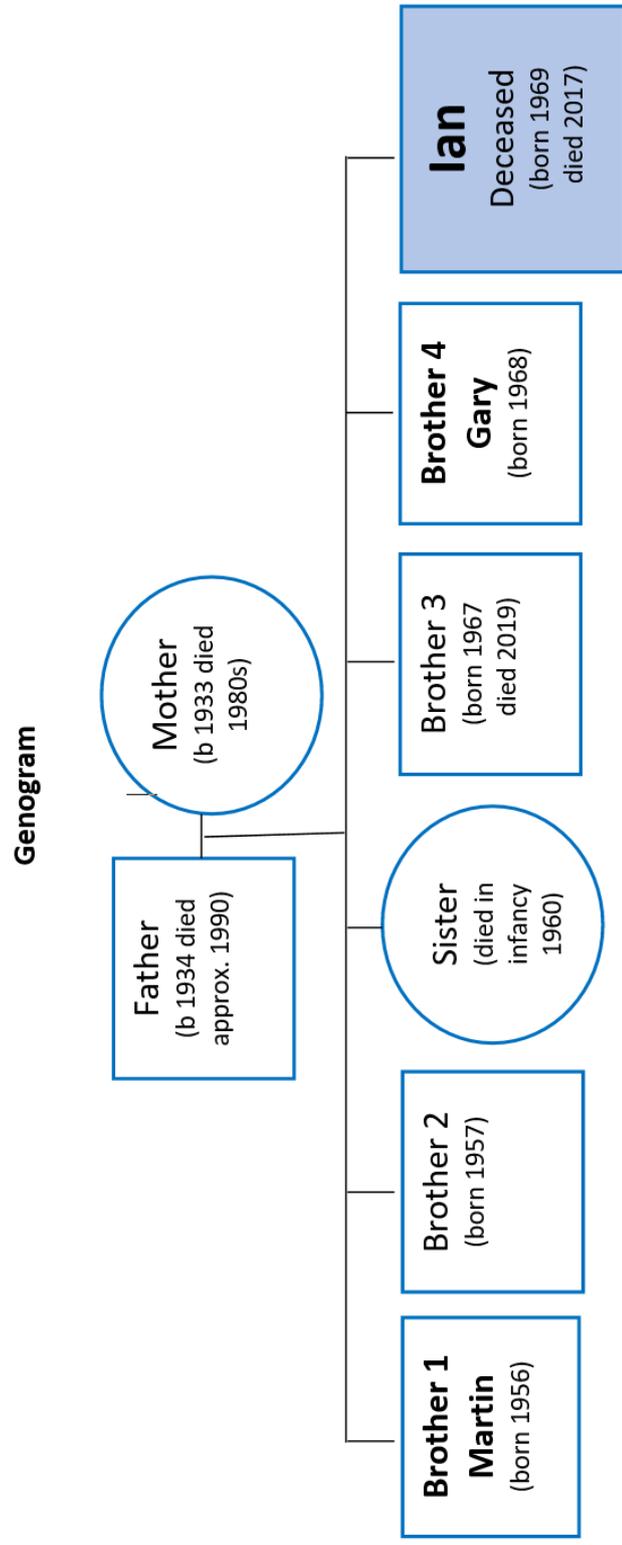
- 5.5 On 4th June 2014, Ian attended his GP practice for a minor matter. This was the first time he had visited his GP in nearly four years. The doctor prescribed medication to treat his (physical) ailment. The GP noticed that Ian spoke quickly and was difficult to understand.
- 5.6 On 6th June 2014, following a telephone call from a housing key worker, Ian reattended his GP practice, accompanied by the key worker. Ian stated he had been hearing voices saying he should attempt suicide. The GP noted Ian appeared to have low mood but that he did not plan to act on what the voices were telling him. Ian sat in the waiting room while the GP made a referral to mental health services. However, while the key worker was distracted, Ian left the surgery. Later that evening, the homeless hostel contacted the police and reported Ian as 'missing.' They were concerned for his welfare.
- 5.7 In the early hours of 7th June 2014, police found Ian wandering along the side of the busy A59 road. He was returned to the homeless hostel.
- 5.8 At 11.00pm on 7th June 2014, the hostel again reported Ian as 'missing' to the police. He had climbed over a rear wall. The police located him 35 minutes later. Officers transported him (voluntarily) to Harrogate District hospital where they left him in the care of medical staff. Police were called back to the hospital a short time later when Ian displayed inappropriate behaviour towards female staff. Officers located Ian elsewhere in the building and staff continued to treat him. Emergency department staff contacted the Intensive Home Treatment Team (IHTT) who made an initial assessment and decided Ian needed to be transferred to a 's. 136 MHA suite.'
- 5.9 Ian was assessed at Bootham Park Hospital in the s.136 suite and detained under section 2 MHA. He was then transferred to the Danby Ward at Cross Lane Hospital Scarborough. This is an all-male ward.
- 5.10 On 11th June 2014, Ian was transferred to a 'mixed' ward at the Cedar Ward (Briary Wing) at Harrogate District Hospital.
- 5.11 On 2nd July 2014, Ian was formally detained under Section 3 Mental Health Act 1983 for a period of treatment of his identified mental health disorder. Part of the treatment was to prescribe antipsychotic and antidepressant medications.
- 5.12 Following an appeal, a Mental Health Tribunal was held on 5th September 2014 to review Ian being detained under Section 3 Mental Health Act. The tribunal highlighted recommendations with regard to Ian's care and treatment as they were not fully convinced he would comply with his treatment outside of his 'section.' Therefore they agreed the 'section' was to remain in place.

- 5.13 Ian was accompanied to a housing assessment on 15th September 2014 at Hill Street. Staff there felt Ian's needs were too high for them, but they did recommend Larkwood House. The staff at Larkwood House requested that the Rehabilitation and Recovery service (TEWV) worked closely with Ian to assist him with a normal sleeping pattern and in taking his medication independently before they could support him.
- 5.14 Ian left the care of the mental health acute ward on 22nd September 2014. He was supported by the Rehabilitation and Recovery service from that date.
- 5.15 From 19th November 2014 his 'section 3 MHA' was rescinded and he was an informal inpatient from that date.
- 5.16 Discussions continued about the most appropriate premises that could support Ian. Professionals recommended The Woodlands as their preferred option, but Ian expressed a preference for Larkwood House which was closer to the town centre.
- 5.17 On 25th March 2015 a discharge planning meeting was held. A 'Section 117' (after care following hospital admission) meeting was held on 1st April 2015. The agreement was that Ian would be discharged as an inpatient on 8th April 2015.
- 5.18 Following several visits and temporary overnight stays, together with CPA planning, Ian moved into Larkwood House on 8th April 2015.
- 5.19 On 23rd July 2015, after six months on a work placement, Ian decided he no longer wished to continue with the placement and communicated this to his social worker.
- 5.20 From April to September 2016, support staff at Larkwood House staff noted that Ian appeared unkempt, he was not taking his medication and his mental health was deteriorating.
- 5.21 On 23rd September 2016, Ian's Care Coordinator met with him for his CPA (Care Programme Approach) review. This was also a handover as the current Care Coordinator was leaving their position and Ian was introduced to his new Care Coordinator at this meeting.
- 5.22 On 6th December 2016, after there had been no correspondence from their patient, the GP stopped the repeat prescription for Ian's medication.
- 5.23 On 21st February 2017, support staff at Larkwood House made records relating to complaints from other residents that Ian was leaving windows open and turning down the thermostat. This was causing tension plus Ian was becoming aggressive with other residents at Larkwood House.

