North Yorkshire Safeguarding Adults Board

Safeguarding Adult Review – Marie

Draft and confidential

Jane Gardiner

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1. Introduction

Marie[1] was a 30-year-old woman living in North Yorkshire. She was married but separated and had 3 children who were aged 7, 8 and 14 at the time of her death.

She was found unresponsive on 4 March 2023 from a drug overdose and was taken to hospital. She discharged herself the following day. On 6 March 2023 Marie was found unconscious and in cardiac arrest, and despite efforts of medical professionals she sadly died that day.

The inquest, concluded on 15 December 2023, determined that Marie died by suicide. Toxicology findings confirmed the presence of codeine (at high levels), mirtazapine, paracetamol, pregabalin, zopiclone, cocaine, diazepam and clonazepam, recorded as drug toxicity.

A Section 44 referral for a safeguarding adult review (SAR) was submitted by York & Scarborough TH NHS FT. The North Yorkshire Safeguarding Adults Board (SAB) and the SAB Learning and Review Group, which makes decisions on proceeding to a SAR, agreed that the case highlighted areas of potential learning, and decided that that a SAR should be undertaken.

This SAR considers a period from 1st January 2022 until Marie's death in March 2023.

2. Purpose of the Safeguarding Adults Review

The purpose of SARs is to gain, as far as is possible, a common understanding of the circumstances surrounding the death of an individual and to identify if partner agencies, individually and collectively, could have worked more effectively. The purpose of a SAR is not to re-investigate or to apportion blame, undertake human resources duties or establish how someone died. Its purpose is:

- To establish whether there are lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults.
- To review the effectiveness of procedures both multi-agency and those of individual agencies.
- To inform and improve local inter-agency practice.

[1] 'Marie' is the pseudonym chosen for this report by her mother.

- To improve practice by acting on learning.
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

There is a strong focus on understanding issues that informed agency/professionals' actions and what, if anything, prevented them from being able to properly help and protect Marie from harm.

3. Independent Review

Jane Gardiner was commissioned to write the overview report. She has been the co-author of four SARs and has a background in working in women's safety, victim services within the criminal justice system, and substance use.

4. Methodology

A multi-agency panel of the North Yorkshire Safeguarding Adult Board was set up to oversee the SAR and commissioned the author to complete the review. Information was sought from agencies involved with Marie by requesting Individual Management Reports (IMRs) comprising a chronology and analysis of agency involvement. More detailed information and insight was sought from the involved agencies via a Practitioners' Workshop on 22nd November 2024.

The following agencies were involved in the process:

- Primary Care
- Yorkshire Ambulance Service
- Tees, Esk and Wear Valleys NHS Foundation Trust
- York and Scarborough Teaching Hospitals NHS Foundation Trust
- North Yorkshire Council Living Well Team
- Children and Young People's Service
- North Yorkshire Horizons
- North Yorkshire Police

The author additionally consulted with an expert in Gypsy, Roma and Traveller (GRT) culture from the York Travellers Trust.

All information was analysed by the author and an initial draft of the report was produced and went to the SAR Subgroup in April 2025. Further changes were made, and a final draft was completed in September 2025.

5. Family contact

An important element of any SAR process is contact with family. Marie's mother was a significant influence in her life and Marie's three children have resided with her mother since August 2022. As part of this review the author had a conversation with Marie's mother who was able to offer valuable insights into Marie's life. The author is very grateful for her input which has greatly informed this process.

6. Parallel processes

There were no parallel processes such as Police or Coronial inquiries that coincided with the review.

7. Protected Characteristics

7.1 It is against the law to discriminate against anyone because of their age, gender, race, religion or belief.

7.2 The review identified the characteristics and identity of Marie and her family. Marie's protected characteristics will be commented upon throughout the review and consideration given as to whether there was any evidence of any direct or indirect discrimination because of those characteristics.

8. Cultural context

8.1 Marie was a woman from the Gypsy, Roma and Traveller (GRT) community. This aspect of her identity is an important part of understanding her experiences and the barriers she may have faced in accessing support. Cultural factors may have influenced her ability to speak openly about distress, to seek help for issues such as substance use or domestic abuse, and to engage with services that were not always equipped to respond in a culturally sensitive way.

8.2 This review recognises the role that cultural identity can play in shaping both risk and resilience. Marie's Traveller heritage is therefore considered throughout the

analysis, particularly in relation to engagement, safeguarding, kinship care, and bereavement. The learning set out in this report reflects the need for services to recognise and respond to the diverse cultural contexts in which people live their lives

9. Background and personal information

9.1 Marie is described by her mother as being a devoted '*fun mother'* who '*loved her children with all her heart'*. She enjoyed singing, dancing, and making TikTok videos with her children, and her children and mother now enjoy looking back at these videos with fondness to remember her.

9.2 Marie's mother stated that '*her children were her world*', and this is supported by her contacts with professionals who note the children as being a strong protective factor. Professionals who worked with her have described Marie as straight talking, high spirited and fiercely independent. For leisure, Marie enjoyed going to Bingo and taking the children on trips away.

9.3 Marie was from a Traveller background, described by her mother as '*a proud Traveller'*.

9.4 Marie had a history of expressing feelings of low mood and anxiety and seeking support for this. She had received formal diagnoses of emotional dysregulation and generalised anxiety.

9.5 She had disclosed a personal history of substance use, domestic abuse, and childhood trauma including sexual assault. Her eldest child was conceived as a result of rape, with Marie having previously expressed feelings of guilt that her uncle was in prison for the offence of killing the person who raped her.

9.6 At the time of her death, Marie was separated from and not living with her husband, who was on a tag after release from prison. Her husband was the father of the two youngest children. There was long standing domestic abuse within their relationship.

9.7 At the time of her death Marie's children were under a child protection plan and were placed in the care of their maternal grandmother with an arrangement of supervised visits only with their mother.

10. Overview chronology of the review period

14th January 2022 – Marie and her husband were arrested at home after Police received intelligence that drugs were being supplied from the address. She received a caution for possession of an offensive weapon due to having a knuckle duster. Marie stated that this was for protection because she was from a Traveller family.

May 2022 – Marie informs professionals that she is getting a divorce.

12th June 2022 – A high speed Road Traffic Collision – Marie not present. Marie's husband was driving at very high speed, the car flipped several times *"crashing spectacularly into a roundabout"*. There were two girls inside the car aged 13 and 15, one of whom was Marie's eldest daughter. He had no licence and tested over the specified limit for THC (cannabis) and cocaine. He fled the scene leaving the girls trapped in the car.

