

Safeguarding Adult Review- Anne.

Who sadly died on the 4th January 2018\*.

*(\* as recorded in the Coroners post-mortem report)*

Overview Report. Author: Richard Proctor. January 2021

ACKNOWLEDGEMENTS

*North Yorkshire Safeguarding Adults Board would wish to place on record their sincere thanks to Anne’s parents who worked with the Independent author and provided valuable information and an insight into her life which was used to inform this review.*

*This Safeguarding Adults Review would not have been possible to undertake without the co- operation and information supplied to the SAR Panel by those agencies who provided care and support for Anne. This contributed significantly in the production of the final report and helped to identify recommendations for improvement.*

*This report reflects the combined views of the SAR Panel who have invested their time, commitment, and expertise throughout this process. The input and professional support provided by the Safeguarding Adults Board Manager and support staff were invaluable throughout this process.*

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# Introduction

* 1. **Statutory Framework**

Section 44 of The Care Act 2014 states that the Safeguarding Adults Board must arrange for there to be a review of a case involving.

1. an adult in its area with care and support needs (whether the local authority was meeting any of those needs)
2. if there is reasonable concern about how the Board, or members of it or other persons with relevant functions worked together to safeguard the adult and
3. the adult has died and the board suspects that the death resulted from abuse or neglect. (whether it knew about or suspected the abuse or neglect before the adult died).

On the 30th July 2019 a request by North Yorkshire County Council (NYCC) was made to the North Yorkshire Safeguarding Adults Board (NYSAB) for the case relating to the tragic death of Anne to be considered as appropriate for a Safeguarding Adult Review (SAR) to be undertaken. On the 29th October 2019, the Independent Chair of the Board, after considering the case decided that the criteria to undertake such a review was met.

The timeline period for this review to consider was identified as the 4th January 2015 up to and inclusive of the 5th January 2018.

# Background & circumstances leading to the review.

* 1. On the 4th January 2018 Anne was found dead in her room at the supported housing accommodation where she resided. Anne was a female aged in her mid- thirties who had a history of mental health and substance misuse issues. Following her death, a subsequent coroner’s inquest concluded that her death was accidental, due to Pregabalin and Haloperidol toxicity. Pregabalin and Haloperidol were two of several medications Anne was prescribed. All medication other than her anti- psychotic depot injection of Zuclopenthixol decanoate were prescribed by her General Practitioner (GP 1), the anti -psychotic depot injection medication being prescribed by the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) Adult Mental Health Services.

Pregabalin was prescribed to treat a persistent lower back pain and Haloperidol prescribed to treat psychosis.

As a general rule Anne received daily prescriptions prescribed by GP 1, which were generated on a weekly basis and delivered to the supported housing accommodation.

* 1. Anne had a history of mental health problems and was supported by mental health services for periods of her lifetime. At the time of her death she was being supported by TEWV Community Mental Health Services (CMHT) predominantly in relation to her diagnosis of Emotionally Unstable Personality Disorder (EUPD) and was seen regularly by her TEWV Care Coordinators (CC1) and (CC 2).
	2. Anne was supported by a drug and alcohol recovery service commissioned by North Yorkshire County Council (NYCC) for the abuse of alcohol. Anne was discharged on the 11th September 2017 owing to the positive progress they felt she had made and abstinence from alcohol for a period of 15 months.

**1.24.** Prior to the commissioning of this review, three other reviews examining the circumstances of Anne’s death have already been undertaken. The first commissioned by TEWV utilising the Health based Serious Incident Review approach, the second a Safeguarding Enquiry commissioned by (NYCC) and thirdly an investigation by the Coroner to establish the cause and circumstances of Anne’s death. It is important to highlight the purpose of this SAR is not to conduct a reinvestigation of these prior reviews but seek to identify if there is additional learning in relation to how agencies work together to safeguard “Adults at Risk”.

The SAR is independent of the three previous reviews. The findings and recommendations for improvement are based upon the analysis of the information provided to inform this SAR.

# 2.0 Service Involvement.

The review was informed by information provided by the following agencies.

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)

North Yorkshire County Council (NYCC) North Yorkshire Police (NYP)

Supported Housing Provider (Anonymised to protect the right to privacy of current and future residents)

NHS North Yorkshire CCG (Formerly known as NHS Scarborough and Ryedale Clinical Commissioning Group) (CCG)

Drug and Alcohol recovery service (Anonymised to protect the right to privacy of current and future clients)

# Glossary of Names.

GP 1 CCG General Practitioner

CC 1 TEWV Care Coordinator

CC 2 TEWV Care Coordinator

# Methodology

Safeguarding Adult Review (SAR) methodology is non- prescriptive within the Care Act with the overall aims that wherever possible the review is conducted in a timely and proportionate manner.

The process undertaken was as follows.

# Panel Membership

A Safeguarding Adult Review panel was established consisting of senior managers from agencies who were involved with Anne, although they had no personal involvement in the case, with the authority to effect change in their own agency.

(SAR Panel membership)

|  |  |
| --- | --- |
| Agency | Role |
| Independent consultant | Chair and review author |
| North Yorkshire County Council (Safeguarding Adults Board) | Governance Manager |
| North Yorkshire County Council | Assistant Director of Care and Support |
| North Yorkshire Police | Chief Inspector |
| North Yorkshire CCG | Designated Nurse Safeguarding Adults |
| Tees Esk and Wear Valleys NHS Foundation Trust | Associate Director of Nursing (Safeguarding) |
| North Yorkshire County Council | Head of Practice |
| North Yorkshire County Council | Alliance Director |

The Independent Chair and author of the Overview Report has been commissioned by NYSAB to produce an independent report. They were not involved in the delivery of any services; line management for any service or any individual mentioned within the report. They are a former senior police officer experienced in undertaking SARs on a national basis.

The author and the SAR Panel agreed terms of reference as detailed below to guide and direct the review. They undertook responsibility to look openly and critically at individual and agency practice; to identify whether this SAR indicates changes could and should be made to practice and if so, how these changes will be brought about. An expert pharmacist advisor was sought via the CCG to support the review who provided remote support in answering queries raised throughout the process.

In this case agencies involved in providing care and support for Anne produced chronologies in relation to the agreed timeline, which were later shared with the lead reviewer and author.

Following receipt of this initial information and analysis of the content, the lead reviewer and author identified a number of key questions for agencies to respond to that were felt to be pertinent to the case.

# Terms of Reference.

1. Was the multi-agency response adequate to work and respond to the needs of Anne?
2. Were Anne’s views heard throughout? Was there an appropriate process in place for ensuring Anne’s views were heard?
3. Did the agencies involved know enough about Anne to support her?
4. Were there missed opportunities for information sharing between agencies?
5. Are there opportunities to improve how organisations work together for complex cases that involve multiple organisations for people living in supported housing environments?
6. Could Anne’s death have been prevented?

# Family Involvement

* 1. It was a priority for the panel to allow the family to have a voice in shaping and informing this review. As a consequence of the COVID19 pandemic and restrictions imposed at the time it was not possible for the lead reviewer and author to meet face to face with Anne’s parents.

However, despite the challenges presented by the COVID19 pandemic, contact was initially established with Anne’s parents by the lead reviewer and author by telephone. A subsequent further meeting was held virtually so as to allow the lead reviewer and author to discuss the content of the SAR with the parents and allow them the opportunity to provide feedback on the SAR, with additional comments invited to be provided via email. Upon the parent’s request, the timeline for their response was extended so as to allow them further time to consider the report.

Several updates of the SAR progression were shared by email with the parents during the timespan of the SAR. These were generally composed by the lead reviewer and author, together with establishing a point of contact via email at NYSAB, should the parents have any queries.

During these engagements, the lead reviewer and author displayed empathy to the parents in recognition of the anticipated impact the tragic loss of Anne’s life may have had upon them.

The lead reviewer and author emphasised on several occasions during contact with the parents what the purpose of the SAR was, that its aims were to learn lessons so as to improve future actions to safeguard adults and not to seek to apportion blame to any individual or agency.

* 1. The lead reviewer and author discussed the terms of reference set for the review, which the parents deemed to be appropriate.
	2. The parents upon initial contact raised concerns as to the independence of the lead reviewer and author due to the appointment being made by NYCC, one of the agencies they believed to be neglectful, as commissioners of the supported housing provider where their daughter had died. The Care Act requires every Local Authority to establish a Safeguarding Adults Board (SAB for its area and are responsible for arranging the commissioning of a suitable lead reviewer and author. NYSAB have an appointed Independent Safeguarding Adults Board Chair who is ultimately responsible for making the decision to commission a SAR.
	3. The parents described how their daughter had a history of substance misuse spanning several years. They detailed how she abused several substances including alcohol, heroin, ecstasy, and amphetamine. They had faint praise as to how their daughter’s health and well-being had improved when she became supported by a local substance misuse service.
	4. They explained how she had suffered with mental health issues and subsequently diagnosed with schizophrenia. They described how she had been supported by the TEWV Community Mental Health Team, who provided her with regular depot injections for her mental health condition.
	5. It was disclosed that Anne had three children all of whom had been placed into care owing to child protection concerns. The children were or had been cared for by Anne’s parents during this time and they described a time in 2017 when their relationship became difficult with Anne when she was attempting to reinstate contact with her children.
	6. Anne’s parents expressed concerns as to how agencies had worked together to safeguard Anne leading up to her death, whom in their belief had been neglectful in failing to carry out their duty of care towards her. They spoke of being fatigued of hearing agencies quote that “lessons were being learnt” where in their opinion practice remained unchanged.
	7. They reported making numerous complaints since her death to NYCC and believed the staff at the supported housing accommodation were neglectful in not intervening sooner to save their daughter, in the time leading up to her death.
	8. They questioned the objectivity of the police investigation into their daughter’s death where to them it appeared owing to their daughter’s offending antecedent history, assumptions as to the cause of her death had already been made without further investigation.
	9. Their feelings regarding the other reviews undertaken in relation to Anne’s death, were that they lacked transparency. They stated from their perspective the reviews were a process for agencies to manage and minimise reputational damage, describing a culture of agencies apparently blaming each other for a lack of action to protect their daughter rather than acknowledging their own individual poor practice.