- 5.24 Staff continued to note a deterioration in Ian's appearance and demeanour. He was also proving very difficult to engage with. On 31st March 2017, staff knocked at Ian's door but there was no answer even though they could hear noises from his room. When staff attempted to open the door it was blocked, and the lock had been tampered with. The Housing manager spoke through the door to tell Ian that the police may be called. Ian passed a note under the door stating "I am fine, ok. Can you go away please? If you break the door down I will fight back. I am prepared to die,"
- 5.25 On 12th April 2017, after repeated attempts to get an answer from Ian's room had failed, housing staff called the police.
- 5.26 Officers from North Yorkshire Police attended and were informed Ian had not been seen since 3rd April. Officers forced entry to the room at Larkwood House. They found Ian's body inside. Police called the ambulance service who confirmed no sign of life. A petrol strimmer was in the room and several people present reported feeling 'lightheaded' and having a sore throat. The Fire Service attended and noted all the ventilation points had been sealed. The cause of death was later confirmed as carbon monoxide poisoning.

6 Family Involvement

6.1 Genogram:



- 6.2 Ian's family were involved in the Safeguarding Adult Review. Their memories of him and life experiences are reflected here. The Independent Author met twice with the family to verify facts or clarify incidents. Their help was invaluable, and the SAR panel express their thanks and condolences for their loss at this difficult time. Ian was the youngest of six children. There were five brothers and one sister, but sadly the little girl died when she was only about six months old. To tell the family story, yet maintain confidentiality, pseudonym's have been used for two of Ian's brothers.
- 6.3 The eldest of all of the children (13 years older than Ian) is referred to as 'Martin.' The Independent Author spent several hours with Martin, discussing the family history. Due to the breakdown of their parent's marriage, there are still many gaps in looking at Ian's earlier life.
- 6.4 Another brother (only one year older than Ian), is referred to as 'Gary.' Gary was reluctant to be involved closely with this review. He spent more time with Ian during their teenage years and adult life. The Independent Author for this SAR has spoken on the telephone with Gary. He did not wish to meet in person and his decision was respected.
- 6.5 Martin recalls that Ian suffered an accident when he was a baby. His mother had left him in his pram by the front door but had forgotten to set the brake. Ian fell out of the pram and struck his head on a set of six concrete steps. Their mother never forgave herself. Martin was about 13 years old at that time. He states that Ian was never the same after the accident. He couldn't speak properly and couldn't communicate very well.
- 6.6 The family lived in a village outside Harrogate. Their mother suffered serious and sustained domestic violence from their father. Martin remembers a particular incident when he was a teenager when his father assaulted his mother so badly that there was blood all over the floor and walls. Martin and another brother were made to clean up the blood by their father. He also stated his father had removed door handles in advance so that his mum could not escape. He had assaulted her over a lengthy period with his fists and boots. The police were involved but Martin believes his father received only a very lenient sentence. Martin is adamant that before this incident his mum would never have left their father, but after this attack police advised her to leave and she moved out to live in Bradford. At this point Martin and the two older brothers were approaching school leaving age and had jobs at nearby farms. The second and third brothers moved out soon after this incident and started work. Martin (the eldest) was at his father's address but had no wish to remain there. One day, his father made it plain to Martin that he knew where their mother was living in Bradford. His father gave him bus fare to visit his mother and take a message and items of property. However, the money only covered a one-way journey. When Martin arrived in Bradford, he made the

decision on the spot that he was not going back, and he stayed with his mother. That left Ian and Gary living with their father. The younger boys were about three or four years old. Martin did not see his younger brothers for many years.

- 6.7 Martin describes life living at home with his mother and father as 'constantly worrying and treading on eggshells.' Whenever, their father went out drinking, they dreaded what it would be like when he returned. In addition to beating their mother, he also displayed a temper with the children. Martin remembers an incident when he had a very bad episode of 'flu. He was shivering and coughing. His father threw a large pint size mug of tea at him which struck Martin on the head, shouting at him "coughing bastard". Martin states his father insisted they all did their chores and life was very regimented. His father never showed any kind of love or affection towards any of them.
- 6.8 There are still many gaps in the family history and full details cannot be confirmed. We know that Ian and his younger brother spent time in foster care, but we can only speculate at the environment in which Ian grew up.
- 6.9 As an adult, Ian and his brother Gary lived together and shared a flat. Martin believes there was a fall out over the paying of the rent. Following the argument Ian left the flat and in turn this episode of homelessness led to Ian's in-patient stay with mental health services in June 2014. Ian was 45 years old at that time. Martin believes Ian had never been in any kind of long term relationship.
- 6.10 Martin was contacted shortly after his brother's death. He would like organisations and professionals to learn from Ian's experiences. Martin was disappointed about the initial communication with him. He states that when he visited Larkwood House he was told by a member of staff that they knew nothing about the incident, and he was asked to return another day. When he was given a manager's telephone number he found her dismissive and she simply told him she was "Going on holiday" and someone else would speak with him. When he finally did meet with several professionals, one of those present was a male who had found his brother's body. Martin is adamant this was the same male he had met a few days earlier who stated he knew nothing about the incident.
- 6.11 The family would like professionals to appreciate that Ian had a long history of suicide attempts. Gary was the one who was closest to Ian and had grown up with him and then lived together as adults. In particular, Gary states "If Ian doesn't take his medication it is like waiting for a bomb to go off." Clearly the family believe this was a major factor in Ian's death. They recall several previous suicide attempts which occurred after he had stopped taking his medication.
- 6.12 Ian's family are supportive of the SAR process and have expressed a wish that lessons can be learned to help support other vulnerable people.

7 Analysis

- 7.1 Ian was a 47 year old male who had been known to services for many years. He had a diagnosis of schizophrenia and had been an 'in-patient' with mental health services going back at least as far as 1995. However, there were also gaps spanning several years where Ian was not in contact with services. There have already been separate multi-agency agency reviews into the circumstances of his death (one conducted by North Yorkshire County Council and another by Tees, Esk and Wear Valleys NHS Foundation Trust). This SAR will consider the decision-making and responses across all agencies.
- 7.2 This Safeguarding Adult Review has been commissioned by the North Yorkshire Safeguarding Adult Board to identify lessons learned and work on a multi-agency basis to review actions and decision-making which leads to recommendations for improvements to services across agencies.

TERMS OF REFERENCE

What were the systems for risk assessment of harm and how were reviews of risk conducted and managed? Did any review take account of any change(s) in the person's circumstances?

- 7.3 When Ian visited his GP (accompanied by a housing key worker) on 6th June 2014, the GP sought an appropriate mental health assessment. Ian left the waiting room before the arrangements could be confirmed. However, the GP notes suggest the risk assessment was that Ian was not suicidal, and some level of support was in place (he had arrived with a support worker and had somewhere to stay). The GP's response was proportionate to the presenting circumstances.
- 7.4 On 8th June 2014, Ian was taken to the Emergency Department at Harrogate District Hospital after he had been found wandering along a busy main road. Staff assessed the risks to both Ian and others (he was displaying inappropriate sexual behaviour towards female staff). The risk was further managed by a timely call to the Intensive Home Treatment Team (IHTT). Ian was transported initially to Bootham Park hospital in York (all-male ward) for assessment (under section 2 MHA) and then to Danby Ward, Cross Lane hospital, Scarborough (which was a 'mixed' ward).
- 7.5 Ian was further examined, and a detailed assessment of the risks carried out. His assessment included a reference to a diagnosis of schizophrenia together with a possible mild learning difficulty. The main risks recorded were his vulnerability and deterioration. The team used the 'FACE' risk assessment tool (Functional Analysis of Care Environment). This is a nationally recognised risk assessment for mental health services. Also recorded was that Ian was *acutely unwell and that he responds to acoustic hallucinations* (chronic paranoid schizophrenia). Further notes

indicate Ian's lack of compliance and so a full physical examination could not take place.