Marie gave a sworn statement to the Police saying that he had taken the car without her permission, which she later withdrew.

6th July 2022 - Marie drove a car onto a garage forecourt whilst intoxicated with her two youngest children in the car. She entered the shop and smelt strongly of alcohol and could barely stand up. The witnesses at the shop were clear that she was very drunk and had been driving. No action was taken by the Police in pursuing a prosecution, but a Children's Services referral was made.

11th July 2022 – Emergency Child Protection strategy meeting held. Marie's three children were residing at their grandparents.

1st August – Initial Child Protection Conference held. All three children subject to Child Protection Plans for emotional abuse. Marie to engage with mental health services.

8th September 2022 – Marie is noted by her Mental Health Care Co-Ordinator during a home visit to be "*pale, tired, lost weight. Not seen children, relationship breakdown with parents."*

30th September 2022 - Marie took cocaine and crashed her car whilst not wearing a seat belt, "*driving at speed and (took) off into the air when she left the road"*, stating to Police that this had been a suicide attempt. At the time she was on the phone to her daughter and said that she didn't want to live anymore, her daughter then heard a massive crash and Marie became unresponsive. Toxicology results showed her as being 16 times over the specified limit for Benzoylecgonine (a metabolite of cocaine) and 3 times over the specified limit for cocaine itself.

1st October 2022 – Marie was seen by the Mental Health Team in Police custody - She stated during her assessment that she had left the house as she didn't want to be

anyone's problem anymore and that is why she chose to drive her car in an attempt to end her life. She described it as an immediate decision and denied any current thoughts of suicide or self-harm stating that her children were a protective factor.

31st October 2022 – Marie's husband received a 12-month prison sentence for the offence of the 12th June.

4th December 2022 – 3rd February 2023 - there were 10 x 999 calls made by Marie to Police during this period. The calls were all quite similar in nature – Marie seemed to be experiencing hallucinations and was scared, believing that there were intruders in her house. Police attended the first five calls and the following five calls were logged as hoax calls.

1st February 2023 – Marie's husband was released from prison.

10th Feb 2023 – Meeting with Care Co-ordinator at the Mental Health Trust. Marie described hallucinations and paranoia about someone breaking into the house. No thoughts of self-harm.

4th March 2023 - Marie was found unresponsive at home having taken an overdose, suspected to be of opiates with alcohol intoxication and was taken to hospital. Ambulance and hospital records note an empty packet of Polish-branded benzodiazepine at the scene. Marie's children were unattended in the house. She was conveyed by ambulance to the Emergency Department where a decision was made to admit her.

5th March 2023 - Marie refused to speak to the Mental Health team and it was assessed that she had the capacity to make that decision. She was discharged from the emergency department at 17:27hrs.

6th March 2023 – Marie was found at home unresponsive and in cardiac arrest due to an overdose. She was sadly pronounced dead on arrival at hospital.

11. Analysis

The rest of this report explores key themes which emerge from the 14-month period before Marie's death:

- Substance use
- Difficulties with engagement
- Criminal justice system interventions
- Domestic abuse
- Mental health and suicidality
- Multi-agency management

- Professional curiosity and trauma-informed approaches
- Safeguarding interventions and use of the Mental Capacity Act
- Gypsy, Roma and Traveller (GRT) cultural context

12. Drug, alcohol and prescription medication use

Marie was known to use alcohol, cocaine and other substances.

12.1 Prescription drugs and stockpiling

Marie had diagnoses of Emotional dysregulation, Generalised anxiety, Rheumatoid arthritis, Asthma and Migraine and was prescribed regular repeat medications:

Diazepam (benzodiazepine), Pregabalin (for pain), Promethazine (sleep), Quetiapine (antipsychotic), topimarate (pain/headache), dihydrocodeine (pain), laxatives, vitamins and diet supplement (after gastric weight loss surgery).

During the last few months of her life Marie had contacted the GP surgery quite frequently to try to obtain additional analgesia medication or sleeping tablets, reporting that she had lost her medications/prescription or had an increase in pain symptoms following a series of trips, falls and low impact RTCs.

The practice identified a potential risk with regard to suitable controls and boundaries around safe prescribing and the reissue of medication, and this was managed appropriately. Marie had a nominated GP who would manage her medication and requests; they made attempts to reduce the dose of opiate medication and a weekly prescription was set up to reduce the risk of over medicating. Marie was known to the practice prescribing clerk who highlighted to her usual GP if she was requesting additional medications. Prescriptions were offered weekly to manage the risk of stockpiling.

Marie was noted to disengage at times and when structured medication reviews were scheduled in order to maintain her prescriptions she would not attend or engage with this process.

12.2 Alcohol use

The extent to which alcohol was a risk factor in Marie's life is unclear. We know that she did drink alcohol from the incident on 6th July 2022 when she was alleged to have driven her car under the influence of alcohol. Staff at the forecourt garage had reported that she smelt strongly of alcohol. However, the notes from the Drug and Alcohol Service mention only her cocaine use.

We know that for individuals with issues involving the use of drugs other than alcohol, their use of alcohol can be overlooked due to the focus on the identified primary drug of choice[2]. In Marie's case, there are additional factors that may have felt more all-consuming to her, such as her children being subject to care proceedings, domestic abuse, and mental health issues and these may have impacted her self-reporting of alcohol use. It is also known that people who have experienced childhood trauma are more likely to drink alcohol at harmful levels.

Perhaps most pertinent to Marie's case is that for people known to undertake risky and impulsive behaviours, the use of alcohol can hinder self-regulation and increase the risk of suicide[3].

It is noted by Primary Care that no questions were asked of Marie with regard to her use of non-prescribed substances including alcohol during the scoping period of this review. At the very least, this suggests the need for routine screening for early identification of alcohol dependency and risks associated with drinking at harmful levels. The World Health Organisation provide a tool for this, AUDIT, the Alcohol Use Disorders Identification Test[4], use of which is supported by NICE Public Health Guidance 24. Marie's case reminds us that routine use of this is beneficial.

12.3 Drug and Alcohol Service support

Information in this section was drawn primarily from the chronology provided by the Drug and Alcohol Service. Referrals were made to the service during the review period and unsuccessful attempts at contact were made. Marie did attend a triage assessment where she disclosed using up to 7 grams of cocaine daily, but she failed to attend for further comprehensive assessment. Two weeks before her death, Marie self-referred to the service, but it does not appear that she saw anyone there.