# Documentary Review

* + - West Yorkshire, North Yorkshire and York Multi Agency Safeguarding Adults Policy and Procedures -2018
		- Joint Multi-agency Safeguarding Adults Policy and Procedures West Yorkshire, North Yorkshire, and City of York - 2019
		- The Care Act 2014
		- TEWV Serious Incident Review Report
		- HM Coroners Report
		- Mental Capacity Act 2005
		- NYCC Safeguarding Enquiry

# 4. Synopsis

* 1. Anne became resident at the supported housing accommodation on the 9th February 2015. The accommodation was commissioned by NYCC and Scarborough Borough Council and managed by a third-party provider. The project outline identified the aim of the service was to provide housing with intensive outreach support and timely access to a wide range of support services, which are able to work flexibly to engage and meet the needs of a particularly chaotic and hard to reach group of individuals.
	2. The required criteria for individuals to be accepted at the accommodation included having issues such as being known to criminal justice agencies, a history of substance misuse, homelessness, mental health issues, and anti-social behaviour. Additionally, the individuals may be considered as vulnerable owing to risk factors including violence, abuse, neglect, and exploitation. Individuals prior to acceptance as residents were assumed to have mental capacity, with the ability to make informed decisions and choices of their own as per Principle 1 of the Mental Capacity Act 2005.

https://[www.legislation.gov.uk/ukpga/2005/9/section/1](http://www.legislation.gov.uk/ukpga/2005/9/section/1)

Staff who were employed to support the residents are not healthcare professionals or social workers. Prior to recruitment some of the essential criteria requirements that applicants were required to meet included having knowledge of certain subject matter areas such as the causes of alcohol and substance misuse, mental health, and homelessness, safeguarding practice, and relevant legislation. They were additionally required to demonstrate experience in a number of areas, including working in a multi-agency operating environment and supporting vulnerable people.

Following appointment, the staff were required to undertake training as part of their continuous development. Some of the training undertaken included the following subject matter areas. Safeguarding, mental health and dual diagnosis, homelessness, and housing options, risk assessment and risk management, basic drugs awareness and emergency first aid.

* 1. The initial assessment of need completed by the provider indicated Anne had support needs in relation to the prevention of anti-social behaviour, recovery from substance misuse, physical and mental health needs, and support to maintain a tenancy, having been evicted from her previous tenancy. Individuals accepted into the accommodation are expected to be supported for a maximum period of up to 2 years, before moving on to live independently in the community.
	2. In March 2015 Anne was referred into the Drug and Alcohol Recovery Service by the housing accommodation provider. Anne disclosed substance misuse issues in relation to alcohol, diazepam and mephedrone, which is a stimulant type of drug.
	3. On 16th April 2015 Anne was seen by the Drug and Alcohol Recovery Service at her accommodation so they may assess her. Anne reported being low in mood as it was the anniversary of the death of her partner and she reported having concerns in relation to contact arrangements with her children. Anne identified her aims of engaging with the Drug and Alcohol Recovery Service were to become abstinent from drugs and alcohol.
	4. In October 2015 Anne’s application for funding an inpatient detoxification and rehabilitation provision was considered by the Drug and Alcohol Recovery Service panel. Concerns were noted about the risk of potential relapse Anne faced and her suitability for detoxification. These concerns included a recent positive drug test for benzodiazepines, which Anne was not being currently prescribed, and information provided by her accommodation provider of suspicions she had been selling her buprenorphine medication to others.
	5. On the 29th January 2016 a further application for the funding of an inpatient detoxification and rehabilitation provision was successful. Anne was admitted to a community alcohol detoxification unit to commence her alcohol detoxification programme. Whilst there she became ill due to breathing difficulties resulting in her being transferred into hospital, where she remained under their care until March 2016. During this period of time in hospital Anne had inadvertently become abstinent from alcohol. Anne upon discharge returned to reside at her supported housing accommodation.
	6. On the 5th May 2016, an assessment of Anne was undertaken by the Drug and Alcohol Recovery Service with additional inputs provided by the local community mental health team, the supported housing provider, and Anne’s parents. It was recorded she was making exceptional progress in relation to addressing her substance misuse issues.
	7. On the 6th June 2016 after several failed attempts by the Drug and Alcohol Recovery Service to engage with Anne it was reported by the accommodation provider that Anne had been aggressive towards accommodation staff, was experiencing hallucinations and that she was consuming alcohol. The accommodation provider described finding several bottles of empty vodka in her room and that she had been witnessed drinking from a bottle of vodka by staff. Despite efforts to engage with Anne, she refused to engage with the Drug and Alcohol Recovery Service further and withdrew her consent to allow the accommodation provider to share any information with other agencies about her, or to arrange appointments with support services on her behalf. Anne was considered to be a capacitated adult with Mental Capacity to make her own informed decisions and had volunteered to seek support from the Drug and Alcohol Recovery Service. There is no established policy or criteria that requires to be met, regarding discharge from the Drug and Alcohol Recovery Service. The overarching aim being for individuals was to reach their treatment goal upon discharge, which in Anne’s case as detailed at **4.5** was to be abstinent from drugs and alcohol.
	8. Anne had a history of mental health problems periodically throughout her life and was supported by TEWV at the time of her tragic death on the 4th January 2018. On the 22nd June 2016 owing to concerns regarding her mental health, she was detained under Section 2 of the Mental Health Act and admitted into an in-patient mental health service for treatment and was subsequently discharged on the 19th July 2016.

# <http://www.legislation.gov.uk/ukpga/1983/20/section/2>

* 1. Following discharge from hospital Anne was subject to the Care Programme Approach (CPA). CPA is a key component of the mental health delivery system in England and is a package of care used by secondary mental health services to support individuals with mental health problems. It promotes the establishment of a care plan for the individual concerned, that is subject to regular review that includes the consideration and assessment of risk. It promotes joint working and communication between health professionals who are supporting the individual. It provides the basis for multi-agency case conferencing and triggering of safeguarding action, as well as co-ordinated planning of care and future moves of accommodation.

Anne following discharge from hospital was supported by TEWV Care Coordinator CC1.Information provided to inform the review demonstrates that Anne’s last Care plan was written on the 16th December 2016. The care plan in line with TEWV CPA policy should be reviewed and updated every six months and was not reviewed or updated further prior to Anne’s death, albeit the original identified issues of care remained current up to the time of her death.

[https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-](https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/) services-and-charities/care-for-people-with-mental-health-problems-care- programme-approach/

* 1. TEWV records indicate that Anne’s last risk assessment occurred in May 2017 which coincided with a medication review and was consistent within the TEWV harm minimisation policy that states that safety summaries should be completed as a minimum on an annual basis. The risk summary assessment included risks relating to alcohol misuse. A letter informing GP 1 of this review was shared by TEWV.
	2. Anne was supported by CC 1 who saw her usually on a weekly basis. During these meetings Anne was administered an anti-psychotic medication depot injection prescribed by TEWV. Anne was prescribed in total 21 types of medication by GP1 usually on a weekly basis, however this number was reduced following the discovery Anne was suspected to be stockpiling medication. Medication prescribed by GP 1 included Pregabalin and Haloperidol, the drugs identified by the Coroner as the ones, that had through toxicity resulted in Anne’s death.
	3. Anne had been prohibited from having contact with her children for several years owing to child protection concerns. On the 15th February 2017 CC 1 was contacted by NYCC Children’s Social Care in relation to a court application made by Anne seeking to regain direct contact with her children. CC 1 recommended contact could take place in a supported environment as there was no current evidence indicating Anne was misusing substances. Anne reported to CC 1 spending time cleaning her flat in preparation for the visit of Children’s Social Care who were inspecting the accommodation for suitability. Anne reported to CC 1 being proud of having done so.
	4. On the 6th March 2017 CC1 informed Anne they were leaving their position and was replaced by TEWV Care Coordinator (CC 2). CC 2 was a dual diagnosis lead at TEWV. Dual diagnosis describes a patient who experiences mental illness and a substance use disorder simultaneously.

A joint meeting was held with CC 1, CC 2, and Anne on the 17th March 2017 to facilitate the transfer of care. This SAR review identifies this as good practice.

# [https://www.mind.org.uk/information-support/types-of-mental-health-](https://www.mind.org.uk/information-support/types-of-mental-health-problems/drugs-recreational-drugs-alcohol/dual-diagnosis/) [problems/drugs-recreational-drugs-alcohol/dual-diagnosis/](https://www.mind.org.uk/information-support/types-of-mental-health-problems/drugs-recreational-drugs-alcohol/dual-diagnosis/)

* 1. On the 20th March 2017 Anne informed CC 2 of receiving a report from Children’s Social Care, informing Anne the request for direct contact with her children was unsupported, albeit it was recognised the positive progress she had made. Anne informed CC 2 that she was finding the report emotionally difficult to deal with, causing her visualising consuming alcohol again. Anne reported finding a Diazepam tablet which she considered taking but then had thought better of it. In response CC 2 discussed with Anne using coping strategies and distraction techniques to deal with these cravings.
	2. On the 23rd March 2017 Anne contacted CC 1 in relation to the report received from Children’s Social Care. Anne described feeling defeated. CC 1 spent time attempting to rationalise the decision made, securing Anne’s agreement to continue applying learned coping strategies, in an attempt to prevent her mental health deteriorating.
	3. On the 27th March 2017 CC 2 saw Anne to administer her depot injection. Anne expressed increasing anxiety regarding the imminent court case regarding contact with her children. Anne reported feeling the report from Children’s Social care recommending no direct contact with her children would be the final outcome. She additionally raised concerns about deteriorating vision for which she was awaiting an operation.
	4. On the 30th March 2017 CC 1 attended the contact court hearing with Anne to provide moral support. The subsequent outcome was that direct contact with the children was refused. The support provided by CC 1 in attending the court hearing is identified as good practice.
	5. On the 12th April 2017 TEWV CMHT medical staff reviewed Anne in the presence of CC 2. Anne reported feeling stressed and anxious owing to the court case, together with sharing concerns regarding deteriorating eyesight. Anne highlighted not taking any unprescribed medication or alcohol for the past 11 months. TEWV recorded Anne was not expressing thoughts of self-harm or harm to others and was forward thinking. Anne explained experiencing auditory hallucinations and was hearing voices of her deceased ex-boyfriend. In response the TEWV CMHT registrar prescribed Anne a two-day course of Diazepam medication, the review assumes as a short-term treatment for anxiety.

[https://www.nhs.uk/conditions/generalised-anxiety-disorder/treatment](https://www.nhs.uk/conditions/generalised-anxiety-disorder/treatment/)/

* 1. On the 18th April 2017 Anne was reviewed by the TEWV CMHT registrar and a prescription for Diazepam was issued for the next 4 days. The plan being to reduce dosage over the coming days and review this further on the 21st April 2017.This review went ahead with the outcome being Anne was prescribed a further 10 days of Diazepam. This was not in line with her usual prescription collections which were undertaken on a daily basis.
	2. On the 1st May 2017 following reports Anne was vomiting blood whilst at the supported housing accommodation, she was taken by ambulance to the local hospital emergency department. It was noted by the hospital she was hot and clammy, had low oxygen levels, was breathless and experiencing discomfort. Anne voluntarily discharged herself the same day.
	3. On the 2nd May 2017 TEWV CMHT contacted the supported housing provider. The provider shared concerns with TEWV that Anne was presenting as confused, agitated, and not functioning at her optimum levels. The provider suspected Anne may be exceeding her prescribed dosage of Diazepam.
	4. On the 3rd May 2017 CC 2 contacted the supported housing provider. At this time, the provider informed CC 2, Anne was presenting as drowsy and suspected she was taking more Diazepam than prescribed. They shared information with CC 2 that Anne was reporting having suicidal thoughts of hanging herself, stating she wished to be with her deceased ex-partner. Additionally, it was confirmed Anne had a lung infection and was being treated with antibiotics. Following a consultation between CC 2 and the TEWV Consultant Psychiatrist it was agreed a full physical and mental health assessment of Anne was required. Consequently CC 2 and the Psychiatrist visited Anne at her accommodation. Anne presented as agitated, confused, and was reporting suicidal thoughts. She stated the protective factors of her children no longer mattered, as they would be better off without her. Protective factors are things that contribute to mental health and allow people to be resilient in the face of challenges.