- 7.6 On 12th June 2014 Ian was reviewed by a consultant psychiatrist at Cedar Ward, Briary Wing at Harrogate District hospital. There was an impression of probable psychotic illness. Changes in treatment were considered as was the need for an urgent review of Ian's housing need (his room at the hostel had been re-let). He was subsequently prescribed olanzapine (anti-psychotic medication). This was an effective assessment. The clinician not only considered Ian's direct medical needs but also looked at the wider environmental issues (e.g. housing). The risk assessment was updated on 14th June. Ian's historic medical notes were reviewed, and the risks noted included past suicide attempts, dangerous behaviours (including fire setting), violence and aggression. This was a comprehensive review of Ian's presenting risks. Of note, two days later, the records indicate Ian's medication (olanzapine) was further increased to manage the identified risks. The dosage was increased still further on 18th June. Ian also commenced an anti-depressant on that date (sertraline).
- 7.7 On 25th June 2014, some of Ian's possessions were brought to the hospital following the re-letting of his room at the homeless hostel. These included a 'gun' (air rifle) and night vision goggles. Police were informed (to make the air rifle safe). At Ian's review five days later, the weapon and goggles were considered. Ian made some concerning remarks about the items *making him feel safer*. On 11th July, the consultant psychiatrist noted Ian *held them for self-protection, second to persecutory ideation*. Ian's previous suicide attempts included driving a car into a barrier at an RAF base. The consultant's notes indicate a good assessment which was reviewing the presenting risks. Following his review, Ian's plan was updated:
- recommend detained (s. 3 MHA) for treatment
 - contact his brother for further history
 - air rifle given to brother for safe keeping
 - continue with olanzapine and sertraline
 - look at accommodation options
 - section 17 leave (the responsible clinician authorises Ian to leave the building where he is detained).
- 7.8 This plan keeps Ian safe (s. 3 MHA detention) while treatment continues. The family are involved to gain a better understanding of Ian's experiences. It ensures medication is continued to control or mitigate his symptoms and it makes provision for longer terms plans regarding his accommodation needs. The plan is timely and thorough.
- 7.9 On 30th July 2014, Ian had a brief visit to Moordale House (a TEWV facility for rehabilitation and recovery). The same notes also state *sertraline increased to 150mg*. The notes are not detailed but it is a reasonable assumption this medication was increased to assist in managing Ian's planned temporary stay at the

rehabilitation and recovery unit. During this SAR process, the Independent Reviewer discussed this hypothesis with an expert witness (consultant psychiatrist) who confirmed this was likely.

- 7.10 There was a review by a psychiatrist on 6th August 2014. When reviewing Ian's risks, the determination is that he is not yet ready to move to Moordale House – *due to his suicidal ideation / level of risk*. This intervention clearly demonstrates an active review process linked to Ian's presenting risks. The clinician intervened to delay further external visits at that stage as the presenting risks outweighed any benefits. It was a further two weeks until Ian actually visited Moordale House (as part of the planning for his transition). Simultaneously, his dosage of sertraline was increased again.
- 7.11 A further review of Ian's risks and associated treatment was conducted on 1st September by a 'Second Opinion Appointed Doctor' (SOAD). The SOAD was in agreement with both the diagnosis and the management plan. The SOAD considered Moordale House (Rehabilitation and Recovery) as suitable follow-on accommodation. The medication was also reviewed and other anti-psychotic drugs (clozapine) were considered. A *small improvement* was noted in Ian's presentation, but it is also recorded Ian is still isolative. Finally, the notes indicate that psychotic features were present on admission but not currently. The SOAD service safeguards the rights of patients subject to the conditions of the Mental Health Act. SOADs are consulted in certain circumstances when a patient refuses treatment or is too ill or otherwise incapable of giving consent. This episode is clear evidence of the mental health team ensuring all of Ian's rights are respected.
- 7.12 On 10th September 2014, the consultant psychiatrist reviewed Ian's mental health. Their professional opinion is recorded as *No changes in mental state or risk profile*. The psychiatrist also had access to daily notes made by nursing and occupational therapy staff and Ian was reviewed every weekday by a multi-disciplinary team.
- 7.13 On 15th September 2014, Ian was accompanied to a meeting at Hill Street (a large house containing independent flats). Staff there felt Ian's needs were *a little too high for them*, however they did suggest Larkwood House which they believed would better cater for his needs. The staff at Larkwood (a large house with individual rooms and some limited support) in turn commented that Ian would need to establish a normal sleeping pattern and be able to take his medication independently before they could *take him on*. The comments from staff at both facilities (Hill Street and Larkwood House) clearly indicate their concerns that Ian's needs at that time are above what they can deal with.
- 7.14 On 22nd September 2014, Ian was again reviewed by a consultant psychiatrist in Cedar Ward. They record that Ian's mental state *remained much the same* and that *Ian is apprehensive about the move to Moordale House* (the rehabilitation and recovery facility). The notes state that Ian has spent temporary periods at Moordale House in the last few weeks and is *more comfortable about the move*.

The psychiatrist notes also state that Ian is *reluctant to go out unaccompanied and that at times has thoughts that life is not worth living but no plans to act on these and they are short lived*. During this meeting, professionals also record that they discussed accommodation after Moordale House with Ian. Ian replied that he had not considered this, but the records confirm that Ian had been made aware that referrals for accommodation for after Moordale had been made.

- 7.15 Ian did move out to Moordale House later that same day. The day after his move to Moordale, Ian was supported on a visit to Larkwood House. Larkwood is accommodation offering limited support. Housing support staff are available, but they are not based at the premises and only call in to the premises from an office elsewhere in the town. There are no staff on duty after 8.00pm and there is no cover at weekends. However, at this stage, Ian was only viewing the property as potential future accommodation.
- 7.16 In relation to Ian's medication; the psychiatrist notes show he made two observations following discussions with Ian. Firstly, he was *happy* to take the medication at the rehabilitation & recovery facility. Secondly, that he was *not sure on discharge*. These comments are an early indication that there may be problems with Ian taking his medication once he is discharged (though it should be noted that at this point, Ian's discharge is not envisaged in the near future).
- 7.17 On 22nd October 2014, an Occupational Therapist commenced a 'recovery star assessment' (this is a self-assessment with Ian supported during the process by a professional). The 'star' contains ten areas covering the main aspects of people's lives (e.g. living skills, relationships, self-esteem etc). Ian's needs were still high. This is confirmed when a referral was received at the Assertive Outreach Team (AOT) from the Community Psychiatric Nurse (CPN) on 27th October 2014. They recommended that Ian is *deemed more appropriate for AOT than CMHT*.
- 7.18 At a review on 29th October 2014, it is recorded that Larkwood House had rung to enquire if Ian would be going there. These notes confirm they require feedback from the AOT if they would support him if he is to start living independently. Clearly, the assessment for Ian is that he must have the more intensive support of the AOT (rather than the Community Mental Health Team or CMHT) if he is going to make progress at Larkwood House. These notes also state *mentally no concerns* and that Ian *does as he is asked*.
- 7.19 During November 2014, there are several references to assessing the most appropriate accommodation for Ian. Entries record that Ian is still waiting for an assessment from the AOT. Staff discussed two options with Ian. These were Larkwood House (semi-independent supported living), or The Woodlands which was an adult supported living project. Ian preferred Larkwood House as it was closer to the town centre. Although it is positive that mental health professionals were involving Ian in making choices, this should be balanced with professional opinion regarding the suitability of the accommodation. Subsequent conversations

between housing staff and mental health practitioners all indicate that the Woodlands was more suitable to Ian's needs. When reading notes made at that time, it is clear that staff at Larkwood House had reservations about their ability or capacity to support Ian. In particular, they cite The Woodlands would be a better option for Ian *as he requires support taking his medication*. The Occupational Therapist also records that Ian *requires prompts to take his medication and that he will probably not take it on discharge if not prompted*. The OT discussed the likelihood of relapse and suggested to Ian that he should look again at The Woodlands for his accommodation. This view is supported by the CPN who records that Larkwood House have concerns about Ian's lack of compliance with medications. The CPN agreed to speak to the AOT to look at *assisting with medication compliance*. As part of his planning, this is a reasonable adjustment to support Ian with his choice of accommodation and mitigate risks of non-compliance with his medication.