12.4 Difficulties with engagement

The pattern of referrals made to the Drug and Alcohol service indicate a willingness on the behalf of the agencies supporting the family and of Marie herself to seek support for her substance use. However, when attempts to engage Marie into the service were unsuccessful, her case was closed citing "*NYH policy*" due to "*2 failed attempts have*[ing] *been made*":

[2] Staiger, P et al (2013) Overlooked and underestimated? Problematic alcohol use in clients recovering from drug dependence, Deakin University

[3] Rizk, M et al (2021) Suicide Risk and Addiction: The Impact of Alcohol and Opioid Use Disorders https://pmc.ncbi.nlm.nih.gov/articles/PMC7955902/

[4] https://www.who.int/publications/i/item/WHO-MSD-MSB-01.6a

Although a triage assessment was later carried out on 25th November 2022 following another referral into the service, a further 'comprehensive' assessment was booked for 8th December which Marie reported being unable to attend due to ill health. We know from the Police chronology that Marie was struggling at this time with hallucinations and fears about intruders in her house, so it isn't surprising that she did not feel well enough to attend. Following a failure to attend the next booked assessment, no contact was made until Marie self-referred into the service 2 weeks before her death:

- November 2022 – Referral received from Children's Services, 2 x telephone attempts at contact made, referral closed.
- November / December 2022 – Referral received from Children's Services, triage assessment attended, failed to attend comprehensive assessment x 2, no further contact.
- February 2023 – Marie self-refers.

It is known that women who have children and who use substances are more likely to experience difficulties maintaining engagement with, or completing, substance use treatment[5]. Despite this, it would appear as though efforts to engage Marie were minimal, although the risks of an attempt to end her own life, exacerbating factors of having her children undergoing care proceedings, mental health issues and a high level of cocaine usage were known. Indeed, it was commented in the practitioner's workshop that a *"three strikes and you're out"*[6] policy might not be ideal for vulnerable adults like Marie.

Whilst Children's Services made repeat referrals to the Drug and Alcohol Service and were proactive in seeking support for Marie's substance use, there is no evidence that other agencies who were also aware of her harmful drug and alcohol use facilitated referrals or actively supported her engagement. This represents a missed multi-agency opportunity to reinforce the importance of treatment and provide additional pathways into support.

12.5 Cultural considerations

Marie's Traveller heritage may have significantly shaped how she experienced and responded to her substance use. In many Gypsy, Roma and Traveller (GRT) communities, harmful substance use, particularly by women, is deeply stigmatised and associated with shame, secrecy, and moral judgement. For a Traveller woman, particularly a mother, acknowledging a problem with drugs or alcohol may risk rejection by family or community, or may undermine her role and identity within those circles. This cultural context can create a powerful barrier to engaging openly with support services,

[5] Greenfield et al (2007) cited in Social Care Institute for Excellence (2022) Mothers who use substances and implications for the care system: desk-based literature review

[6] Quote from Practitioner's Workshop

especially if those services lack cultural competence or fail to create a safe, non-judgemental environment. It is therefore critical that Drug and Alcohol Services recognise these dynamics and work proactively to build culturally sensitive, trust-based relationships, offering flexible, discreet, and respectful support that takes these community values into account.

12.5 A women centred service

There is a relatively low level of substance use support in the UK specifically for women, yet research shows that women-specific services have good outcomes and are preferred by women. Positive approaches or ways of working with women with substance use problems include providing services that are gender-responsive, trauma-informed, strengths-based, relationship-based, collaborative and family-centred.[7]

North Yorkshire has already begun to develop such approaches, for example through the Women's Whole System Approach (funded by the MCA), which includes an outreach provision and a women's centre in Scarborough, as well as the emerging Women's Health Network led locally. Marie's case illustrates why continuing to strengthen women-centred substance use support remains vital.

13. A need for more assertive engagement

Regardless of gender, engagement into services is a problem for services working not just with Marie, but for many others like her. We know, for example, that only 18% of dependent drinkers nationally are in treatment[8], and 53.3% of opiate users are in treatment[9]. When services rely on a person to be motivated to want to access their support, this leaves a very large group of vulnerable people unsupported.

It was not only the Drug and Alcohol Service who reported difficulties in engaging Marie into their services. The Rheumatology Clinic note nine failed appointments leading to her being discharged back to GP care on three occasions, and the Living Well service note difficulties in achieving contact and three missed attendances.

For people like Marie who are experiencing multiple unmet needs, often arising from past trauma combined with current adversity, their complex needs require appropriate

[7] Social Care Institute for Excellence (2022) Mothers who use substances and implications for the care system: desk-based literature review

[8] House of Commons Committee Report (2023) https://publications.parliament.uk/pa/cm5803/cmselect/cmpubacc/1001/report.html#footnote-025-backlink

[9] https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021/adult-substance-misuse-treatment-statistics-2020-to-2021-report#meeting-the-needs-of-people-who-are-dependent-on-alcohol-and-drugs

support, but these same needs can also create barriers to accessing that support. It is not always reasonable to expect someone to show obvious motivation.

Alcohol Change UK's Blue Light Approach[10] has shown that if people need support but don't come into services, services may need to go out and find them through assertive outreach. That means making time to work with people in their own settings and build engagement with them through persistent and consistent interactions. The Draft UK Clinical Guidelines for Alcohol Treatment published by the Office for Health Improvements and Disparities[11] further endorse this as being an effective way of working. Similarly, the Making Every Adult Matter (MEAM)[12] approach provides an evidence-based framework for supporting people experiencing multiple disadvantage through coordinated, person-centred, and flexible support.

The North Yorkshire Elaine SAR[13] also highlights the importance of rethinking engagement strategies, stating:

"Engagement is the fuel on which any care process runs. Without client engagement care cannot progress. The impression is that agencies continued to attempt to engage with Elaine in the same way: making an appointment, turning up or calling and hoping she will accept contact this time. This seems to be a case of "professional optimism" triumphing over the need for a more "professionally curious" approach."

This assessment seems very appropriate to Maries' case also.

13.1 A collaborative approach

To effectively engage people with multiple unmet needs - especially those who services often struggle to reach - a new approach is required. Rather than expecting individuals to fit into existing service models, a truly collaborative approach means shifting the dynamic from expecting individuals to engage on the service's terms to adapting services to fit the individual's needs. This requires:

- Flexible, proactive engagement – Moving beyond traditional appointment-based systems and instead making persistent, low-pressure offers of support.