Anne made demands to be supplied with further Diazepam. This request was declined by the Psychiatrist who explained the danger of doing so, owing to her current physical health problems, medication regime and low oxygen levels following her recent admission to hospital. A letter informing GP 1 of the action taken, the decision to decline the prescribing of Diazepam and a request for a medication review to be undertaken was sent by TEWV to GP 1. It was agreed that the TEWV Home Based Treatment Team (HBTT) would commence treatment with Anne who would meet with her the following day.

* 1. On the 4th May 2017 following a deterioration in Anne’s physical health, she was admitted into the local acute hospital with reported low oxygen saturation levels and had also fallen injuring her face. Anne was subsequently discharged the following day. That evening the accommodation provider contacted TEWV Mental Health Crisis Team raising concerns that Anne appeared confused. The Crisis Team provide specialist assessment for people aged 16yrs and older who need urgent mental health care. The Crisis Team advised the provider if they felt the concerns were mental health related, contact should be made with the acute hospital or to recontact the Crisis Team again for further support.

Later that evening Anne was discovered walking the streets in a confused state by North Yorkshire Police who brought this to the attention of the TEWV mental health street triage team, who later visited Anne at her residence. She presented to them as confused and was apparently hallucinating. An ambulance was requested which transported Anne to the emergency department at the hospital and she was later discharged.

# <https://www.tewv.nhs.uk/services/street-triage/>

* 1. On the 6th May 2017 following discharge from the hospital Anne was seen by the TEWV Liaison Psychiatry Team Registrar. Anne’s mental health was assessed, and it was suspected by the Registrar that Anne was potentially experiencing delirium due to medical causes, together with polypharmacy. Polypharmacy is terminology used to describe the concurrent use of multiple medications by an individual. The Registrar discussed with Anne rationalising her current medication regime owing to the belief this may be adding to her confused state. It was recorded Anne refused to stop or reduce the intake of her prescribed Promethazine, Amitriptyline or Diazepam medication, albeit by this time the prescribing of Diazepam had ceased as detailed at **4.24**.

<https://bnf.nice.org.uk/drug/promethazine-teoclate.html>

<https://www.nhs.uk/medicines/amitriptyline-for-pain/>

The Registrar documented that they would withhold Diazepam and Buprenorphine medication. Buprenorphine is often used to treat opioid use disorder together with acute and chronic pain.

# <https://www.evidence.nhs.uk/search?q=buprenorphine>

* 1. On the 7th May 2017 Anne was seen by the TEWV Home Based Treatment Team at her supported housing accommodation. She reported feeling brighter in mood stating she needed extra amounts of Diazepam and Buprenorphine to supplement her medication regime but was advised she must discuss this with GP 1 as it contradicted the recommendations of the TEWV Consultant Psychiatrist as detailed at **4.24.** The HBTT clinician then physically checked with Anne the current amount of medication she possessed and discarded the tablets and tablet boxes she apparently did not use. It was unrecorded the type or amount of medication discarded or if any investigations were undertaken in relation to the unused medication. This information was not shared with GP 1. HBTT contacted CC 2 following this event to update them accordingly.
	2. On the 10th May 2017 Anne was seen by GP 1 regarding concerns that she had found a lump on her breast. Anne raised concerns of feeling stressed and being unable to sleep. Anne attended the appointment with a member of staff from the supported housing accommodation. Following the appointment GP 1 contacted the TEWV psychiatrist to share concerns Anne may be obtaining medication from alternative sources, but there is nothing recorded to indicate the source of this information.
	3. On the 11th May 2017, a medication review was undertaken with Anne by TEWV CMHT’s Medical Registrar. Anne requested to be provided with Diazepam. Following a consultation with the TEWV Consultant Psychiatrist they identified risks including respiratory depression and recent low oxygen saturation levels if Diazepam was prescribed. Consequently, a decision was made not to prescribe Diazepam. Alternatively, Anne was asked to consider taking Promethazine which she reluctantly

agreed to. Promethazine is an antihistamine medicine often used to relieve the symptoms of allergies and is also used for short-term sleeping issues.

<https://www.nhs.uk/medicines/promethazine/>

* 1. On the 12th May 2017, the supported housing provider contacted TEWV CMHT to highlight concerns regarding Anne’s presentation. CMHT spoke with Anne who reported hearing a radio noise in her head. Anne identified her stressors as being unable to see her children and having poor physical health. It was noted by CMHT that Anne’s speech was slurred though she deniedusing alcohol or illicit substances. CMHT did offer to attend at Anne’s residence but were informed Anne had a prearranged appointment with GP 1 for a blood test.

Anne attended the appointment with GP 1. GP 1 recorded that Anne reported to be struggling with her mental health, feeling distressed and suicidal. Anne reported researching how to take her life by hanging. In response GP 1 prescribed Anne with Diazepam to calm her. Information provided to inform the review does not indicate the amount or strength. GP 1 contacted the supported housing provider to request their attendance owing to concerns that Anne was confused, disorientated, and threatening to take her own life. Later on, this day the supported housing provider contacted TEWV CMHT to highlight concerns in relation to Anne’s presentation.

Anne reported the promethazine medication she had been prescribed as detailed at

**4.29** was ineffective and requested a medication review. After consultation with the CMHT clinician, the Registrar agreed Anne would be prescribed a 3-day course of Diazepam at 2mgs strength, to be taken twice a day and her risk assessment was updated. This was the last occasion prior to Anne’s death the risk assessment was updated. Anne was seen by HBTT and CC 2 on 2 occasions over the next 3 days where she reported feeling better attributing this to the prescribed Diazepam.

* 1. On the 24th May 2017, a worker from the supported housing accommodation contacted GP 1 to share concerns that Anne was stockpiling medication. It was recorded by GP 1 that in her room they found medication which included 60 promethazine tablets, 120 paracetamol tablets, 137 codeine tablets and procyclidine. The provider stated they were unable to remove the medication as they were prescribed for Anne. No apparent consideration was made that Anne may be an “Adult at Risk” as described in the West Yorkshire, North Yorkshire and York Multi Agency Safeguarding Adults Policies and Procedures in operation at that time and that with Anne’s consent, a Safeguarding Concern should be raised as described in

these policies or procedures. The policies and procedures detail a concern should be raised when concerns exist in relation to a person over 18 years who has or may have care and support needs (whether or not the local authority is meeting any of those needs) is experiencing or is at risk of abuse or neglect and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. It further advises such concerns should be reported to the local authority. These Policy and Procedures were applicable for the timeline of this review though have now been replaced by the Joint Multi-agency safeguarding adults Policy and Procedures West Yorkshire, North Yorkshire and City of York, which were introduced in October 2019 and still remain current.

An Adult at Risk is described in the Care Act 2014 as an individual over the age of 18 years, has needs for care and support, is experiencing or at risk of abuse or neglect and as a result of the needs is unable to protect themselves against the abuse or neglect, or the risk of it.

Safeguarding Policies Various\Operational Guidance Safeguarding Adults NYCC.pdf

[http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-](http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted) [adults-at-risk-of-abuse-or-neglect/enacted](http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted)

* 1. On the 25th May 2017, a meeting was held by the drug and alcohol recovery service, with Anne and staff from the supported housing provider. The staff from the supported housing accommodation reported the information in relation to the medication found in Anne’s room and informed the worker from the service they additionally found what they believed to be 2 illicit Diazepam tablets wrapped in silver foil paper. Anne denied having any knowledge of the presence of the illicit Diazepam found in her room and claimed the other medication were just outstanding items which she had failed to use. There was nothing recorded to indicate whether the find of the illicit Diazepam was investigated further or how it was accounted for.
	2. On the 26th May 2017 GP 1 ceased prescribing Anne promethazine, paracetamol, and codeine, as a result of the recent stockpiling of medication. GP 1 contacted the supported housing provider who confirmed they had now discarded the stockpiled medication.
	3. On the 27th May 2017 GP 1 contacted TEWV CMHT to inform them of the recent issue relating to Anne stockpiling medication. No enquiries were made as to how Anne had managed to acquire such quantities of medication or the information used to inform and update Anne’s risk assessment. No Safeguarding Concern was raised.
	4. On the 1st June 2017 CC 2 and GP 1 received contact from the supported housing accommodation to inform them of concerns it was suspected Anne was using “street” Diazepam. They reported Anne presenting as drowsy and with slurred speech. They further reported the previous discovery of the 2 tablets of suspected illicit Diazepam. CC 2 subsequently visited Anne at her residence finding her asleep on the sofa. When roused by CC 2 Anne stated she had taken Zopiclone which was prescribed by GP 1. Zopiclone is a drug used to treat insomnia. Anne explained that this medication was the reason for her tiredness. Advice was provided to the supported housing accommodation provider by GP 1’s practice that if there were concerns about overdose then Anne should attend the acute hospital emergency department.

[https://bnf.nice.org.uk/drug/zopiclone.htm](https://bnf.nice.org.uk/drug/zopiclone.html)l

Anne demanded that CC 2 should seek further supplies of Diazepam for her from the TEWV Registrar. When informed by CC 2 this would not be possible, Anne became verbally abusive towards CC 2.