- 7.20 At Ian's mental health review on 12th November 2014, professionals note *no change in physical or mental health*. This is lacking detail and so we can only speculate what the current observation is being compared to. We do not know where this sits on a scale of Ian's mental health. i.e. has he made progress? At this review, there is also an acknowledgement that Ian would prefer to go to Larkwood House but that staff there believe The Woodlands would offer Ian a better level of support.
- 7.21 A further mental health review two weeks later states *no concerns of mental health* but then adds *still needs prompting re medication and personal hygiene*. We know that not taking his medication directly impacts on Ian's mental health and that personal hygiene has historically given indications of Ian's poor or declining mental health. Management of his future care is heavily dependent on the right level of support being available and Ian's acceptance of this support.
- 7.22 The level of need is acknowledged on 2nd December 2014 when Ian was formally transferred from the Community Mental Health Team (CMHT) to the Assertive Outreach Team (AOT). The appointed Care Coordinator was from the AOT.
- 7.23 A bed became available at The Woodlands (24 hour adult supported living) on 7th January 2015. Ian went to stay on temporary overnight leave. He was not keen but was encouraged by staff to go. On his return, Ian stated he would prefer to go to Larkwood House. A review took place on 21st January 2015. The notes at the review confirm Ian had capacity to make the decision and discussed his 'right to choose.' It is correct he had a right to choose but that choice should have been limited to those premises which were suitable to his assessed needs. It should be acknowledged during this SAR that it is difficult to assess exactly what accommodation was available four years earlier, but we do know The Woodlands was available at that time. During many assessments and discussions, practitioners from different professions and organisations had voiced their concerns that Larkwood House simply did not have the facilities, resources or trained staff to

make a placement there a success for Ian. They could not meet his identified needs, especially regarding the taking of his medication. This is acknowledged by Ian's Care Coordinator on 3rd February 2015 when they again request a further visit for Ian at The Woodlands. Ian insisted he wanted to go to Larkwood House and not The Woodlands. The following day, a psychiatrist records that she is *not overly concerned if he does not go to The Woodlands*. This statement is at odds with all the previous comments that staff at Larkwood House will not be able to assist Ian taking his medication. Ian had a high risk of relapse and a major factor in this happening would be if he did not take his medication.

7.24 Ian signed his support agreement with NYCC on 13th February 2015 and his actual tenancy agreement for a room at Larkwood House the following week on 20th February 2015. At the same time, the AOT recorded their concerns that Ian will withdraw in that environment. A further warning is evident when the same day the AOT are noting he may withdraw when he arrives at Larkwood, the Care Coordinator records that Ian may withdraw from his work placement which had been arranged. These risks of not taking his medication and of discontinuing his work placement (i.e. a lack of interaction and positive activity) were clearly recorded but action was not taken to prevent or mitigate them. Ian moved into Larkwood House.

7.25 Immediately prior to Ian leaving the rehab & recovery facility, there were two reviews recorded (one on 18th February and one a week later on 25th February). Although only one week apart, they suggest different perceptions on the level of risk at this point in Ian's life:

- 18th February – *Mood subjectively okay. Sleeping okay. Occasional odd feelings and thoughts. Down in the dumps at times. Denies any thoughts of harming self but unable to expand further.*
- 25th February – *Mental health stable. Not exhibiting signs of depression ...appears bright. No current thoughts of ending own life or not wanting to be here....forgot meds this morning as in a rush.*

These two assessments / discussions were within the same mental health team. The later assessment appears a little more positive. However, it should also be noted that Ian's mood was changeable. But when considering events that followed, it must remain a possibility that Ian may have been minimising his symptomology during this discussion to assist in his move to the lower intensity supported accommodation. Plus of course, even when still in the rehab and recovery unit, Ian had already forgotten to take his medication. Nothing in the notes suggests Ian's nearest relative (his brother Gary) was consulted about the proposed move to Larkwood House or if family involvement was discussed with Ian. Gary was very aware of what had happened in the past once Ian had stopped taking his medication.

- 7.26 Ian was discharged on 8th April 2015 and moved into Larkswood House. It was recorded on his discharge that Ian would be visited three times per week at his new accommodation. Ian's Care Coordinator did visit him three times during his first week at Larkswood House. On his second week they visited once. There were issues with Ian's medication. The prescription had not gone to the pharmacy, so the support worker collected them directly, which was good practice. After Ian's second full week at Larkswood House, there was a gap of over two weeks until the next AOT visit. Even then, there was no reply at Ian's door. It was a week later that Ian was seen at his work placement (on 14th May 2015). He was seen again two weeks later on 28th May. From very soon after his arrival at Larkswood House he was not receiving the level of support from the AOT that was assured within his Care Plan. The plan was for three visits per week. This was never achieved at any time after his first week at Larkswood House. By May, his visits had slipped to once per fortnight. He was seen three times in June. On 19th June, the plan was amended to reduce his visits to once per week, but this decision was not fully documented. He did receive a visit four times in July, twice in August, once in September, four times in October, not at all in November and once in December. The frequency of planned visits was rarely achieved.
- 7.27 One of the perceived positive aspects to Ian's initial stay at Larkswood House was his work placement which had been arranged by his care team. However, on 23rd July 2015 (only two days after the decision was made to transfer his care from the Assertive Outreach Team (AOT) to the Community Mental Health Team) he told his social worker that he no longer wished to attend saying "I have done my 6 months." This cancelling of his work placement, together with the lack of engagement observed by housing support staff working at Larkswood House, suggests a review is necessary to ensure there is no deterioration in Ian's mental health.
- 7.28 On 8th September 2015, a support worker from the AOT took Ian to his planned outpatient's appointment. They record *not much conversation, appears to have put on weight, stopped work placement*. These appear to be negative indicators of a withdrawal from services, but no intervention or escalation is suggested. The notes also state *Denies problems with mood. Denies any psychotic symptoms*. But of course, these are simply Ian's responses to the practitioner's questions. The AOT staff put in the notes *Spoke to Larkswood House about taking over the weekly medication run – they agreed*. This seems to be a step back by the AOT (the medication run is still an opportunity to see Ian), at a time when the evidence is that Ian's health may be starting to deteriorate. The final comment in the AOT notes is *Will visit Ian next week*. They did not see Ian again for over three weeks.
- 7.29 For several months during the remainder of 2015, supported housing staff working at Larkswood House continued to record a lack of engagement from Ian. These concerns were reported to the TEWV mental health professionals on 1st October and 23rd October. The latter entry (23rd October 2015) records the Care

Coordinator is informed that *Ian is not accepting support and all staff are doing is mental health monitoring*. They record the Care Coordinator is aware of this. No subsequent intervention appears to take place.

- 7.30 On 3rd December 2015 a review of Ian's care took place at Larkswood House. Ian, the Care Coordinator and the supported housing manager were present. They discussed that Ian was difficult to engage, not keen to form any relationships with support staff or take part in social integration. However, Ian had historically found social integration difficult. Ian was informed that due to staffing changes, he would be appointed a new Care Coordinator in the coming weeks. The notes do say that Ian *continues to access his medication independently*, but they are not clear if staff actually witness any concordance with his medication. There are no comments about poor hygiene and so this meeting should be viewed as a proportionate response ready for Ian's transfer to a new Care Coordinator. Unfortunately, the TEWV records indicate there was no further direct contact between their mental health staff and Ian for the next three months. This is not an adequate level of care and support and not in compliance with his CPA plan.
- 7.31 Ian's CPA review took place on 9th March 2016. At this meeting, Ian told professionals he had stopped taking his medication two weeks earlier and he no longer wanted to take it. The review records *no significant risk of anything untoward evident today*. We know from the family input and Ian's historical mental health records that his medication is essential to his maintenance of good mental health. We know his prognosis was a *high risk of relapse*. The stopping of his medication was a significant event and an escalation to consider options available to practitioners should have taken place. It did not. This was a missed opportunity. The risk assessment was not updated (the previous risk assessment was in December 2015 and this development should have formed part of an updated risk assessment). This lack of intervention suggests there may have been a poor quality handover of information relating to Ian's history and Care Plan between the outgoing and incoming Care Coordinator.
- 7.32 During April 2016, supported housing staff notes show that Ian's health was deteriorating. There are several entries which give cause for concern about Ian's personal hygiene, unkempt appearance and him not taking his medication. When they did manage to convince Ian to answer his door, the room was in darkness and there was no television switched on. An e-mail outlining these concerns was sent to Ian's Care Coordinator on 6th April. This SAR has confirmed this e-mail was received at TEWV but there is nothing recorded of any action taken. The housing notes suggest staff are not aware of the updated information about Ian deciding not to take his medication. This gives confusion on their role, i.e. are they encouraging Ian to take his medication or accepting his decision not to take it? The plan appears to be to 'monitor his mental health' but this lacks clarity.
- 7.33 The Care Coordinator visited Ian on 13th May 2016. Their record of the visit is contradictory with the housing staff observations during the previous six weeks.