[10] Ward and Holmes (2014) Working with change resistant drinkers The-Blue-Light-Manual.pdf
[11] https://www.gov.uk/government/consultations/uk-clinical-guidelines-for-alcohol-treatment
[12] https://meam.org.uk/
[13] Elaine-SAR-report-final-110324.docx

- Building trust through small, meaningful interactions – Recognising that engagement is a process, not a one-off event, and that trust is built over time through consistent, non-judgmental contact.

- Multi-agency coordination – Ensuring that services work together to create wraparound support, so individuals do not experience fragmented or siloed interventions.

- Recognising engagement in all its forms – Small steps, such as responding to a text or expressing a need, should be seen as an invitation for further support, rather than a passive action.

Marie's case illustrates the need for a more assertive and relational model of engagement - one that understands the realities of trauma, adversity, and complex needs, and that prioritises persistent, person-centred support over traditional reactive models.

13.2 Motivational interventions

Commonly used in settings such as smoking cessation or diet compliance, Motivational Interviewing[14] recognises that methods based on persuasion, challenge, or confrontation are often ineffective for behaviour change and may even reinforce the defences of people who use substances. Instead of trying to persuade or confront people, which often doesn't work, it views 'denial' as a sign of deeper uncertainty about change. Practitioners focus on this uncertainty to help people move forward.

It was reassuring to hear at the Practitioner's Workshop that Marie's Care Co-ordinator used a motivational interviewing approach when considering her substance use with her. This should be considered good practice in this area.

13.3 The role of brief interventions

The NICE clinical guideline 51 highlights that opportunistic brief interventions focused on motivation should be offered to people in limited contact with Drug Services if concerns about drug use are identified by the service user or staff member. They should explore ambivalence about drug use and possible treatment, with the aim of increasing motivation to change behaviour and the provision of non-judgemental feedback.[15]

[14] https://motivationalinterviewing.org/understanding-motivational-interviewing
[15] https://www.nice.org.uk/guidance/cg51/evidence/drug-misuse-psychosocial-interventions-full-guideline-pdf-195261805

It is unclear from the chronology submitted whether Marie was offered any advice or support from Drug and Alcohol Services beyond the initial triage assessment, or indeed by other services that Marie accessed. While it is entirely possible that this happened, it is not shown in any notes provided to support this process. It is also unclear whether any harm reduction advice was given that may have supported Marie's safety while she wasn't accessing support services.

13.4 Harm reduction

Harm reduction strategies are a key element of effective substance use interventions, particularly for individuals who are not yet ready or able to stop using substances. Even where full engagement in treatment is not possible, harm reduction measures can minimise risks and improve overall safety. Key harm reduction strategies that could have been offered to Marie include:

- Advice on safer drug use - Educating her on reducing frequency, managing doses, and avoiding dangerous combinations (e.g. mixing alcohol with cocaine).
- Overdose prevention – Information on signs of overdose and how to seek emergency help.
- Access to harm reduction supplies – Providing naloxone (if opioid use is a concern), clean paraphernalia, or supervised use options.
- Peer or community support referrals – Encouraging engagement with harm reduction-focused peer groups or community services that offer low-barrier access to support.

Given Marie's known substance use and previous willingness to self-refer, the provision of clear harm reduction advice and consistent motivational support may have helped mitigate some of the risks she faced while she was not in structured treatment.

By integrating motivational interventions with a strong harm reduction framework, services can better support individuals like Marie, even in periods of disengagement or uncertainty about change.

13.5 Self-referral

In the final two weeks of her life, Marie made proactive attempts to seek support, demonstrating a level of motivation that was significant given her history of disengagement with services. For any individual, these actions would be important. However, given Marie's Traveller heritage - and the well-documented stigma around help-seeking within Gypsy and Traveller communities - her self-referrals represent a particularly meaningful act of trust and vulnerability.

Despite this, there is little evidence to suggest that her efforts were met with timely or meaningful intervention.

- On 22nd February 2023, Marie contacted the Drug and Alcohol Service to self-refer, disclosing that she was using cocaine every two days. However, there is no indication that this self-referral was followed up.

- On 23rd February 2023, Marie reached out to the Living Well service, expressing a desire to address her debts through CAB and to enrol in English and Maths courses. She acknowledged previous difficulties in engaging with support but expressed a renewed willingness to engage. Despite this, Marie was informed that her case was due to close, with a follow-up not scheduled until after staff annual leave.

These interactions suggest that Marie was taking active steps to improve her circumstances, yet the response from services was delayed or insufficient. This is especially significant when viewed through a cultural lens. For a GRT woman - where stoicism, privacy, and fear of judgement may prevent open help-seeking - Marie's outreach should have been treated as an urgent window of opportunity.
Given her known vulnerabilities, this represents a missed opportunity to provide immediate, structured support at a crucial time.

14. Criminal Justice System

Marie was well known to the Police, with 35 intelligence reports concerning her involvement with drugs, ranging from personal use to suspected supply and distribution.

During the Practitioners' Workshop, it was noted that Marie only came to police attention after meeting her husband, marking a significant shift in her circumstances. Intelligence reports documented patterns of financial transactions, known associates, and visits to her property, suggesting a level of involvement in drug activity that extended beyond personal use.

Additionally, concerns were raised about her child, who was reportedly supplying drugs from their home, further highlighting the complex and concerning environment surrounding Marie. Other intelligence linked her to fraudulent activity and various vehicles, both owned and driven by her.

Key Police contacts during the review period:

- **6th July 2022** - Marie drove a car onto a garage forecourt whilst intoxicated with her two youngest children in the car.

- **30th September 2022** - Marie took cocaine and crashed her car, stating to Police that this had been a suicide attempt.

- **4th December 2022 – 3rd February 2023** – 10 x 999 calls were made by Marie to the Police complaining of experiencing hallucinations and being scared of intruders to the house.

As a result of these incidents, Police interactions with Marie resulted in strong inter-agency collaboration, particularly in ensuring the safety of her children. Children's Social Care became involved where appropriate, and efforts were made to manage immediate risks. However, there were also missed opportunities to engage with Marie in a more meaningful way.