* 1. On the 2nd June 2017 NYP received intelligence Anne was attempting to purchase illicit “street Diazepam. This was one of ten intelligence reports received by NYP between the 19th February 2017 and the 14th September 2017 in relation to Anne. These included reference to Anne being sighted with individuals known to NYP, references made to drug exchanges and purchases by others of illicit substances on behalf of Anne taking place and information relating to Anne’s association with Diazepam and Pregabalin. Two of the intelligence submissions after assessment were circulated for officers to be proactive with the named individuals if seen by patrols by conducting stop checks. There is no information provided to inform this review to demonstrate the information being shared with TEWV, GP 1 or the supported housing accommodation provider for the purposes of safeguarding Anne, or a safeguarding concern being raised by NYP.
	2. On the 15th June 2017 Anne had an appointment with GP 1, owing to issues in relation to anxiety. Consequently GP 1 prescribed Anne a 7-day course of Diazepam. No contact was made by GP 1 with TEWV to share this information.
	3. On the 23rd June 2017 it was recorded by the drug and alcohol recovery service, they held a joint professionals meeting with staff from the supported housing accommodation and a TEWV staff member. They did not record who the TEWV representative was and TEWV have no record of the event taking place. Discussions of suspected illicit drug use by Anne were held and that Anne was in denial. It was recorded her current presentation was consistent with the use of depressant substances and that the support provided by the drug and alcohol service was only for the misuse of alcohol and on a voluntary basis. It was agreed by the service to extend support until September to help manage the transition into independent living. Nothing was recorded in relation to a response relating to the emerging issue of concern that Anne may be misusing illicit drugs.
	4. On the 28th June 2017 Anne attended an appointment with GP 1 where she requested more Diazepam medication. GP 1 noted that Anne looked better. Anne informed GP 1 she had made the previous 7-day course last for 14 days. GP 1 issued Anne with a further 7-day prescription of Diazepam.
	5. On the 7th July 2017 Anne attended an appointment with GP 1 and requested more Diazepam, which was subsequently issued by GP 1 for the next 5 days.
	6. On the 11th July 2017 Anne attended an appointment with GP 1. Prior to the appointment GP 1 had been informed by staff at the supported housing accommodation Anne had been purchasing illicit Diazepam, where images of the event had been captured on CCTV. GP 1 questioned Anne in relation to this allegation. Anne denied purchasing Diazepam explaining that it was tobacco she had been purchasing. The CCTV footage was later examined by NYP and was found to be non-conclusive as to what items had been exchanged. GP 1 recorded Anne’s presentation did not indicate Diazepam overuse and subsequently issued Anne with a 7-day prescription of Diazepam. The information regarding the allegation of Anne purchasing illicit Diazepam was shared by the supported housing provider with the drug and alcohol recovery service. No further action in relation to this new information was taken by the drug and alcohol recovery service.
	7. On the 18th July 2017 Anne was seen by CC 2 who administered Anne’s depot injection.CC 2 noted Anne was bright and positive in mood, informing CC 2 she had viewed a property of which she was hopeful of securing.
	8. On the 22nd July 2017 Anne attended an appointment with GP 1 to undertake a medication review. GP 1 recorded Anne was presenting well, and that the diazepam was benefiting her. It was recorded she was on a low dose of Diazepam. GP 1 subsequently issued Anne with a 7-day prescription for Diazepam.
	9. On the 5th August 2017 Anne attended an appointment with GP 1 for the renewal of her Diazepam medication prescription. GP 1 highlighted to Anne the risk of developing addiction to Diazepam suggesting it would be advisable to wean herself off the drug. GP 1 subsequently issued Anne with a 7-day prescription of Diazepam.
	10. On the 9th August 2017 Anne attended an appointment with GP 1 for a medication review in relation to her Diazepam medication. GP 1 recorded Anne appeared to be in a good mood. GP 1 recorded the Diazepam would continue to be prescribed on the understanding it would only be taken when needed and that Anne would not take it every day. There was nothing recorded as to how the medication intake would be monitored.
	11. On the 19th August 2017 Anne attended an appointment with GP 1 for the renewal of her Diazepam medication prescription. Additionally, Anne presented with a heavy cold and possible chest infection. GP 1 subsequently issued Anne with a prescription for a course of antibiotics and 2 prescriptions for Diazepam, with one prescription forward dated for use from the 26th August 2017.It was unrecorded the reason the forward dated prescription was created.
	12. On the 30th August 2017 Anne attended an appointment with GP 1 for the renewal of her Diazepam and Buprenorphine medication prescription. GP 1 subsequently issued Anne with a prescription for Diazepam andBuprenorphine.
	13. On the 14th September 2017 NYP received an intelligence report that Anne was asking other people to obtain for her illicit Diazepam and Pregabalin. There is no information provided to inform the review this information was shared by the police with those agencies supporting Anne or a safeguarding concern raised.
	14. Over the following months and up to the 19th December 2017 GP 1 issued Anne with prescriptions for Diazepam at 2 milligram strength on a weekly basis and Buprenorphine at 8 milligram strength on a fortnightly basis.
	15. On the 19th October 2017 as CC 2 was absent on leave Anne was visited by the TEWV Assertive Outreach Team (AOT) to administer Anne’s depot injection. The assertive outreach team is part of community mental health services and works with adults with severe mental illness who have difficulty engaging in services, have repeat admissions to hospital and may have other problems such as violence, self- harm, homelessness, and substance abuse. Anne informed the AOT worker of suffering with anxiety and emotional dysregulation. Anne stated she feared her medication was not working. The AOT worker discussed with Anne she should develop distraction techniques and positive coping strategies, so she was not over reliant purely upon medication to manage her condition. It was advised she may benefit from completing a “Staying Well” plan with CC 2. Anne additionally mentioned a wish to attend a “Survivors” meeting but felt she would need somebody to support her with attendance. The Survivors meetings are organised by a local [mental health charity run by people with lived experie](https://scarboroughsurvivors.org.uk/futher-information/)nce of mental illness**.**

https://scarboroughsurvivors.org.uk/futher-information/

There is no information provided to inform the review to demonstrate a “Staying Well” plan was completed, or a support worker identified to support Anne with attendance at the “Survivors” meeting.

* 1. On the 26th October 2017 AOT received a telephone call from Anne. It was recorded Anne was tearful, anxious, and paranoid staff at the supported housing accommodation were monitoring her movements. She reported the reason for her anxiety were concerns regarding an impending move from the supported housing accommodation. AOT staff reassured her that the move should be seen as a positive, demonstrating the progress she had made, and it was explained she would be supported throughout the process.
	2. On the 16th November 2017, an AOT worker visited Anne at her residence to administer her depot injection. Anne reported to the worker that she was experiencing negative thoughts but denied feeling a risk to herself or others. Anne once again commented of being anxious regarding her impending move from the supported housing accommodation.
	3. Towards the middle of December 2017, the exact date unrecorded, staff at the supported housing accommodation recorded concerns in relation to Anne’s welfare. They noted a perceived change in her presentation in that she appeared to be slurring her words and was unsteady on her feet. Staff believed it was due to Anne misusing prescribed medication or illicit medication. There is nothing recorded to demonstrate this information was shared with CC 2, GP 1 or that a safeguarding concern was raised.
	4. On the 19th December 2017 Anne attended an appointment with GP 1. She requested an increase of Diazepam medication for the forthcoming Christmas week to assist in managing the issues of being unable to see her children over this time period. GP 1 recorded that Anne presented well and no concerns were identified. Subsequently GP 1 increased Anne’s Diazepam medication to 5 milligram strength to be taken once daily, from the previously prescribed 2 milligram strength medication which was taken twice daily. The course was for 7 days. Additionally, 3 weekly prescriptions were also issued by GP 1 for Diazepam medication of 2 milligram strength that were future dated to commence on the 23rd December 2017. GP 1 then began a period of annual leave and did not return to the practice until the 8th January 2018.
	5. On the 20th December 2017 CC 2 visited Anne at the supported housing accommodation to administer her depot injection. It was recorded by CC 2 that Anne’s speech was slurred. When questioned by CC 2 why this was the case Anne stated it was because GP 1 had prescribed her with 9 milligrams of Diazepam. There is nothing to indicate CC 2 made any contact with GP 1 in relation to Anne’s presentation at that time or a safeguarding concern being raised. No assessment of Anne’s mental capacity was recorded as having been undertaken at this time by CC 2 as per the Mental Capacity Act 2015 regarding Anne’s decision to consent to the administration by CC 2 of the depot injection.

https://[www.legislation.gov.uk/ukpga/2005/9/section/1](http://www.legislation.gov.uk/ukpga/2005/9/section/1)

* 1. On the 21st December 2017, a multi-agency tasking meeting was held during which according to information provided by the housing provider to the Coroner, Anne’s case was discussed. However, when the notes of the meeting were reviewed as part of the SAR review process, it identified there were no notes or actions that referred to Anne recorded within notes of the meeting. The review has been informed this local meeting provides agencies with opportunities to discuss individuals who are victims of crime and anti-social behaviour, together with identifying vulnerable individuals in the community to ensure support is established through access to services and by ensuring enforcement activity occurs where criminality is suspected. The governance and accountability for the tasking process is the responsibility of the community impact team. The community impact team is a multi-agency community safety hub made up by the agencies of NYP, TEWV and NYCC. The staff include the NYCC community cohesion officer, a TEWV mental health worker and NYCC Adult Social Care staff who attend the multi-agency tasking meetings. The team report to the community safety and safeguarding manager at Scarborough Borough Council. At the meeting it was reported that staff from the supported housing accommodation raised concerns that Anne was potentially misusing illicit substances. No actions in response to this information were recorded as being enacted. No safeguarding concern was raised.
	2. On the 23rd December 2017 Anne was seen by staff at the supported housing accommodation who observed she was unsteady on her feet and described Anne as being “spaced out”. This information was not shared with CC 2 or GP 1, a safeguarding concern was not raised, or concerns in relation to Anne’s presentation responded to.
	3. On the 25th December 2017 Anne was seen by staff at the supported housing accommodation. They formed the view from her presentation that she was currently under the influence of a substance. Anne informed them she had recently taken one of her prescribed medications namely Buprenorphine.
	4. On the 27th December 2017 CC 2 recorded in the TEWV electronic care records, concerns regarding Anne’s presentation of having slurred speech and uncoordinated body movements. CC 2 recorded querying whether Anne had purchased illicit street Diazepam. It was unrecorded what date this entry was referring to, but the review assumes it was referring to the visit to Anne, undertaken by CC 2 on the 20th December 2017 as detailed at **4.55**. In response to these concerns CC 2 contacted the GP practice. It was clarified GP 1 had prescribed medication in the form of 7 x 5 milligrams of Diazepam. Concerns raised by CC 2 in relation to Anne’s presentation were not brought to the attention of the duty GP covering the practice in GP 1’s absence but shared with GP 1 upon their return from leave, 4 days after Anne’s death. CC 2 additionally contacted staff at the supported housing accommodation who shared concerns they suspected Anne had been involved in a drugs transaction in one of the streets close by. CC 2 visited Anne at the supported housing accommodation to administer her depot injection and found her lying on her sofa. CC 2 observed the room was unkempt and chaotic though apparently this not unusual in relation to the home conditions. CC 2 reported Anne presented as settled but tired. Anne explained the reason she was so tired and had slurred speech was her GP had prescribed Diazepam to help her manage the Christmas period. Despite Anne’s presentation, the amount of medication she was currently being prescribed and the information provided by the housing provider regarding recent suspected illicit drugs transaction, no decision was made to review Anne’s current prescribing regime and no safeguarding concern was raised.
	5. On the 29th December 2017 Anne was seen by staff at the supported housing accommodation, where they observed that she had bloodshot eyes, a substance of some sort around her mouth and was slurring some of her words when she spoke. There is nothing recorded to evidence this information was shared with CC 2, GP 1 or a safeguarding concern raised.
	6. On the 2nd January 2018 Anne was seen by staff from the supported housing accommodation returning to the premises. They observed she appeared groggy and her speech was slurred when she spoke. It was recorded Anne was “bumping into walls” and apparently paranoid that she was being followed by people who were recording her movements on their phones. Anne informed the staff that her deceased ex-partners friends whom he had met “up there” which the review assumes was a reference to the “after life” were dancing in her flat. The staff member suggested Anne should contact the TEWV Crisis team in recognising the behaviour was a potential indicator of mental health deterioration. Anne did not contact the Crisis team as suggested, or neither did the supported housing provider. No safeguarding concern was raised.