The housing staff repeatedly record their concerns about Ian's unkempt appearance and poor hygiene. But on their one visit, the Care Coordinator notes *Appeared well kempt and relatively buoyant in mood. Engaging with support staff.* No member of the support staff was present even though this was a planned visit. The Care Coordinator can only have taken Ian's word on the positive engagement as support staff were not there and did not know the Care Coordinator had visited until a few days later when they had cause to telephone the mental health team. This visit was a missed opportunity for dialogue directly between the Care Coordinator and the housing support staff.

- 7.34 There were no other visits to Ian by the Care Coordinator for over two months. This is contrary to his CPA plan (the updated plan on 11th March had reduced the frequency of visits to once per month). The notes of the visit on 14th July are very brief. There is nothing in the record about Ian's appearance, mood, hygiene or medication. It states *Regular contact with support staff.* In reality, Ian's contact with support staff was minimal. The support staff make many entries in their own records detailing concerns about Ian's deteriorating health. They record that messages are left for the Care Coordinator on 18th May and that the Care Coordinator returned the call on 19th May. The housing staff notes record the conversation. Another e-mail with further concerns was sent to the Care Coordinator on 31st May. The NYCC records show an e-mail reply from the Care Coordinator was received on 7th June with the coordinator apparently confirming they will be visiting that week. None of these contacts are recorded in the TEVV (Care Coordinator) notes including any visit to Larkwood House in June.
- 7.35 Gaps began to appear in the level of contact between Ian and the supported housing staff. During the previous year, contact varied from every couple of days to around once a week. By 2016, this had slipped significantly. There are gaps of two or three weeks where there is no recorded contact with Ian.
- 7.36 On 23rd September 2016, Ian's outgoing Care Coordinator introduced him to his new Care Coordinator. This was his third Coordinator in two years. The supported housing manager was also present. During this CPA review they recorded *Ian presents with no current risk factors.* This assessment is difficult to understand. There have been many concerns listed over many months. Housing staff were represented so we should presume their views were expressed by their manager. The conclusion can only be that this CPA review was not robust in identifying the serious and ongoing risks to his health.
- 7.37 Housing staff continued to record their concerns during autumn and winter 2016. Ian became increasingly isolated. He does not appear to have been seen by anyone for nearly six weeks over Christmas and New Year.
- 7.38 The following month, housing staff began to receive complaints from other vulnerable residents regarding Ian's mood and aggressive behaviour. When adding this to other concerns about isolating himself, not taking his medication, his

unkempt appearance and poor hygiene of both himself and his room it is plain to see Ian was on a downward spiral and required intervention.

- 7.39 Ian's Care Coordinator saw him on 18th November 2016. They did not visit Larkwood House for another two months - calling on 18th January 2017. But there was no answer at Ian's door, and he was not seen. The Care Coordinator did not visit again for another two months until 2nd March 2017. Once again, they could not get a reply. In fact, the last time Ian's Care Coordinator met him was in November 2016; five months before Ian's death.
- 7.40 On 31st March 2017, supported housing staff at Larkwood House tried to conduct a welfare check on Ian. They could hear movement from his room but were unable to get in. The locking mechanism on the door had been tampered with. Staff talked through the door to let Ian know that if they could not check if he was okay they would telephone the police. Ian passed a note under the door stating *I am fine ok. Can you go away please? If you break the door down I will fight back. I am prepared to die.* Housing staff contacted Ian's Care Coordinator and raised their concerns. The Coordinator did not offer to visit. They advised housing staff to call the police if necessary to detain Ian under section 136 Mental Health Act. They also asked to be informed of the outcome. Ian was in his own residential setting and so section 136 powers were not available to the police. Housing staff discussed the police attendance option with their own manager who advised police would not attend simply for welfare checks. The police were not contacted so this avenue was not explored. There is no doubt that the Care Coordinator should have attended to assess potential interventions and escalation. There was insufficient action and ownership of this event by the Care Coordinator. The incident was clear evidence of a deterioration in Ian's health.
- 7.41 Housing staff sent an e-mail to the Care Coordinator on 5th April 2017. They expressed their concerns about Ian's behaviour and aggression and that they believed his mental health was deteriorating. They did not receive a response. TEWV have no record of this e-mail.
- 7.42 On 12th April 2017, police were called and forced entry to Ian's room at Larkwood House. Ian was found dead inside his room. He had died by suicide from carbon monoxide poisoning.

How effective was the person's care plan? Did the plan operate within the policies and procedures for each agency? Did the plan meet his identified needs? How was the plan implemented?

- 7.43 The first plan during the timeframe of this SAR was carried out when Ian was an inpatient (s. 2 MHA assessment) at Danby ward, Cross Lane Hospital Scarborough. Following assessment, the plan is recorded as:
- 1/. Further assessment of patient required.

- 2/. PRN meds on drug chart completed.
- 3/. General observations needed.
- 4/. Physical examination to be carried out when possible.'

The plan is sound and provides for measures to protect Ian but also clearly shows it requires review to gain further information when Ian is compliant.

- 7.44 On 22nd September 2014, although still an inpatient under section 3 Mental Health Act, Ian transferred to the TEWV rehabilitation and recovery service. This was part of his plan to assimilate back into the community. It is worth noting that Cedar ward staff recorded a telephone call from staff at Larkswood House on 24th September. The notes state *the longest time they can keep a room open is 2-3 weeks*.
- 7.45 A Care Coordinator was appointed when Ian left Cedar ward. Although on 1st October 2014, the Care Coordinator recorded that the Assertive Outreach Team (AOT) had agreed to assess Ian as he seemed suitable for them, they also note that Ian *hasn't got a CPA care plan*. As a section 3 patient, it is mandatory that Ian has a section 117 aftercare plan in place.
- 7.46 On 19th November 2014, professionals held a 'Section 117' meeting to plan for Ian's continuing care. They noted Ian had been referred for an employment placement and had been responding well to 'recovery star'. This is an outcomes measure which enables people using services to measure their own recovery progress and are supported in this process by mental health professionals. Ian was made an informal patient following this meeting. As part of this plan for ongoing care and support, the meeting specifically states staff are looking at The Woodlands for Ian's longer term accommodation, and that *AOT to sort out referral and funding for this*. Although the planning is for The Woodlands, it is clear that the reality did not match the plan; Ian went to live at Larkswood House which professionals agreed did not meet Ian's higher level of need. The final notes in the record of this Section 117 planning meeting state *No concerns regarding medications – needs prompting, and Ian does admit he would forget to take medications*. These comments are contradictory. There are indeed concerns about medications and the reasons are listed immediately after the comment 'no concerns.' The continuance of Ian taking his prescribed medication is absolutely crucial to improving Ian's mental health and maintaining that health. To be fair to staff at the planning meeting, they do seem to be using the rationale that Ian will go to The Woodlands rather than Larkswood House where he actually moved to. What is not clear is why the plan was not followed. The plan may have met his needs to a certain extent, but the reality did not as this plan was not implemented as intended.
- 7.47 On 11th February 2015, when Ian signed for his accommodation at Larkswood House, the AOT noted their concerns that *he will withdraw in that environment but*

will be assertive in supporting him when he moves. However, a plan was formulated:

- 1/. Bloods to be taken
- 2/. To source a GP when he moves
- 3/. To encourage Ian to ask staff for his medication for a couple of weeks and see how it goes.