One such missed opportunity arose after the 6th July incident. Rather than focusing primarily on the likelihood of prosecution, greater attention could have been given to understanding the circumstances that led Marie to act in such a dangerous manner, especially with young children in her car. This could have provided an early intervention point to link to support, safeguarding, and necessary services. However, it is important to acknowledge that Marie actively evaded police contact following this event, which will have further complicated engagement efforts. Nonetheless, it is positive to note that, despite these challenges, the children's safety remained a priority.

Conversely, the 30th September incident demonstrated an example of effective intervention. Following her crash, there was a robust mental health assessment, and appropriate liaison with Marie's Care Coordinator. Risk was identified and appropriately managed, highlighting the benefits of a coordinated, multi-agency approach when dealing with individuals in crisis.

14.1 Mental Health and safeguarding procedures

Throughout the series of 999 calls there is a common theme of Marie being distressed and demonstrating paranoia that there are intruders in her home or garden, and it is evident that there were missed opportunities in terms of safeguarding responses. Key concerns include the lack of Public Protection Notices (PPNs) or referrals at the time of police attendance, as well as an absence of a structured follow-up mechanism. Of the two instances where safeguarding considerations were noted, neither appeared to result in onward referrals.

A recurring theme in these incidents is Marie's paranoia, specifically her belief that there were individuals in her garden or home. These episodes were consistently recorded as drug-induced behaviour. On each occasion, a family member or friend was present at the address, which likely influenced the assessment of immediate risk. The presence of a known individual may have contributed to a lower perceived level of harm, assuming that those present would escalate concerns if Marie's condition deteriorated. However, it is important to question whether the response would have been different had she been at home alone.

14.1.1 Hoax calls and safeguarding

A particularly notable example is the series of five calls to emergency services on 12th January. Given the frequency and nature of these calls, an Ambulance could have been requested to assess Marie's condition. The family member present also referenced drug use, further reinforcing the need for medical intervention. Despite this, subsequent calls on the same day were recorded as hoax calls, raising concerns about how these were assessed in the wider context of Marie's vulnerabilities.

In emergency services, a hoax call is typically defined as a deliberately false report made to mislead or misuse resources. However, in Marie's case, her calls appear to have stemmed from hallucinations and paranoia - symptoms often associated with underlying mental health or substance use issues. The repeated nature of her distress suggests that she was experiencing an ongoing crisis rather than intentionally misleading emergency responders.

By labelling these calls as hoaxes, there is a risk that Marie's condition was misunderstood and that her urgent needs were deprioritised. This misclassification raises questions about how emergency services assess vulnerability, particularly when mental health or substance use is a factor.

This theme has been highlighted in another North Yorkshire review, the Domestic Homicide Review of Emma[16], which observed:

"Comments on incident logs such as 'Both parties suffer from mental health issues' or 'Emma is well known for making hoax calls' suggest that in some situations staff had some preconceived ideas of what they were facing... The danger is that professionals could allow the circumstances of an incident to fit within these parameters. This would prevent a more investigative mindset to what was actually taking place."

[16] Executive Summary DHR EMMA.pdf

In Marie's case, the bias was linked to substance use and hallucinations rather than mental health, but the impact was similar: her repeated calls were deprioritised, engagement ceased, and opportunities for structured risk assessment were lost.

The decision to record Marie's later calls as hoaxes likely had several consequences. Once these calls were deemed hoaxes, Police response ceased entirely, removing a potential safety net for her. Without further intervention, Marie was left without professional assessment, which could have helped determine whether she required medical or mental health support. This classification may have also prevented referrals to the appropriate services that could have provided the necessary care and assistance.

Another significant consequence of this misclassification was the increased risk posed to Marie and those around her. Each time she contacted emergency services, she expressed a strong belief that there were intruders in her home or garden. Despite her clear distress, these claims were consistently dismissed. Without proper evaluation, it would have been impossible to determine the true extent of her vulnerability, and any potential escalation of her paranoia could have resulted in harm. The absence of any structured follow-up meant that Marie remained at risk, with no formal mechanism in place to assess or mitigate the potential dangers she faced.

Beyond immediate safety concerns, the way her calls were handled may have also influenced her willingness to seek help in the future. If Marie became aware that her reports were being categorized as hoaxes, she may have been discouraged from reaching out again, even in genuine emergencies. A lack of engagement from emergency responders could have reinforced feelings of isolation and paranoia, further exacerbating her distress and leaving her unsupported during future crises.

14.1.2 Multi-agency working

On 3rd February, a Police Officer noted in the incident log that Marie was "*well known to us*." The fact that Marie was known to Police raises critical questions regarding the level of support and intervention she received. Given the ongoing nature of her distress, it would have been important to establish whether any multi-disciplinary team meetings were convened to discuss her case and determine a structured plan of support.

Further concerns arise regarding what safeguarding measures, if any, were in place. The repeated calls to emergency services indicate a pattern of vulnerability that should have prompted a proactive safeguarding response. No safeguarding referrals were made.

Additionally, the question of which agency held primary responsibility for coordinating Marie's care remains unanswered. In cases involving complex mental health and substance use issues, a lead agency should oversee intervention and ensure continuity of care. This reflects statutory duties under the Care Act 2014 (Sections 6 and 42) and best practice guidance which emphasise the need for clearly identified lead coordination in multi-agency safeguarding work.
If no lead agency was identified in Marie's case, this would suggest a significant gap in multi-agency communication and responsibility-sharing, ultimately leaving Marie without the structured support she required.

Had a more proactive approach been taken, such as engagement with mental health services or contact with her GP, alternative interventions may have been considered. An earlier log entry by FCR Triage noted that Marie was not known to their service. In cases like this, where an individual presents with recurring mental health and substance use concerns, a more joined-up approach involving local Officers, health professionals, and safeguarding teams is essential.

A key takeaway is the need for a structured approach to assessing vulnerability, including early engagement with ambulance services and mental health teams. The presence of a family member or friend should not be the sole determining factor in risk assessment, as this may lead to missed opportunities for intervention.

Although cuckooing is a recognised risk in the context of drug supply, there is no evidence this was a factor in Marie's case. The calls about intruders occurred while she was living with her in-laws, and Police found no evidence of anyone present. Agencies did not identify exploitation.

14.2 Right Care, Right Person approach

The Right Care, Right Person (RCRP) model[17] is designed to ensure that individuals in crisis receive the most appropriate response from the right service at the right time. It recognises that while the Police play a vital role in safeguarding, they are not always the most suitable agency to lead on incidents primarily related to health and social care needs. Instead, RCRP promotes a multi-agency approach, ensuring that Health Professionals, Mental Health Teams, and Social Services take the lead where appropriate.