Later that evening, staff at the supported housing accommodation undertook a welfare check upon Anne and heard the sound of snoring from the door, though did not physically enter the room.

* 1. On the 3rd January 2018 at 0230 Anne attended the supported housing accommodation office to enquire with staff if anyone had found her cigarettes. She was informed they must be in her room. Anne then alleged staff had removed medication from her room but then returned to the office at 0350 to confirm she had now found it. This was the last confirmed occasion anyone spoke to Anne prior to her death. No information provided to inform the review details how Anne presented at that time.
	2. Sometime in the morning (the exact time unknown) on the 3rd January 2018, CC 2 contacted staff at the supported housing accommodation querying whether Anne was attending at TEWV in person to receive her depot injection. This owing to CC 2 having tried to contact Anne on her mobile phone which was switched off. CC 2 asked the staff member to contact Anne on CC 2 ‘s behalf but was informed operational practice did not permit the staff member to enter a resident’s flat whilst lone working.
	3. Later on, the 3rd January 2018 at 1045 a welfare check in relation to Anne was undertaken by staff at the supported housing accommodation following additional members of staff now being present. Staff found Anne asleep on her sofa which was the usual place she slept according to staff.
	4. On the 3rd January 2018 at 1205 staff knocked on Anne’s flat door but there was no response.
	5. On the 3rd January 2018 at 1530 CC 2 was contacted by the supported housing accommodation who shared information in relation to Anne’s presentation as detailed at **4.61.** The staff member stated they would instruct Anne to contact CC 2 the following day so her depot injection may be administered.
	6. On the 3rd January 2018 at 1715 staff entered Anne’s flat and found her still upon the sofa. They described her as visibly breathing forming the assumption, she was asleep.
	7. On the 4th January 2018 at 1215 after it was reported that Anne had not been seen by anyone at the supported housing accommodation all that day, following advice from a supervisor, staff entered Anne’s room. Anne was found to be cold and unresponsive. Anne was subsequently confirmed as having died by attending paramedics.

The scene of Anne’s death was investigated by officers from NYP. They described finding several packets of unopened medication prescribed to Anne, including the drugs Pregabalin and Diazepam within her room. A mobile telephone belonging to Anne when examined by NYP detailed 13 messages dated from the 14th December 2017 to the 28th December 2017, the content of which indicated to NYP they referred to the purchase and misuse of illicit prescription medication. The view of the investigating officer provided to the Coroner was that there was no third-party involvement connected to Anne’s death and the evidence suggested her death was a tragic incident, possibly linked to her lifestyle.

# Analysis

**Was the multi-agency response adequate to work and respond to the needs of Anne?**

* 1. Following a period of homelessness, Anne in line with the selection criteria was accepted as a resident at the supported housing accommodation as detailed at **4.2.** The identified the aim of the accommodation was to provide housing with intensive outreach support and timely access to a wide range of support services, which are able to work flexibly to engage and meet the needs of a particularly chaotic and hard to reach group of individuals.

By the very nature of the accommodation selection criteria, it must be anticipated many of the individuals who take up residence there, will have complex health and social issues.

* 1. Anne’s initial assessment at the accommodation identified support needs in relation to the prevention of anti-social behaviour and substance misuse. The assessment identified she had physical and mental health needs, with assistance required to maintain a tenancy having been previously evicted from other accommodation.
	2. The provider was expected by the commissioners NYCC and Scarborough Borough Council to have established minimum standards that included residents were required to have an outcome-based support plan that ensures individuals are not left at risk without the provision of support. The commissioners service schedule details the provider should work with other agencies including TEWV and the CCG to ensure any risk the service user poses to themselves or others, is communicated at the time the concern is identified.
	3. The accommodation has written client welfare principles which state that they have a “duty of care” to the clients they support and acknowledges a number of their clients are often at risk. The Social Care Institute of Excellence describes the “duty of care” to care workers as being one as to act responsibly in the best interest of individuals and others, not to act in a way that results in harm and act within your competence, further advising not to take on anything you do not believe you can safely do.

<https://www.scie.org.uk/workforce/induction/standards/cis05_dutyofcare.asp>

The staff employed at the supported housing accommodation are neither qualified health professionals nor social workers. As detailed at **4.2** they were required to have relevant experience and knowledge of certain subject matter areas appropriate to the role which included alcohol and substance misuse, mental health, and homelessness, safeguarding practice, prior to appointment. Upon appointment as detailed at **4.2,** staff received training in several areas to assist them in supporting residents which included safeguarding, mental health and dual diagnosis, homelessness, and housing options, risk assessment and risk management, basic drugs awareness and emergency first aid.

The accommodation is not registered with the Care Quality Commission as it did not deliver care and treatment to its residents and was deemed not to be applicable to these regulations. Homelessness regulation and policy sits outside of The Care Quality Commission regulations and supported housing is a non-regulated service. The service specification that was established set out the expectations that the commissioners required to be met by the accommodation provider for example staff training requirements. As it was a non-regulated service the provider was expected by the commissioners to work to and self-assess against the “Supporting People” quality assessment framework, which was a former national framework. The provider was required to demonstrate how relevant policies and procedures were in situate and provide evidence to the commissioners how they were used by staff and residents through the application of a self-assessment template. These included the areas of assessment and support planning, security and health and safety, safeguarding and protection from abuse (policies and procedures in accordance with

legislation at the time), fair access diversity and inclusion, client involvement and empowerment.

The completed self-assessment would then be provided to the commissioners so it could be quality assured and monitored on an ongoing basis.

[http://transact.westminster.gov.uk/docstores/publications\_store/supporting\_people/q](http://transact.westminster.gov.uk/docstores/publications_store/supporting_people/qaf_guidance.pdf) [af\_guidance.pdf](http://transact.westminster.gov.uk/docstores/publications_store/supporting_people/qaf_guidance.pdf)

<https://www.cqc.org.uk/what-we-do/services-we-regulate/services-we-regulate>

The absence of regulation for housing accommodation supporting vulnerable individuals such as Anne the review identifies as an area of concern. This should be examined further by NYSAB commissioning a peer review of such arrangements with the potential outcome of representations being made to seek changes to policy at a regional and national level.

# Recommendation 1.

**NYSAB should commission an independent review of the supported housing accommodation arrangements, to identify risks and opportunities, with a view to influence changes to policy at a regional and national level.**

The role staff undertake in supporting individuals with complex needs such as Anne, often operating as lone workers the review identifies as a challenging one to perform. To support them in undertaking this role drawing upon the learning from this case, there should be a requirement for the workers to have relevant training and accreditation in areas of practice which by the very nature of the operating environment they are likely to encounter.

# Recommendation 2.

**NYCC and Scarborough Borough Council drawing upon learning from this case should ensure staff employed at the accommodation have relevant training with accreditation to help equip them to safeguard residents at the premises.**

* 1. From mid December 2017 up to the time of Anne’s death several concerns were identified by staff at the accommodation in relation to Anne. These included changes in Anne’s presentation, unsteadiness on her feet, slurring of her words, suspicion of substance misuse and reports of experiencing hallucinations of her dead partners friends “dancing in her bedroom”. On the 3rd January 2018, the day prior to Anne’s confirmed death, CC 2 contacted staff at the supported housing accommodation requesting Anne make contact so her depot injection could be administered as they were unable to contact Anne on her mobile phone as it was switched off. The staff member informed CC 2 that owing to lone working policies they were unable to enter Anne’s room alone.

Later that morning when other staff were on duty a welfare check was conducted by staff entering Anne’s room. Staff reported finding Anne asleep on the sofa, a place staff reported that she often slept. Despite recent identified concerns, no attempt was made to awaken her from her sleep.

Approximately 90 minutes later staff attempted to attract her attention by knocking on her room door, but there was no response.

Approximately 5 hours later staff entered Anne’s room and found her still on her sofa describing that she was visibly breathing, staff assuming she was asleep. Despite the recent identified concerns and the fact Anne had not been seen conscious for nearly 13 hours, no attempt was made to awaken her.

No further attempts were made that day to speak to Anne or further checks made upon her welfare.

It was not until 1215 the following day after seeking advice from a supervisor, that staff entered Anne’s room, after she had not been seen by staff that day. It was here she was found to be cold and unresponsive, and shortly afterwards confirmed to have died by attending paramedics.

NHS guidance regarding response to suspected poisoning recommends seeking advice from NHS 111 if it is not believed to be serious or if serious call 999 to request an ambulance.

https://[www.nhs.uk/conditions/Poisoning/](http://www.nhs.uk/conditions/Poisoning/)

The provider of the supported housing accommodation is expected to ensure individuals residing there are not left at risk without the provision of support as per the service specification. The response by staff in relation to Anne’s identified risks

when aware of her recent deteriorating presentation and suspicions of substance misuse, lacked professional safeguarding curiosity, where her presentation and lack of visibility were apparently assumed to be a consequence of her normal lifestyle**.**

Professional curiosity in relation to safeguarding is defined as having the capacity and communication skills to explore and understand what is happening rather than making assumptions or accepting things at face value. [https://www.manchestersafeguardingpartnership.co.uk/resource/professional](https://www.manchestersafeguardingpartnership.co.uk/resource/professional-curiosity-resources-practitioners/)- [curiosity-resources-practitioner](https://www.manchestersafeguardingpartnership.co.uk/resource/professional-curiosity-resources-practitioners/)s/

Following Anne’s death, the provider has reviewed the guidance and support provided to staff as to the circumstances in which they should enter an individual’s flat on the basis of when they are concerned about the well-being of a resident.