The final sentence of the plan (*to see how it goes*) lacks any clarity of who will review and when and how. If problems were anticipated with Ian taking his medication (which they were) this needed to have ownership and a date to intervene if necessary. There is no rationale why The Woodlands is not being accessed (with its higher level of support than Larkwood House).

7.48 Ian's discharge planning meeting took place on 18th March 2015. Ian attended the meeting. The notes state:

No new concerns, doing well with his leave to Larkwood House. AOT are still supporting and will continue to do so. Physical health: no new concerns. Staff at Larkwood report Ian is very quiet, and that Ian reports he is okay, but this may not always be accurate. Will need prompting and monitoring for his self-neglect symptoms.

These comments at the planning meeting are a cause for concern. They suggest staff at Larkwood House believe Ian is not always open in stating he is okay. They also state Ian needs prompting to take his medication. Also, reference to AOT involvement is not prescriptive. i.e. *'are supporting and will continue to do so'* does not give any indication of timeframe when this may be withdrawn.

Later in the planning meeting there are further comments which also cause concern. The deputy manager at Larkwood House tells the mental health professionals *they will be short staffed for a while and she did not want to promise what they will and will not be able to provide.*

The next day, a further planning meeting was held. Concerns were expressed about the level of support Ian required and the risk of relapse should he not engage with staff or take his medication. The untrained housing staff would try to visit him daily but they are short staffed so this may not always be possible. The AOT noted they will visit at least three times per week, but *this is reliant on Ian letting us in the building.*

These plans do not stand up to scrutiny. Ian is at high risk of relapse and this is recorded, especially if he does not take his medication. The housing staff are not trained mental health professionals and they state clearly that due to staff shortages they probably will not be able to prompt Ian on a daily basis. The AOT commit to visiting three times per week but are already acknowledging their involvement is dependent upon Ian letting them into the building (presumably

because there is an acceptance that housing staff will not always be present). Given Ian's history of relapse, of failing to engage and knowing the consequences of him not taking his medication, then this planning meeting should have 'pressed the pause button' and escalated this case to senior practitioners / management to seek a review of this accommodation for Ian.

- 7.49 Ian was discharged on 8th April 2015 and a further section 117 aftercare plan was put in place. He moved in full time to Larkswood House. Even on the day of discharge, the notes state *confirmation given that AOT will attempt 7-day follow-up visits from tomorrow*. This wording on the notes creates ambiguity. In fact, a visit was attempted.
- 7.50 On 19th June 2015, Ian's Care Coordinator collected him from Larkswood House and accompanied him to his Care Programme Approach (CPA) meeting with the consultant psychiatrist. The notes from this meeting state Ian is doing well and is attending his work placement twice per week, *that he is happy and concordant with meds, no thoughts of harm to self or others*. The plan records *to be seen by psychiatrist in three months and to transfer to CMHT in six months*. To manage Ian's symptoms he is to continue with the anti-depressant, sertraline (200mg), and the anti-psychotic drug olanzapine (10mg).

To what extent was the individual, his family or other advocate involved in the planning of his care?

- 7.51 There was early involvement with Ian's family from his admission as an inpatient in June 2014. His brother (whom Ian had lived with until recently) provided a long history of Ian's issues. When Ian was transferred from Cross Lane Hospital in Scarborough to the Cedar ward in Harrogate, his family were informed of the move which was good practice.
- 7.52 On 12th June 2014, it is documented Ian was offered an advocate regarding any appeal to his being detained in hospital. This was in full compliance with the Trust policies and their legal obligations.
- 7.53 Following Ian's detention for treatment (s.3 MHA), he was offered access to a Mental Health Advocate on 3rd July 2014. He accepted and this was arranged. The advocate subsequently supported Ian during his (s.3 MHA) appeal. The tribunal upheld the 'section 3' treatment until suitable accommodation and aftercare was in place. On 5th September 2014, Ian attended a Mental Health Review Tribunal. He was supported throughout by a solicitor who made representations and successful argument to the panel that Ian's benefits had been stopped unfairly. Following this, Ian's consultant psychiatrist provided a supporting letter for a new benefit application.
- 7.54 Although Ian often did not wish to have involvement with his family, this contact with close relatives could have been further explored. Many of the difficulties that

led to Ian's deterioration were because he was not accommodated in the right place after his discharge. Staff could have been more persuasive for his brother to have been involved. They had grown up together and lived together as adults. He may have had more success in convincing Ian to move to the Woodlands which offered more support than was available at Larkwood House. The health or housing records do not indicate these discussions were ever attempted with Ian.

How effective was information sharing and liaison both with single agencies (intra) and between multi-agency partners (inter)? Did the information exchange adhere to agreed protocols?

7.55 There were some good, positive exchanges between professionals and organisations in November 2014 (Occupational Therapists from TEWV and Housing staff from NYCC) regarding the most appropriate outpatient accommodation for Ian.

7.56 On 6th March 2015, TEWV notes state that staff had *several conversations with Larkwood House staff to discuss what type of support Ian needs*. However, a week later there are two entries made on the same day relating to notes made by the two agencies.

The first was a.m. and says staff member explained that Larkwood House is not really supported housing but is independent living.

The second was p.m. and says that the manager at Larkwood confirmed Larkwood is supported and for high needs. Discussed Ian's needs. Manager stated that staff can support from 8.00am to 8.00pm. Advised that Ian will need care and support for taking medication, personal care and diet.

These two conversations are only a few hours apart and appear to give differing messages about the level of support available at Larkwood House.

7.57 There are several entries of missed appointments to see Ian soon after his arrival at Larkwood House. He was not present when his Care Coordinator called because he was actually out at his work placement.

7.58 There was a delay of three months from Ian's discharge from the Mental Health Trust to his GP being made aware. Even then, there appears to be confusion about what Ian's actual address was. The GP tried to trace the address through other means and again it is surprising that they did not simply contact TEWV to obtain Ian's address. TEWV confirm their records state the letter was sent on time but the GP practice did not receive it for three months.

7.59 Shortly after Ian's transfer to Larkwood House, housing staff had been keeping records of Ian's lack of engagement. When they did raise these with the TEWV team office they were informed the Care Coordinator had visited Larkwood House the previous week. This is poor as there is no joined-up approach. The supported

housing staff were no longer based at Larkwood House by this point. Enquiries carried out during this SAR process suggest this was an individual member of staff decision which was made due to staff shortages being experienced. Staff were now reporting on duty at Hill Street (a premises some distance away) and only calling in at Larkwood intermittently. This was not communicated to TEWV mental health staff. Arrangements for Care Coordinator visits should have been made in advance with the staff based at the Hill Street office. The supported housing staff did not even know the coordinator had been to the building. This is poor communication from both organisations.

- 7.60 On 30th July 2015, NYCC Housing staff made an entry in their records *Ian is not accepting support and this needs bringing up as an issue with him and his care team*. However, there are no subsequent references to whether these concerns were actually raised with his care team. It should though also be noted that there are several examples where the housing staff have left telephone messages for the Care Coordinator including sending detailed e-mails listing their concerns. The Care Coordinator did not always reply to these messages. But not all concerns from the housing staff were reported.
- 7.61 At a CPA review meeting in March 2016 the outgoing and new Care Coordinators were present. There were insufficient details recorded and the meeting did not match the actual risks Ian was facing. One reason for this must be the poor quality of a handover between the two coordinators.

What were the missed opportunities for intervention to protect him?

- 7.62 On 10th November 2014, a CPN took a call from staff at Larkwood House who were expressing concerns about Ian complying with his medications. The CPN agreed to speak with the AOT to look at assisting with medications. This does not ever seem to have been implemented.
- 7.63 On 19th November 2014, the plan was clearly documented for Ian to move to The Woodlands when a place was available. This offered a higher level of support given Ian's risk factors. Ian was given a choice of two accommodations. As has been stated already, his immediate family could have been contacted to help persuade Ian of the benefits of The Woodlands. Ian never was suitable for being accommodated at Larkwood and the original plan should have been followed.
- 7.64 Again as already documented, in March 2015 the 'pause button' should have been pressed. All evidence suggested that Ian was not ready to move on to Larkwood House. This should have been escalated and plans held until Ian was ready to make progress.