On 31 January 2023, North Yorkshire Police (NYP) adopted the RCRP approach[18], aligning with National Police Chiefs' Council (NPCC) legal advice and the National Partnership

[17] National Partnership Agreement: Right Care, Right Person (RCRP) - GOV.UK
[18] 'Right Care, Right Person' to be rolled-out from 31 January 2023 | North Yorkshire Police

Agreement between the Home Office and the Department of Health and Social Care, formalised in July 2023.

Under this policy, RCRP in North Yorkshire applies only to calls made by partner statutory agencies concerning the following categories:

- Concern for Welfare
- Walkout of Healthcare
- AWOL Patients (individuals who have left a medical location while under a Mental Health Act Section or as voluntary patients)
- Medical Support

Importantly, RCRP does not apply to calls from members of the public, meaning police responses to incidents involving individuals experiencing mental health crises, including drug-induced paranoia and hallucinations such as those experienced by Marie, should still be assessed on a case-by-case basis.

Several missed opportunities were identified that highlight gaps in the application of safeguarding principles and multi-agency coordination:

- Lack of oversight from force control room (FCR) triage (TEWV): Only one of the incidents appears to have been reviewed by the triage team. However, this review did not result in any actionable safeguarding steps, such as notifying the Community Mental Health Team (CMHT).
- Failure to conduct checks or consider referrals: Across multiple occurrences, particularly the repeated calls on 12th January, there is no evidence that attending Officers made background checks or considered appropriate safeguarding referrals. Given the frequency and nature of the calls, a more structured intervention should have been explored.
- Absence of a handover process: No formal handover was provided to the next shift, meaning that follow-up welfare checks were not conducted, and the case was not raised for discussion at the morning Daily Management Meeting (DMM). This lack of continuity reduced the opportunity for a coordinated response.
- Incorrect Application of RCRP: A review of the incident on 3rd February references RCRP, despite the fact that it would not have qualified under the current policy. This suggests a potential misunderstanding of the scope of RCRP and its application within NYP.

It should be noted that since this incident, North Yorkshire Police have implemented morning meetings around RCRP between themselves and TEWV.

15. Domestic abuse

Marie had described her husband as controlling, isolating her from friends, and having made her have weight loss surgery. Her mother described Marie's marriage as abusive, noting that he was a drug user and had cheated on her. She also mentioned that Marie had confided in her about the children witnessing inappropriate situations.

Marie retracted her statement to the police following the 12th June RTC involving her husband and daughter to say that she lied in her original statement and that her husband did not steal the vehicle.

Following the RTC in June 2022, Marie filed for divorce in July 2022. During her husband's imprisonment, Marie is reported to have appeared more positive and hopeful for her future. However, after his release, Marie moved in with him and his family, distancing herself from her mother and children. She became increasingly isolated from her family, and her mother reported having little contact with her in the final four weeks of her life, although she did see her eldest daughter.

It is clear from the information provided that Marie was experiencing domestic abuse and coercive control, which impacted her well-being and ability to seek support. There are multiple points where safeguarding opportunities may have been missed or where a more proactive approach could have been taken. The key points around Marie's relationship, the retraction of her statement, and her withdrawal from her family highlight some of the challenges faced by professionals when working with victims of domestic abuse.

15.1 Coercive control and isolation

Marie's husband's behaviour, as described, fits the pattern of coercive control. His controlling nature, isolating Marie from her family, and coercing her into undergoing weight loss surgery are indicators of abusive behaviour. The fact that Marie's isolation became more pronounced following her husband's release from prison, when she withdrew from her mother and children, highlights that the abusive dynamic continued to control her actions and decisions.

15.2 Withdrawal from family

After her husband's release from prison, Marie's withdrawal from her family, including her mother and children, and her lack of contact with them during the last month of her life, indicates that the abusive environment was escalating and may have led to further psychological or physical harm.

Proactive outreach by agencies, such as Children's Social Care, Mental Health Services, and Domestic Abuse Teams, could have encouraged more consistent contact and offered more direct interventions to ensure Marie's safety. In practice, however, support for Marie was delivered in silos, and no agency coordinated continuity of outreach as her isolation deepened.

15.3 Retracted statement to Police

Marie's retraction of her original statement to the police regarding her husband stealing the vehicle could be seen as a sign of fear of retaliation from her abuser or a result of coercion. Victims of domestic abuse often retract statements due to fear of further violence or manipulation, especially when the perpetrator is a close partner.

Following the retraction, it should have triggered further safeguarding actions from the Police, such as a risk assessment for domestic abuse and more direct engagement with Marie, offering her access to services like victim support and domestic abuse advocacy. There should have been an understanding that retraction often occurs in situations of coercive control, and as such, further attempts to engage Marie in a safe, confidential manner could have been pursued.

While Police records show that Marie was linked to three incidents of domestic abuse, there is no evidence that a DASH risk assessment was completed in relation to her. This limited the opportunity to assess her vulnerability systematically and to share a structured risk assessment with other agencies.

15.4 Family members assumed to be supportive

During the period of 999 calls to the Police between 4th December 2022 and 3rd February 2023, it is noted by attending Officers that Marie is supported in the home by her in-laws, and this is assumed to have reduced the risk of harm to Marie. While it might be very reasonably assumed in most situations that the presence of family members would reduce the risk of harm and that they would take appropriate action such as calling an ambulance when needed, it is worth considering that when domestic abuse is present, this might not always be the case.

15.5 The intersection between alcohol and drug use disorders and domestic abuse

Alcohol and drug use was a recurring factor in the relationship between Marie and her husband. While it is crucial to emphasise that substance use does not directly cause domestic abuse, it can contribute to it in several ways. Specifically, substance use may have:

- Increased the likelihood of abusive behaviour from the perpetrator, due to the disinhibiting effects of alcohol and drugs;
- Heightened Marie's vulnerability to abuse, making it more difficult for her to take protective actions in both the short and long term;
- Served as a coping mechanism for the ongoing abuse she experienced;
- Functioned as a tool of control, with the perpetrator supplying or encouraging drug or alcohol use as part of the abuse.

The specific impact of substance use on Marie's situation remains unclear due to limited available information. However, it is highly likely that these factors played a role at various points in her life.