# Recommendation 3.

**NYCC and Scarborough Borough Council as commissioners of the accommodation drawing upon the learning from this review should ensure the guidance and support provided to staff as to the circumstances in which they should enter a resident’s flat is sufficiently robust and explicit so as to safeguard the individual concerned.**

* 1. TEWV supported Anne with her mental health intermittently during her adult life, predominantly in relation to her diagnosis of Emotionally Unstable Personality Disorder. After being discharged from hospital following detention under Section 2 of the Mental Health Act in 2016, she was subsequently provided support by TEWV CMHT.

<http://www.legislation.gov.uk/ukpga/1983/20/section/2>

* 1. To help support Anne with her mental health TEWV visited Anne usually once a week to administer a weekly depot injection of Zuclopenthixol decanoate which is an anti-psychotic medication. These were usually administered by CC 1 initially then subsequently afterwards by CC 2. Medication reviews were undertaken by TEWV either on a weekly basis or usually in response to a deterioration in Anne’s mental health. This was in line with TEWV policy and NICE guidance.

[https://www.nice.org.uk/guidance/ng5/chapter/1-Recommendations#medication-](https://www.nice.org.uk/guidance/ng5/chapter/1-Recommendations#medication-review) [review](https://www.nice.org.uk/guidance/ng5/chapter/1-Recommendations#medication-review)

# <https://bnf.nice.org.uk/drug/zuclopenthixol-decanoate.html>

* 1. TEWV records show risks were systematically considered with Anne, applying the TEWV Clinical Risk Assessment and Management Policy initially then subsequently using the Harm Minimisation Policy thereafter, which encourages a recovery-orientated approach to clinical risk assessment and management.

[https://www.evidence.nhs.uk/search?q=harm%20minimisation&ps=30](https://www.evidence.nhs.uk/search?q=harm%20minimisation&amp;ps=30)

* 1. TEWV used approved risk assessment tools to formally assess and record Anne’s risks. The last risk assessment was completed on 12th May 2017 and was within keeping of the Harm Minimisation Policy that stipulates that these should be reviewed as a minimum on an annual basis. However, as information began to increase in relation to the emerging issue of suspected Benzodiazepine addiction the risk assessment was not updated accordingly. If it had been the issue of dual diagnosis and increasing risk of substance misuse may have been given more consideration. This would have facilitated a review by a TEWV medic and encouraged information to be shared with other agencies, such as substance misuse services to seek additional support for Anne*.* The issue of not fully updating the risk assessment with this additional information has been identified as an improvement action for TEWV following the Serious Incident Review that was undertaken.
	2. There were examples of CC 2 being responsive to concerns about Anne misusing Diazepam by exploring these concerns with Anne on several occasions, albeit Anne when challenged denied this to be true.
	3. When attempting to regain contact with her children as detailed at **4.19** Anne was supported by TEWV CC 1 during the court hearing, despite having changed roles. Additionally, joint meetings were held involving CC 1 and CC 2 with Anne to facilitate a smooth and seamless transition of care. Both these events the review identifies as good practice.
	4. As detailed at **4.27** TEWV HBTT physically checked with Anne what medication she had in her possession, discarding the medication she did not use. It was unrecorded the type or amount of medication discarded, or the issue investigated further regarding the potential Anne was stockpiling medication. The information was not shared with GP 1 which may have enabled further investigations to be undertaken to establish the reasons as to why Anne was not taking her prescribed medication and the associated risks of not doing so. Whilst the information was shared with CC 2 by HBTT, the concerns were not escalated to a TEWV Safeguarding Manager or a Safeguarding Concern raised in relation to the potential Anne was at risk of “Self-Neglect “owing to her apparent inability or unwillingness to take her prescribed medication. Information provided to the Coroner by staff at the supported housing accommodation identified they suspected Anne was stockpiling her medication on purpose, so her health and wellbeing may relapse to permit her to continue residing at the accommodation and not have to move out. They reported finding her discarded medication unopened in the backyard of the accommodation on several occasions. No Safeguarding Concern was raised by the accommodation provider. The benefit of raising a safeguarding concern would have enabled the risks to have been accurately assessed by NYCC, multi-agency information collated and considered, to enable a proportionate investigation and response to this issue being undertaken.

# Recommendation 4.

**NYSAB are required to raise awareness across the Safeguarding Partnership of the requirement of when to raise a safeguarding concern as detailed within the Joint Safeguarding Adults Multi Agency Policies and Procedures, West, North Yorkshire, and York.**

* 1. As detailed at **4.30** Anne’s risk assessment summary was updated by TEWV in May 2017. This was within the timeline as detailed in the TEWV Harm Minimisation Policy, which stipulates that Safety Summaries should be reviewed as a minimum on an annual basis. The purpose of the plan is to assess needs, identify risks, set patient personal goals for achievement, identify support that is available and use the plan to measure progress towards recovery. The risk summary assessment was inclusive of substance misuse in relation to alcoholism but did not reflect the emerging concerns that were recorded in Anne’s case notes that suggested she had potentially substituted her addiction to alcohol for benzodiazepines. Whilst it was recorded by the drug and alcohol recovery service as detailed at **4.38** of a joint professionals meeting being held with the accommodation provider and a TEWV representative being present, TEWV records do not evidence this meeting having taken place. The review has been unable to identify TEWV and the drug and alcohol recovery service working together to formulate a collaborative plan to address these emerging concerns. This has been identified as an area of learning for TEWV by the Serious Incident Review, in relation to the sharing of information between mental health services and substance misuse services.
	2. There is evidence of TEWV responding to Anne’s needs when at risk. These included recommending the use of coping strategies and distraction techniques to deal with alcohol and drug cravings, the short-term prescribing of Diazepam in response to raised anxiety and additional support being provided by TEWV HBTT. Concerns regarding Anne’s concurrent use of multiple medications was responded to by the TEWV registrar by withholding the provision of Diazepam and Buprenorphine medication, owing to the suspicion it may be adding to Anne’s confused state.
	3. As detailed at **4.59** CC 2 following concerns identified from their previous visit to Anne, contacted the GP practice to gain clarity regarding the strength of Diazepam recently prescribed by GP 1. It was recorded by the GP practice that CC 2 highlighted concerns relating to Anne stockpiling medication and that she may be obtaining illicit Diazepam. GP 1 was away from the practice on annual leave at this time and the information was not brought to the attention of the duty doctor who was providing cover. The issue of the information not being shared with the duty doctor at the time, was identified as an area of learning following an earlier practice review. This learning has been cascaded to local GPs at a CCG led protected learning event so the lessons learnt are shared with relevant practitioners and should be linked with **Recommendation 7.** below.
	4. Information provided to inform the SAR show that there were occasions GP 1 was made aware Anne may be sourcing illicit medications as detailed at **4.28** and

**4.41.** On each separate occasion GP 1 responded. Once by contacting the TEWV psychiatrist to consider undertaking a medication review and then providing advice regarding the risk of overdose and attendance at the hospital emergency department. Whilst each individual response appears reasonable, no safeguarding concern was raised regarding the potential emerging issue of illicit medication misuse. Whilst the review deems it reasonable to assume GP 1 may have considered other services were supporting Anne, raising a concern would have been good practice and enabled risks to have been accurately assessed by NYCC, multi-

agency information collated and considered where a proportionate response to this issue could have been enacted. Learning in relation to this issue should be addressed by **Recommendation 4.**

* 1. As detailed at **4.32** and **4.41** the Drug and Alcohol Recovery Service were made aware by the supported housing provider that Anne was suspected of purchasing and misusing illicit Diazepam. Anne on all occasions when challenged denied this to be the case. Anne was considered to be a capacitated adult, with Mental Capacity to make her own informed decisions and choices. Her engagement with the service was purely on a voluntary basis. Her treatment goal was to be.

abstinent from alcohol and drugs, which was her own stated position when she was discharged from the service. The decision to discharge Anne within a relatively short timescale of information being provided that indicated she may be misusing illicit Diazepam the review identifies as premature. Any consideration that Anne may require further monitoring by the service to alleviate concerns that she may have substituted her alcohol addiction for one of Diazepam appear to have been discounted primarily on the basis of her denials without further investigation. The service discharged Anne on the 11th September 2017 referencing her alcohol abstinence as the reason for discharge. The lack of inquisitiveness in exploring this theme further the review deems was a missed opportunity to identify potential additional support for Anne in relation to substance misuse issues.

# Recommendation 5.

**NYSAB should commission an external review of the Drug and Alcohol Recovery Service discharge process where existing concerns of substance misuse are present in-service users.**

**Were Anne’s views heard throughout? Was there an appropriate process in place for ensuring Anne’s views were heard?**

* 1. Anne was resident at the accommodation for approximately 2 years and 11 months. The supported housing provider has an expectation that all residents are expected to move on from the accommodation within a maximum of two years to a position of independent living. Whilst such a move should be viewed as a positive step forward for an individual, it is envisaged an individual with such complex issues as Anne may require additional support to manage such a transition. Information provided to inform the review demonstrates that Anne was of the belief that she may be required to move from the accommodation at some stage which apparently caused her anxiety as detailed at **4.51** and **4.52.** Additionally, it was suspected by staff at the supported housing accommodation that Anne would stockpile medication then abuse it in order to remain resident at the premises and not be forced to leave. In preparation for Anne’s move the accommodation provider had requested NYCC Independence Social Care team to undertake a Care Act social care needs

assessment. This was due to take place in November 2017 but had to be postponed until the 15th January 2018 due to inclement weather. This assessment may have assisted Anne in gaining confidence regarding her move to independent living by establishing a collaborative plan where her care needs were provided for, which subsequently may have reduced her anxiety in relation to the move.

https:[//w](http://www.scie.org.uk/care-act-2014/assessment-and-eligibility/)ww[.scie.org.uk/care-act-2014/assessment-and-eligibility/](http://www.scie.org.uk/care-act-2014/assessment-and-eligibility/)

The review has identified evidence to demonstrate that within the provider support and risk management plan, it did detail some forward planning in relation to the provision of furniture and clothing and continuation of engagement with services. It would have been good practice if a collaborative written plan had been established between the provider, Anne and the agencies providing care and support to her so as to reassure her that the move to independent living would be appropriately managed.