- 7.65 There was no evidence that Ian's recorded historical risks were recognised by his last two Care Coordinators. These risks were recorded on a formal risk assessment document on 17th December 2015 but there is no evidence that risks were formally reviewed or recorded after that date.
- 7.66 Ian stopped taking his medication in February 2016 and declined a medication review but there is no indication that further medication reviews were requested after March 2016.
- 7.67 During April 2016, supported housing staff at Larkwood House (employed by NYCC) noted Ian's deterioration over a six week period. They did eventually leave a message for his Care Coordinator but by then it was the middle of May. Intervention should have taken place much sooner.
- 7.68 The CPA review on 23rd September 2016 represented an opportunity to discuss all the issues that supported housing staff had been documenting over a long period. The CPA meeting was also when the outgoing (2nd) and new (3rd) Care Coordinator were present. The record of the (TEWV) meeting does not match the numerous entries in the housing records in the preceding weeks. Some 'Larkwood' entries are made by the housing manager at Larkwood House, but these are not reflected by her comments at the CPA review. This will be further explored under 'Organisational Context.'
- 7.69 On 5th December 2016, an entry in the supported housing records lists a number of concerns and risks associated with Ian. This entry is worthy of particular note as it states *all staff have expressed concern*. But there is no evidence that any of these concerns were passed to the Care Coordinator in a timely manner.
- 7.70 There is no evidence of a clear plan to manage Ian's poor engagement and relapse prevention following his missed appointment on 18th January 2017.
- 7.71 Ian's CPA review which was due in March 2017 did not take place and there are no records indicating any attempts to arrange such a review meeting.
- 7.72 On 31st March 2017, housing staff rang Ian's Care Coordinator. They outlined issues that firstly Ian had not engaged in the last month, secondly that he had tampered with his door to prevent entry and thirdly that he had passed a note under the door with worrying comments. The Care Coordinator's response was poor and will be evaluated in the conclusions of this report.
- 7.73 A final chance to intervene was missed on 5th April 2017 (one week before Ian's tragic death). The housing team sent a lengthy e-mail to the Care Coordinator discussing their concerns in detail. There was no reply to the e-mail and there is no record at TEWV of the e-mail being received.

What was the mechanism for escalating concerns to senior managers?

- 7.74 There were two agencies involved in Ian's care where escalation of concerns was not always carried out effectively.
- 7.75 Within Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) there is an ethos of a collaborative approach involving the patient, a variety of mental health practitioners and the family of the patient. There are daily and weekly Multi - Disciplinary Team (MDT) meetings to review issues and provide an opportunity to discuss and share any clinical decisions, risks and to seek advice.
- 7.76 A number of multi-disciplinary reviews took place to discuss Ian's care. However, on several occasions matters of concern were not escalated to managers. There was no review of his risk assessment undertaken after December 2015 despite changes in his circumstances (e.g. Ian's decision to stop taking his medication). There was no escalation when he refused to leave his room and passed out notes stating he was 'prepared to die.'
- 7.77 From discussions between the Independent Reviewer appointed to this SAR and a consultant psychiatrist not connected to Ian's case, it was confirmed that the expectation would be for the practitioner to initially discuss their concerns with their immediate line manager (within the parameters of 'what progress is being made? what plans are there to intervene if there is deterioration? Is the patient getting better?'). In particular, the practitioner (in Ian's case his Care Coordinator) should always be aware of the high risk of relapse. Following discussions with their line manager, the next level of escalation would be to discuss the case with a psychiatrist. These methods of escalation were not followed in Ian's case and this forms the basis of one of the recommendations of this SAR.
- 7.78 For North Yorkshire County Council (NYCC) support staff there is supervision available to the supported housing team manger via the Social Care Team Manager. However there is no formal procedure in place for escalating concerns. This meant that although on several occasions when concerns were reported to the TEWV Care Coordinator, there was no escalation to challenge any feedback or decision.

What was the organisational context? Were there cultural issues that impacted on decision-making or actions?

- 7.79 Some of the organisational context relates to physical issues while others are cultural problems.
- 7.80 Tees, Esk and Wear Valleys NHS Foundation Trust has a completely different IT system (PARIS) to the North Yorkshire County Council Adult Care IT system (Liquid Logic Adults LLA). The two systems cannot exchange information directly. This can

prevent timely or accurate updates and the ability of staff to access updated information. Likewise, the GP practice uses 'System One' which does not link electronically to either the TEWV or NYCC systems.

- 7.81 There is clear evidence throughout the review of a lack of professional challenge. There are many instances where records indicate staff from different organisations (TEWV and NYCC) do not agree on a course of action but these concerns are not raised or escalated.
- 7.82 The GP practice is an essential component to maintaining good mental health within a community setting. There was no direct dialogue or engagement between the inpatient or community mental health team and the GP. For example, TEWV records indicate a letter confirming Ian's discharge was sent, but it was three months later when the letter was received by the GP. Much later, the GP stopped the medication prescription as they had not heard from Ian for a considerable period. When the GP tried to find out Ian's new address they contacted various homeless hostels or supported living facilities rather than contact TEWV direct. While Ian was still on a CPA plan such dialogue between health professionals was important to support his care.
- 7.83 It is not clear if Ian's family or some of the health professionals were aware that supported housing staff were not actually based at Larkwood House but in fact had an office at a hostel in Hill Street. There was no 'team' based at Larkwood. If this had been fully understood then it may be that Ian would not have been placed there.
- 7.84 It is unclear what, if any, training is accessed by supported housing staff in relation to dealing with mental health issues. This will impact on their confidence in raising concerns or challenging the responses to those concerns.
- 7.85 Personalisation is an integral element of the Care Act 2014. Of course Ian should have choices. He had the mental capacity to make decisions. However, this led to problems in his discharge and where he was going to live. There is absolutely no doubt that professionals from across agencies agreed that Larkwood was not the right environment for Ian to make progress. But once it was offered to him, he would not consider other options. His views should have been noted and respected but that should not have meant this was the only factor in decision-making about the most appropriate residential placement for a man suffering poor mental health and with an identified high risk of relapse.

8 Good Practice

8.1 Good practice should be considered within the context of the six principles of adult safeguarding:

- Empowerment. People are supported and encouraged to make their own decisions or with informed consent.
- Prevention. It is better to take action before harm occurs.
- Proportionality. The least intrusive response appropriate to the risk presented.
- Protection.
- Partnership.
- Accountability.

8.1 There are lessons to be learned from this case, but a balanced Safeguarding Adult Review should also recognise areas of good practice by individual staff or by organisations. Examples of good practice are shown here:

8.2 At his first visit to his GP with a support worker in June 2014, Ian was assessed by the GP who sought to secure a mental health assessment. (PREVENTION)

8.3 When the GP practice was unable to make contact with Ian (following three separate invitations between July and September 2015), the GP ceased prescribing medications. This was safe practice and followed practice policy. (PROTECTION)

8.4 After Ian's attendance at the Emergency Department at Harrogate District Hospital, he was taken to a 'relative's' room rather than wait in a cubicle. The relatives' room was more private and less 'clinical.' (PROTECTION)

8.5 He was seen by a triage nurse at the Harrogate Hospital within ten minutes of arrival (within national triage guidelines) and the triage nurse made an appropriate referral to a mental health nurse from the Intensive Home Treatment Team (IHTT). (PREVENTION)

8.6 There was a timely notification and information exchange from the Emergency Department to notify the GP of Ian's attendance. (PARTNERSHIP)

8.7 There is extensive evidence of good practice and effective intra-agency working within TEWV whilst Ian was an inpatient and leading up to his discharge. (PREVENTION / PROTECTION / PARTNERSHIP)

8.8 There are many examples of Ian's voice being heard during his stay as an inpatient, and of family and advocacy involvement plus use of a Second Opinion Appointed Doctor (SOAD). i. e. 'person centred care.' (EMPOWERMENT)