15.6 The role of other services

Marie's mental health and the trauma from the domestic abuse she was enduring were significant factors that needed attention. Her mother's report of Marie being more positive when her husband was in prison and that she saw a future for herself at that time indicates that Marie might have been more open to receiving support when she was separated from her husband. However, following his release, Marie distanced herself from her family once again.

While domestic abuse was a significant feature of Marie's circumstances, there is no evidence that specialist domestic abuse or VAWG services were formally engaged in her case. This meant that safeguarding and risk management relied largely on Police, mental health, and children's social care.

Services like Mental Health Services and Social Services could have worked more closely with Marie's family members, offering them guidance and involving them in supporting Marie's safety and recovery. Additionally, Mental Health Services should have been more proactive in assessing her risk in the context of her abusive relationship, considering that domestic abuse can have profound effects on an individual's mental health, particularly when combined with trauma.

Within Children's Social Care, domestic abuse was recognised as a factor in child protection planning. However, there is little evidence that its impact on Marie herself was fully explored within core group discussions or Child Protection plans, which tended to focus on the children's immediate welfare. This limited the extent to which Marie's own needs as a victim were recognised or addressed.

The Domestic Homicide Review of Emma[19] highlighted the significant impact of child removal on a mother's wellbeing. The report noted that Emma was devastated when her children were taken into care, and this loss of her parenting role contributed to a decline in her mental health and increased her reliance on unsafe relationships. While children's needs must remain paramount, this case illustrates the importance of recognising and addressing the heightened vulnerability that parents may experience following child removal.

15.7 Cultural considerations

Domestic abuse is a significant concern within the UK's Gypsy, Roma, and Traveller (GRT) communities. While comprehensive data is limited, available research indicates that between 60% and 80% of women in these communities experience domestic abuse during their lifetimes, a rate substantially higher than the national average of 25% for women in the general population.[20]

Several factors contribute to this elevated prevalence. Cultural norms and traditions within GRT communities can sometimes perpetuate acceptance of domestic abuse, making it challenging for victims to recognise abusive behaviours as unacceptable. Additionally, limited access to support services, low literacy levels, and a mistrust of authorities further hinder individuals from seeking help. The fear of ostracism from both immediate and extended family upon reporting abuse also acts as a significant deterrent.

While domestic abuse is a pervasive issue across all communities, its impact within GRT communities is particularly pronounced due to cultural, social, and systemic barriers.

A 2019 House of Commons Committee report of the Women and Equalities Committee recommended that Local Authorities should ensure that Gypsy, Roma and Traveller women have access to a single, trusted contact who provides them with the information and support they need. Should this contact be from a charitable organisation, local authorities must ensure that the organisation has sufficient funding to sustain the necessary support.[21] The Safeguarding Adult Board should clarify whether North Yorkshire Council Gypsy Roma Traveller contact provision met this recommendation including the provision of sustainable funding.

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19 https://www.nypartnerships.org.uk/sites/default/files/Partnership%20files/Safer%20communities/DHR/Overview%20report%20EMMA%20final%20draft1-converted.pdf

20 https://www.chsgroup.org.uk/supported-services/domestic-abuse-within-the-gypsy-traveller-community/

21 https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/360/full-report.html#heading-13

16. Mental Health

Marie had ongoing mental health and substance use challenges, and there is clear evidence in the chronology that her mental health deteriorated in the final months of her life. Historically Marie was admitted to a CAMHS inpatient unit age 16 after the birth of her first child, conceived through rape during an abusive relationship.

Marie received consistent support from the Community Mental Health Team starting with a self-referral for anxiety in February 2020. The referral remained open until her death, and throughout this period, she received ongoing interventions, care, and treatment including support through the Care Programme Approach (CPA) framework. A dedicated Care Coordinator was responsible for coordinating her care and maintaining contact with her throughout her treatment.

Key interventions included home visits, discussions about her anxiety, trauma stabilisation, and medication reviews. During these visits, Marie revealed significant personal challenges, including relationship difficulties, emotional distress, and physical health issues. She experienced multiple life stressors, including marital separation and concerns related to her children, which impacted her mental health. She also received treatment for rheumatoid arthritis, asthma, and migraines.

In early 2022, Marie struggled with emotional regulation and anxiety and had ongoing difficulties with her children, including safeguarding concerns. Despite this, she engaged in services intermittently, with some cancellations and difficulties attending appointments. Throughout 2022, there were incidents of escalating concerns, including emotional issues impacting her children, her mental health challenges, and the high-risk RTC involving her children and her husband, which was followed by a strategy meeting.

Marie was prescribed various medications, including Pregabalin, Diazepam, Sertraline, and others, to manage her conditions. There was evidence of attempts to address her emotional difficulties, including referrals to Young Carers for her children and support to manage her anxiety. However, her care was marked by periods of disengagement, difficulty in following through with interventions, and concerns about her emotional state affecting her interactions with her children.

Despite receiving a comprehensive range of services, there were several gaps, such as unclear communication between professionals and a lack of coordination between Mental Health and Safeguarding Teams. There was also a delay in addressing some of Marie's emotional and mental health needs, such as failing to fully explore her trauma or adequately assess the impact of her emotional distress on her family and children.

While Marie received ongoing care from multiple services, her mental health needs and complex personal circumstances do not appear to have always been fully addressed, resulting in missed opportunities to provide more proactive or coordinated support.

16.1 Suicidality

Marie's mother reported a decline in her mental health following the car crash involving her husband and daughter in June 2022, which led to Children's Social Care service involvement and safeguarding concerns for her children. Marie had documented in her own notes on her laptop that she felt her life was *"beginning to crumble*" at that time.

Marie's substance use, particularly with opioids, contributed to her vulnerability in this area. People who use opioids are known to be up to 14 times more likely to die by suicide than the general population[22].

Key incidents involving suicidal behaviour:

- **30th September 2022:** Marie crashed her car after using cocaine and told the police that the incident was a suicide attempt.

- **4th March 2023:** Marie was found unresponsive at home after taking an overdose and was subsequently taken to hospital. Upon discharge on 5th March, Marie refused to speak to the mental health team.

- **6th March 2023:** Sadly, Marie passed away from a cardiac arrest caused by an overdose.

16.1.1 Assessment and response

The Mental Health Trust case review noted that Marie had attended ED on 4th March 2023, reporting an overdose of Pregabalin, a medication prescribed for anxiety. However, it was unclear whether a full mental health assessment was conducted to determine her intent when taking the overdose.