# Recommendation 6.

**NYCC and Scarborough Borough Council should ensure that a collaborative plan is drawn up between the provider, resident, and agencies prior to a move to independent living that addresses the individual’s care and support needs.**

* 1. TEWV records demonstrate a person-centred care approach was applied

where Anne played an active part in co-producing her care plans and informing reviews of her care. TEWV records demonstrate that Anne’s Mental Capacity was

considered to gain her consent to participate with assessment and treatment. <https://www.gov.uk/government/collections/mental-capacity-act-making-decisions>

* 1. TEWV records detail care plans that acknowledged Anne’s difficulties in building relationships, where interventions including her preferences in relation to staff communication, so as to encourage and promote a meaningful therapeutic relationship with health professionals to aid her recovery were considered.
	2. TEWV records show Anne participated in her care and treatment, including progress reviews, psychological formulation, and discharge planning meetings. The records show her views, wishes and feelings being recorded with evidence that demonstrated how her wishes influenced key decisions about her care for example suspending interventions such as visits to her by the care coordinators when Anne wished they did not attend.
	3. In October 2017 whilst CC 2 was absent on leave, Anne was provided temporary support by TEWV AOT. They advised Anne would benefit from a “staying well” plan being developed and the provision of a support worker to help her attend “survivor” support meetings. The purpose of a “staying well” plan is a plan to help and manage mental illness that assists overcoming distressing and unhelpful behaviour. The review has failed to identify any such plan or support worker being provided.

https:[//w](http://www.nhs.uk/live-well/)ww[.nhs.uk/live-well/](http://www.nhs.uk/live-well/)

The review identifies the establishment of a “staying well” plan and the provision of a support worker to assist Anne attending the survivor’s meetings would have been good practice, potentially beneficial for Anne’s overall health and wellbeing, together with acting upon her wishes and feelings. The TEWV serious incident review identified that if the Care Programme approach had been followed these issues would have been addressed.

# Recommendation 7.

**NYSAB should seek assurance from TEWV as to how the lessons learnt and improvement actions identified by the TEWV serious incident review including the use of the Care Programme approach to promote multi-agency working, have been shared with practitioners and the improvement activity embedded in current practice.**

* 1. Anne was registered with the same GP practice for several years. Predominantly Anne was seen by GP 1 whom had previously provided her with care whilst operating as a substance misuse lead GP. GP 1 considered knowing Anne well and having a professional relationship with her built over many years. Information provided to inform the review demonstrates that GP 1 saw Anne on a regular basis, listening and responding to her views as demonstrated at **4.37** and

**4.40**. This the review identifies as good practice and in line with NICE guidance which details the need to demonstrate empathy and being non-judgemental in relation to Anne’s substance misuse history and having regular contact with GP 1 provided a consistency of approach.

[https://pathways.nice.org.uk/pathways/coexisting-severe-mental-illness-and-](https://pathways.nice.org.uk/pathways/coexisting-severe-mental-illness-and-substance-misuse-community-health-and-social-care-services/coexisting-severe-mental-illness-and-substance-misuse-community-health-and-social-care-services-overview) [substance-misuse-community-health-and-social-care-services/coexisting-severe-](https://pathways.nice.org.uk/pathways/coexisting-severe-mental-illness-and-substance-misuse-community-health-and-social-care-services/coexisting-severe-mental-illness-and-substance-misuse-community-health-and-social-care-services-overview) [mental-illness-and-substance-misuse-community-health-and-social-care-services-](https://pathways.nice.org.uk/pathways/coexisting-severe-mental-illness-and-substance-misuse-community-health-and-social-care-services/coexisting-severe-mental-illness-and-substance-misuse-community-health-and-social-care-services-overview) [overview](https://pathways.nice.org.uk/pathways/coexisting-severe-mental-illness-and-substance-misuse-community-health-and-social-care-services/coexisting-severe-mental-illness-and-substance-misuse-community-health-and-social-care-services-overview)

* 1. The review has identified the difficult balance GP 1 had to strike regarding prescribing Diazepam to Anne when information indicated she may be sourcing illicit Diazepam. The decision to provide her with a low dose of Diazepam to help relieve her concerns of anxiety and agitation, the review deems as a reasonable and proportionate measure to minimise harm, when taken in the context this may have been a safer course of action in attempting to discourage Anne feeling the requirement to resort to sourcing illicit uncontrolled medication. This followed the principles of care as stipulated for people with coexisting severe mental illness (psychosis) and substance misuse in line with NICE guidance. <https://www.nice.org.uk/guidance/CG120/chapter/1-Guidance#principles-of-care>

However, whilst GP 1 did prescribe Diazepam in limited doses within the recommended daily limit of the drug, the practice fell outside of the established daily prescribing plan for Anne’s other medication, which had been established as part of the harm minimisation pathway adopted by GP 1. In managing the risks posed to Anne from overdose the review has been informed that GP 1 considered owing to Anne’s presentation a one-week prescription would be safe and as she lived in

supported accommodation, they would be able to report back any concerns to the practice.

The supported housing accommodation provider has operating guidance that articulates their role is strictly not to monitor a client to ensure they take prescribed medication in the quantities and timescales prescribed. There is an expectation they report concerns in relation to residents to the relevant healthcare professionals. It is however unclear if GP 1, CC 1, and CC 2 fully understood the role that staff at the supported housing accommodation undertook and potentially created a false sense of security as to the level of support, staff could apply to safeguard Anne. The TEWV Serious Incident Review identified the Care Programme Approach had not been appropriately followed. It recommended when there are multiple agencies involved the care co-ordinator will design a care plan that will explain the role of each of the teams and what they will all do in the event of the person’s risk or presentation changing. NYSAB should assure itself how this recommendation has been embedded in practice by the application of **Recommendation 7.**

# Did the agencies involved know enough about Anne to support her?

* 1. As detailed at **4.56** Anne was discussed at a Multi-Agency Tasking meeting in relation to concerns, she was potentially misusing illicit substances. Despite this concern being highlighted no apparent action was taken. The governance and arrangements for this tasking process are the responsibility of the community impact team as detailed at **4.56.** The review understands that this team are part of the local community safety partnership structure, with no reporting conditions or assurance provided to NYSAB regarding how this potentially vulnerable cohort of individuals are safeguarded. It was identified during this review owing to work demands CC 2 was unable to attend these meetings and GP 1 was unaware of their existence.

Whilst the value of agencies working together and sharing information to safeguard “Adults at Risk” should always be encouraged, the risk of actions not being enacted to safeguard individuals is heightened where there is a potential lack of accountability and where key agencies are not present at meetings can result in important information not being shared.

Anne was considered by TEWV to have mental capacity to make informed decisions regarding the choices she made. At the time of Anne’s death where the situation existed that an individual had capacity to make informed decisions and their likely behaviour or self-neglect may lead to serious harm or death, a structure that provided a coordinated response other than a Safeguarding enquiry under Section 42 of the Care Act was not established in North Yorkshire.

The City of York and North Yorkshire Multi Agency Practice Guidance for working with Adults who self-neglect was introduced in November 2019. It highlights in such cases as Anne’s a Multi-agency self-neglect meeting (MASM) can be used when an individual’s decision making is creating significant concern about their safety, and existing involvement by organisations has failed to resolve the issues. It describes a MASM being appropriate when the individual has capacity to make the decision(s) causing the concern and the concerning behaviour/’self-neglect’ is likely to result in significant harm or may result in their death. The importance of practitioners being able to recognise and respond to self-neglect through the application of this guidance cannot be overemphasised.

In Anne’s case had the MASM been in existence at the time of the escalating concerns it could have been used to develop a coordinated response to address the issues of concern. Whilst the review has been informed that work has already been undertaken by NYSAB in promoting this guidance, the potential benefit in managing similar cases such as Anne, drawing upon learning from this case should be promoted by NYSAB, to the safeguarding partnership.

# [https://safeguardingadults.co.uk/wp-content/uploads/2020/04/York-and-North-](https://safeguardingadults.co.uk/wp-content/uploads/2020/04/York-and-North-Yorkshire-Self-neglect-Practice-Guidance.pdf) [Yorkshire-Self-neglect-Practice-Guidance.pdf](https://safeguardingadults.co.uk/wp-content/uploads/2020/04/York-and-North-Yorkshire-Self-neglect-Practice-Guidance.pdf)

**Recommendation 8.**

**NYSAB drawing upon learning from this case should promote the existence of The City of York and North Yorkshire Multi Agency Practice Guidance for working with Adults whose concerning behaviour/ self-neglect is likely to result in significant harm or may result in their death to promote multi-agency working and information sharing.**

**Were there missed opportunities for information sharing between agencies?**

* 1. The service specification for staff employed at the supported housing accommodation details that if they identify any risk the service user poses to themselves or others, that this is communicated at the time to agencies supporting the individual concerned. There were several occasions the staff raised concerns to TEWV in relation to Anne. These included concerns of her exceeding the prescribed dosage of Diazepam, Anne having suicidal thoughts, presenting as confused after a recent hospital admission, obtaining, and using illicit Diazepam. The suspected use of illicit Diazepam was also shared by the provider with the Drug and Alcohol recovery service.

By sharing these concerns, they provided opportunities for TEWV and the drug and alcohol recovery service to consider how best to support Anne with her mental health and emerging issue in relation to illicit Diazepam use.

* 1. The staff at the supported housing accommodation shared concerns with GP 1 that Anne had been stockpiling prescription medication in her room. This medication included promethazine, paracetamol, codeine and procyclidine all of which were later discarded by the accommodation provider.
	2. From mid December 2017 up to the time of Anne’s death there were several occasions where the review identifies contact by the provider should have taken place with TEWV and GP 1 to alert them of their concerns. These included changes in Anne’s presentation, unsteadiness on her feet, slurring of her words, suspicion of her misusing illicit substances and prescribed medication, experiencing hallucinations of her dead partners friends whom she claimed were “dancing in her bedroom”.

The review identifies it would have been good practice and supported the Care Programme Approach for GP 1, CC 1, and CC 2 together with the housing provider to have worked more closely together to formulate a collaborative care and intervention plan, where everyone had clarity about their role and responsibilities in relation to safeguarding Anne.

The TEWV Serious Incident Review identified the Care Programme Approach had not been appropriately followed and made recommendations that when there are multiple agencies involved the care co-ordinator will design a care plan that will explain the role of each of the teams and what they will all do in the event of the person’s risk or presentation changing. NYSAB should seek assurance from TEWV how this recommendation for improvement has been embedded in practice by the application of **Recommendation 7** of this report.

* 1. As detailed at **4.36** NYP received 10 pieces of separate “police intelligence” in relation to Anne over a period of 7 months, the last in September 2017. NYP identify the purpose of gathering and recording intelligence is to assist in prioritising resources with the aims of increasing crime detections, reducing crime, disorder, and anti-social behaviour. The intelligence included reference to Anne being sighted with individuals known to NYP, references made to drug exchanges, purchases by others of illicit substances on behalf of Anne and information relating to Anne having an association with Diazepam and Pregabalin drugs. This intelligence when considered in the context of Anne’s deteriorating mental health and prescribing regime may have been an indicator of escalating risk.

Whilst the intelligence was used on 2 occasions for policing purposes to task officers to conduct stop checks, the review has been unable to identify it being considered from a perspective of safeguarding Anne. The intelligence was not shared with TEWV or GP 1. No safeguarding concern was raised. The Social care Institute of Excellence (SCIE) identifies that the sharing of the right information, at the right time, with the right people, is fundamental to good practice in relation to safeguarding adults although decisions to share the information must be made on a case-by-case basis.