- 8.9 There was some good individual practice from NYCC support workers during Ian's stay at Larkwood House. For example, in April 2015 when a support worker intervened to make sure he received his medication or in March 2016 when he was given advice and support to complete finance / benefit claims documentation. (PREVENTION / PROPORTIONALITY)

9 Conclusions and learning

- 9.1 Ian had a troubled childhood which included a significant head injury and other adverse childhood experiences. He was diagnosed with schizophrenia.
- 9.2 He had several periods of poor mental health which had manifested during several 'crisis' episodes. These included a number of suicide attempts. The prognosis was that he had a *high risk of relapse*. The episodes dated back at least as far as 1995. He had been an inpatient on several occasions when he was detained for assessment (s.2 MHA) and treatment (s.3 MHA).
- 9.3 Following a crisis episode in June 2014, he received treatment as an inpatient on the Cedar ward (Briary wing) at Harrogate hospital. The treatment was effective which facilitated his move on to rehabilitation and recovery.
- 9.4 During planning for his discharge to outpatient services, several professionals from different agencies expressed reservations about the suitability of his preferred accommodation. These reservations should have been explored further and matters escalated to ensure a review prior to his discharge. He should not have been offered the accommodation under consideration as this could not meet his high level of needs. Staff were only available intermittently and they did not have the skills or experience to support his day to day activity. Other premises, with 24-hour support were available, where he could have been much more closely monitored for signs of deterioration in his mental health and more timely support offered.
- 9.5 Medication was crucial to him maintaining positive mental health. His medical files and risk assessments all record this. The drugs (olanzapine and sertraline) controlled the symptoms. There was confusion between mental health practitioners, housing staff and even the GP practice over how he was to be managed or prompted with his medication. Notes made by support staff do not give details of how staff were satisfied he was concordant with taking his medication. With the stopping of medication almost certain to result in a relapse, these arrangements should have been discussed and agreed with provision for intervention options clear to all involved. It is worth noting his brother's comment

of what happens when Ian does not take his medication: *it is like waiting for a bomb to go off.*

- 9.6 The reviews within his CPA plan were not robust or consistent. There are examples when different sets of observations appear contradictory about the level of Ian's deterioration and his mood or level of engagement. Plans that were agreed were not always implemented (especially relating to the frequency of visits to check on Ian's welfare). Days became weeks, which became months before he was seen by a mental health practitioner. This is not the standard of care which was required.
- 9.7 He had three different Care Coordinators during his time as an outpatient (a period of two years). This is sometimes unavoidable, but some actions of the professionals involved suggest the handovers covering Ian's risks lacked any depth. The risks which were identified during his time as an inpatient seem to have been lost or diluted over time as practitioners moved on.
- 9.8 There were episodes of good practice and these have been acknowledged in this report. However some of the practice can only be described as poor. Entries on records stating 'mentally no concerns' clearly did not match the presenting circumstances and identified risks. There was no formal review of his risks after December 2015. There was a lack of ownership in March and April 2017 just prior to his death when much more proactive intervention was required.
- 9.9 Communication was an issue. The GP did not learn of Ian's discharge until three months later. The GP tried to obtain a new address with external agencies rather than go directly to health colleagues at TEVV. The handovers between Care Coordinators was not detailed. The housing staff kept lengthy records evidencing Ian's deterioration but did not raise these in a timely manner with his Care Coordinator. During one period they waited several weeks to raise their concerns. On another occasion when they did leave messages and sent an e-mail they did not receive a reply.
- 9.10 There was a lack of professional challenge. Housing and Occupational Therapy staff did raise their concerns (both in relation to the residential placement and later in relation to his mental health deterioration). These were discussed but there was never an escalation to senior management to challenge these decisions.
- 9.11 The Safeguarding Adult Board asked the SAR panel to consider three questions;

(1) Was the multi-agency response adequate to work and respond to the needs of the individual?

Although there was some effective practice carried out, some of the multi-agency work was not adequate. The presenting needs were not always addressed or responded to appropriately. The evidence of this is contained within the report.

(2) Did the agencies know enough about the individual in order to support him?

Agencies did have the information, but it was not always shared effectively. Four risks were clearly identified and assessed during his stay as an inpatient. These were:

1. A high risk of relapse.
2. Several previous determined attempts at suicide (electrocution, carbon monoxide poisoning, crashing a car into a military barrier).
3. Poor engagement with professionals.
4. Medication required to control or mitigate his psychotic illness.

The agencies had this information (which was known due to some good practice by those involved with his care). However, through subsequent plans, reviews and handovers the risks seem to have lacked sufficient focus. Staff were either not updated during handovers or did not appreciate the seriousness of what was happening.

(3) Could his death have been prevented?

Ian had a high level of need. Some of the practice involved fell below expectations. With many issues taking place over the last two years of his life, this suggests not simply individual error but more systemic problems either in terms of supervision, escalation procedures, professional challenge, lack of training, poor communication channels or lack of resources.

Ian was an adult with capacity to make decisions about his daily routines. When he had previously reached 'crisis' episodes he was supported well, and staff intervened to protect him. He was given advice, including by appointed advocates. He was not keen for his family to be involved.

His mental health deteriorated, and this was plain to see to those most closely involved in supporting him. Staff rightly respected his liberty and choices. We must be careful not to engage in hindsight bias. Ian tragically took his own life, but at times it could be difficult for staff to work with him in a 'community' based setting. The alternatives would have been removing his liberty and detaining him back in a secure environment. Professionals did miss opportunities to escalate and consider options, but these should be weighed against taking away his freedom. The nature of his death shows how determined Ian had become to take his own life. His death could not have been prevented.

10 Recommendations

Recommendation 1: The North Yorkshire Safeguarding Adults Board to seek assurances that all agencies recognise that deterioration in an individual's mental health does not always manifest itself with a crisis episode. The mechanism for this assurance to be contained within the SAR action plan.

Recommendation 2: The statutory safeguarding partners within North Yorkshire to consider the feasibility of a joined-up IT system to ensure accurate and timely exchange of information which will protect vulnerable people and is readily available to all front line practitioners who require access.

Recommendation 3: The North Yorkshire Safeguarding Adults Board to ensure measures are in place for those organisations with responsibility for Care Programme Approach planning, to have systems for dip sampling of case files and caseloads by team managers. This to include a 'deep dive' of content when necessary and in particular to scrutinise the review processes for identification and management of risk. Operational responsibility will remain with the relevant organisation, but the NYSAB to arrange periodic multi-agency audits be carried out.

Recommendation 4: The North Yorkshire Safeguarding Adults Board to review its multi-agency Information Sharing Protocol for exchange of information between agencies relating to vulnerable people living in its area.

Recommendation 5: The North Yorkshire Safeguarding Adults Board to arrange multi-agency training for front line staff to enhance confidence in the concept of 'professional challenge.' This to include an appreciation of the validity of professional challenge and escalation as key tools in protecting vulnerable people. The training will also incorporate a mutual understanding of the breadth and remit of other professional's roles within the arena of protecting and supporting vulnerable people.

Recommendation 6: North Yorkshire County Council to ensure a comprehensive support plan is completed for all vulnerable people who may take up residence at premises owned or managed by the Council.

Recommendation 7: The North Yorkshire Safeguarding Adults Board explores the role of Clinical Commissioning Groups (fulfilling their responsibility as a commissioner of services) in scrutinising both patient choice and the suitability of proposed accommodation for vulnerable people.

References:

The Social Worker's guide to the Care Act 2014. (Pete Feldon 2017)

The Mental Health Act 1983 Code of Practice (Department of Health 2015)

North Yorkshire Safeguarding Adults Board strategic outcomes 2015-2018 (NYSAB)

Safeguarding Adults – West & North Yorkshire & York multi-agency policy and procedures (December 2015 – revised 2018)

A practical guide to the Mental Capacity Act 2005 (Matthew Graham and Jakki Cowley 2015)

Suicide Prevention (National Institute for Health and Care Excellence September 2019)