<https://www.scie.org.uk/safeguarding/adults/practice/sharing-information>

However, taking account of the totality of intelligence provided over a relatively short time period of 7 months the review deems it would have been appropriate unless the intelligence was deemed to be highly sensitive for NYP to either raise a safeguarding concern, or identify relevant agencies supporting Anne and share the information.

This may have assisted concerns in relation to the risk of escalating substance.

misuse to be addressed. NYSAB has developed a helpful and informative one- minute guide on when information should be shared in relation to safeguarding “Adults at Risk”. NYSAB should promote awareness of this guidance to North Yorkshire Police and the North Yorkshire Safeguarding partnership.

# Recommendation 9.

**NYSAB should raise awareness of the “One Minute” guide on information sharing to North Yorkshire Police and promote its existence to the wider North Yorkshire Safeguarding partnership.**

* 1. As detailed at **4.11** following hospital discharge in 2016, Anne’s mental health was supported by TEWV under the umbrella of the Care Programme Approach. This programme promotes the value of joint working and communication between health professionals supporting the individual. The TEWV Serious Incident Review highlighted the Care Programme Approach had not been reliably followed throughout. Opportunities for a greater collaborative approach involving the multiple agencies involved in supporting Anne were not fully exploited. A greater understanding of each other’s roles and how they may work together were not fully explored and could have created more informed intervention and care plans. Anne’s care plan was last updated on the 16th February 2016. Since that time, a number of issues of concern had been identified in relation to Anne including suspected illicit substance misuse and concerns regarding her presentation. Consequently, this resulted in Anne’s care plan not being reviewed and amended to reflect the new emerging concerns.

# Are there opportunities to improve how organisations work together for complex cases that involve multiple organisations for people living in supported housing environments?

* 1. Whilst resident at the supported housing accommodation the provider established a support and risk management plan for Anne. The plan is outcome focused and comprehensive detailing 6 areas of focus namely Achieving, Economic Well Being, Enjoying and Achieving, Being Healthy, Staying Safe and Making a Positive Contribution. The risk section identified a number of areas of risk that included illicit medicine misuse. The control measures that required to be applied when misuse of illicit medication was suspected was for the provider to contact Anne’s Care Coordinator namely CC 1 or CC 2. As already identified, this did not always occur. The plan identifies the agencies and practitioners who were supporting Anne. Its establishment and usage could have complemented the care programme approach, promoting joint working and multi-agency information sharing. The review has been unable to identify if and how it was used to help safeguard Anne. The current Joint Safeguarding Adults Multi Agency Policies and Procedures, West, North Yorkshire, and York refers to risk management as a responsibility for all agencies who should look holistically at risk and work in partnership. The review recommends current and future residents should be supported by developing an outcome focused support and risk management plan. This should be informed holistically by all agencies involved in providing care and support for the individual and subject to regular monitoring and review to ensure it remains current.

<https://safeguardingadults.co.uk/Resources/>

# Recommendation 10.

**People living in supported housing environments should be supported through the development of an outcome focused support and risk management plan informed by all agencies providing care and support to the resident that is subject to regular review and monitoring to ensure it remains current.**

* 1. Other than when Anne as detailed at **4.10** was detained under Section 2 of the Mental Health Act it was assumed by practitioners, she had mental capacity to make informed decisions regarding the choices she made. Principle 1 of The Mental Capacity Act states that a person must be assumed to have capacity unless it is.

established that they lack capacity. It further clarifies a person lacks capacity if at the material time they are unable to make a decision because of an impairment of, or a disturbance in the functioning of, the mind or brain, whether the impairment is permanent or temporary. As described at **4.55** when CC 2 visited Anne at the supported housing accommodation on the 20th December 2017 to administer her depot injection, Anne presented with slurred speech where it was later recorded by CC 2, they suspected Anne may have been using street Diazepam. TEWV records demonstrate CC 2 clarifying with Anne her understanding of the impact of receiving the depot injection and her consenting to it being administered. This negating the requirement for CC 2 to undertake a formal assessment of Anne’s mental capacity despite her presentation.

<http://www.legislation.gov.uk/ukpga/2005/9/contents>

# Could Anne’s death have been prevented?

* 1. As detailed at **1.21** the coroner’s inquest concluded Anne’s death was accidental, due to Pregabalin and Haloperidol toxicity. Pregabalin and Haloperidol were two of several medications prescribed to Anne by GP 1. Pregabalin for back pain and Haloperidol to treat psychosis. Following Anne’s death, a postmortem was undertaken to establish her cause of death. The toxicology report following analysis of Anne’s blood found that levels of pregabalin in the blood were around 6 times higher than expected from a therapeutic dose. The report added there are isolated reports of fatalities with levels as low as this particularly when the drug is abused, but generally the level associated with fatality is higher. It further clarified that Pregabalin may exacerbate the sedative effects of Haloperidol with the effect potentially more marked at higher pregabalin levels. It was confirmed haloperidol was found in the blood at a level within the range of a therapeutic dose.
	2. At the time of Anne’s death GP 1 prescribed on a daily basis, 2 capsules of Pregabalin at 150 milligrams strength and 2 tablets of Haloperidol at 5 milligrams strength. The strength and quantity of Pregabalin and Haloperidol medication prescribed was within the lower ranges of dosage as detailed within NICE guidance.

<https://bnf.nice.org.uk/drug/pregabalin.html>

<https://bnf.nice.org.uk/drug/haloperidol.html>

* 1. As detailed at **4.68** when NYP attended Anne’s death they described discovering several unopened packages of medication, prescribed to Anne which included Diazepam and Pregabalin. Previous reports of her stockpiling medication would appear to have continued and as previously highlighted these incidents should have been investigated further with considerations made of raising a safeguarding concern in relation to these events.
	2. Anne’s mobile telephone was examined by NYP following her death. This identified 13 text messages which apparently referred to requests to purchase illicit prescription medication and the impacts of its misuse, as interpreted by the police investigating officer. A number of the messages use acronyms and words that were believed to refer to prescription medication. Of particular note was the use of the acronym PGS and the word Pregabs. These NYP attribute to as a reference to Pregabalin. The timeline of the text messages commenced on the 14th December 2017 and concluded on the 28th December 2017. Prior to her death the review has identified multiple occasions where it was suspected by agencies Anne was sourcing illicit medication. It is apparent Anne was supplementing her prescribed medication regime with additional illicit prescription medication. NHS England have recently published guidance in relation to the increasing abuse of Pregabalin in the United Kingdom with an increased number of deaths related to its misuse. The outcome of the consultation process regarding the reported increasing abuse of pregabalin resulted in it being reclassified as a Schedule 3 controlled drug under the Misuse of Drugs Regulations 2001 and classified as a Class C drug in relation to the Misuse of Drugs Act 1971.

[https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2018/01/nhs-cd-](https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2018/01/nhs-cd-newsletter-pregabalin.pdf) [newsletter-pregabalin.pdf](https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2018/01/nhs-cd-newsletter-pregabalin.pdf)

[https://www.england.nhs.uk/wp-content/uploads/2019/03/pregabalin-and-](https://www.england.nhs.uk/wp-content/uploads/2019/03/pregabalin-and-gabapentin-guidance-v1.pdf) [gabapentin-guidance-v1.pdf](https://www.england.nhs.uk/wp-content/uploads/2019/03/pregabalin-and-gabapentin-guidance-v1.pdf)

* 1. The response by staff at the supported housing accommodation to support Anne in the time leading up to her death is analysed at **5.5** with identified recommendations for improvement. The staff at the accommodation as previously described are neither health care professionals or social workers and do not support residents with their healthcare needs. They are expected though to respond to identified risks to individuals. The coroner’s investigation that was undertaken obtained personal accounts from staff at the accommodation. They described it as normal practice for Anne to fall asleep on her sofa and not awaken until lunchtime. It is important when undertaking a review of this nature that we seek to avoid hindsight bias, a psychological phenomenon where past events appear more prominent than they appeared while occurring. This can lead to believing an event was more predictable than it was, resulting in an oversimplification of cause and effect. Hence the review deems it reasonable to believe from the perspective of the support workers that the behaviour of Anne in those hours leading up to her death was neither extraordinary or uncommon and may explain the delay in checking upon Anne’s welfare, when not seen at the accommodation for some time.

<https://www.scie.org.uk/safeguarding/adults/reviews/care-act>

* 1. From the information provided to inform the review it demonstrates, Anne was a capacitated adult, who apparently chose to supplement her prescription medication with additional illicit medication, tragically resulting in her death which could not have been prevented.

# 6.0 Recommendations

**Recommendation 1.**

**NYSAB should commission an independent review of the supported housing accommodation arrangements, to identify risks and opportunities, with a view to influence changes to policy at a regional and national level.**

**Recommendation 2.**

**NYCC and Scarborough Borough Council drawing upon learning from this case should ensure staff employed at the accommodation have relevant training with accreditation to help equip them to safeguard residents at the premises.**

**Recommendation 3.**

**NYCC and Scarborough Borough Council as commissioners of the accommodation drawing upon the learning from this review should ensure the guidance and support provided to staff as to the circumstances in which they should enter a resident’s flat is sufficiently robust and explicit so as to safeguard the individual concerned.**

**Recommendation 4.**

**NYSAB are required to raise awareness across the Safeguarding Partnership of the requirement of when to raise a safeguarding concern as detailed within the Joint Safeguarding Adults Multi Agency Policies and Procedures, West, North Yorkshire, and York.**

**Recommendation 5.**

**NYSAB should commission an external review of the Drug and Alcohol Recovery Service discharge process where existing concerns of substance misuse are present in-service users.**

**Recommendation 6.**

**NYCC and Scarborough Borough Council should ensure that a collaborative** **plan is drawn up between the provider, resident, and agencies prior to a move to independent living that addresses the individual’s care and support needs.**

**Recommendation 7.**

**NYSAB should seek assurance from TEWV as to how the lessons learnt and** **improvement actions identified by the TEWV serious incident review including the use of the Care Programme approach to promote multi-agency working, have been shared with practitioners and the improvement activity embedded in current practice.**

**Recommendation 8.**

**NYSAB drawing upon learning from this case should promote the existence of** **The City of York and North Yorkshire Multi Agency Practice Guidance for working with Adults whose concerning behaviour/ self-neglect is likely to result in significant harm or may result in their death to promote multi-agency working and information sharing.**

**Recommendation 9.**

**NYSAB should raise awareness of the “One Minute” guide on information** **sharing to North Yorkshire Police and promote its existence to the wider North Yorkshire Safeguarding partnership.**

**Recommendation 10.**

**People living in supported housing environments should be supported through the development of an outcome focused support and risk management plan, informed by all agencies providing care and support to the resident that is subject to regular review and monitoring to ensure it remains current.**