At approximately 13:00 on 5th March, an ED clinician contacted the Hospital's Mental Health Liaison Team for a potential referral. However, the referral was not accepted, as Marie was pending admission to a ward for treatment. The clinician was advised to ask the ward to handle the referral, which could have been accepted at that time, potentially improving the response. It was noted that at 17:35hrs, Marie refused to speak to the

[22] https://link.springer.com/article/10.1007/s40429-021-00361-z#Sec7

Mental Health Team, and the ED Sister assessed that she had the capacity to make this decision.

However, the quality of the capacity assessment raised concerns, particularly regarding whether the rationale for supporting Marie's decision was adequately documented. The question remained as to whether a more formal mental health assessment should have been pursued, especially considering Marie's history of suicidality.

Further review by the Acute NHS Trust noted some uncertainty around whether the Mental Health Team was responsible for reviewing Marie during her ED attendance, and there was no documentation confirming if she had the capacity to refuse engagement with the Mental Health Team. This suggests potential gaps in the assessment and referral process.

16.1.2 Risk assessment and management

In her safety summary, last updated in January 2023, risks were identified, including self-harm due to illicit substance use, ongoing life stressors (such as involvement with Children's Services), and the historical trauma she had experienced. While Marie denied thoughts of self-harm and identified her children as protective factors, the safety plan had not been updated with her input, and no evidence suggests that any active risk management strategies were employed to address her increasing vulnerability.

In particular, there was no clear documentation of changes to her risk status or proactive measures to address her suicidality, despite the ongoing pressures she faced in her personal life and the risk associated with her substance use.

While some risk factors were identified, the lack of a clear and consistent approach to monitoring Marie's mental health, particularly following her overdose incidents, raises concerns. The failure to adequately assess her suicidal intent, combined with gaps in the referral process, contributed to the lack of a comprehensive safety plan.

There appear to be missed opportunities to address risks posed to Marie, particularly after the overdose incidents and during Marie's engagement with healthcare services. The lack of a thorough and coordinated mental health response, alongside missed referrals, suggests that more assertive interventions and follow-up support could have been offered.

16.1.3 The children as a protective factor

Following the incident on 30th September 2022 when Marie crashed her car, she described her children as being a protective factor against her risk of suicide. Primary care also describe her children as a protective factor. It is unclear whether the suicide risk was re-assessed at any point following the children being taken into the care of the local authority in November 2022 after a safeguarding referral. Deeper curiosity with regard to the impact of this could have benefited Marie.

16.1.4 Domestic Abuse as risk factor for suicide

In 2024, the government announced that 'Domestic Homicide Reviews' would be renamed 'Domestic Abuse-Related Death Reviews.' This change aimed to acknowledge the often-overlooked victims of domestic abuse who die by suicide as a result of their experiences. A 2022 Lancet study found that nearly half (49.7%) of all suicide attempts in the UK were linked to domestic abuse, highlighting the profound impact of such trauma on mental health.[23]

The Department of Health's Suicide Prevention Strategy also recognises this connection, stating that "new and better-quality evidence has emerged pointing to links between suicide and risk factors such as…domestic abuse".[24]

Marie had experienced domestic abuse in her marriage, but it is unclear whether this directly contributed to her suicide. Other significant factors, such as her history of substance use and the removal of her children into local authority care, undoubtedly played a role. However, her case underscores the importance of professional curiosity - ensuring that practitioners consider the potential impact of domestic abuse when assessing individuals at risk of suicide and, conversely, recognising suicidality as a possible indicator of the existence of abuse.

16.1.5 Cultural risk factors for suicide among GRT women

It is important to recognise the cultural and structural factors that may have contributed to Marie's suicide risk. Research has shown that Gypsy, Roma and Traveller (GRT) women are at significantly higher risk of suicide than the general population, with some studies indicating rates up to six or seven times higher[25]. Contributing factors include experiences of discrimination, social exclusion, poor access to healthcare, low attainment at school, and cultural stigma around mental health and substance use. GRT

[23] Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England - The Lancet Psychiatry

[24] Suicide prevention in England: 5-year cross-sector strategy - GOV.UK

[25] The Traveller Movement (2019). *"The last acceptable form of racism? The pervasive discrimination and prejudice faced by Gypsy, Roma and Traveller communities."* https://travellermovement.org.uk/reports

women may also carry a strong sense of duty as carers and face cultural pressures to maintain family honour and resilience, which can make it particularly difficult to seek help for emotional distress or abuse. Fear of shame, judgement, or ostracism may further prevent engagement with services.

In Marie's case, these cultural considerations, combined with known risk factors such as domestic abuse, substance use, and the loss of custody of her children, may have compounded her vulnerability. A culturally competent understanding of suicide risk among GRT women is essential for early identification and appropriate, sensitive intervention.

16.1.6 The need for a more proactive and coordinated response to suicide risk

Marie had multiple risk factors for suicide, including her cultural identity, substance use, past trauma, mental health deterioration, a history of impulsivity and significant personal stressors. Despite these, there were missed opportunities for proactive intervention, particularly after her overdose incidents. The lack of a formal mental health assessment following her overdose on 4th March, and the uncertainty about her capacity assessment, highlight gaps in the crisis response.

17. Multi-agency management

There is evidence of effective multi-agency communication, particularly in relation to child safeguarding, where timely referrals, attendance at meetings, and inter-agency cooperation were well established. The Mental Health Trust maintained good communication with the GP, Drug and Alcohol Services, and Social Care, ensuring relevant information was shared.

However, missed opportunities were identified. While multiple agencies were involved in her care, there was a lack of multi-agency meetings focused on her risk management, meaning professionals worked in isolation rather than through a coordinated approach. The absence of a structured review process contributed to gaps in updating Marie's safety plan and clarifying agency responsibilities, particularly during crisis episodes.

Poor information sharing between mental health and emergency services meant that significant incidents, such as Marie's "hoax" calls to the police, hospital attendances, and previous overdose, were not fully recognised as indicators of escalating risk. Had a multi-agency meeting framework been in place, these concerns could have been reviewed holistically, enabling a more proactive intervention strategy.

Multi-agency working was effective in child safeguarding but lacked a coordinated response for Marie herself. Improved multi-agency risk management meetings and real-time information sharing between mental health, emergency services, and safeguarding teams could have provided a more structured and proactive approach to her care.

A similar theme regarding a lack of multi-agency meetings was identified in the 2023 North Yorkshire James SAR:

"The review identified that although several agencies held information regarding the risks presented by James, such as self-harm and substance misuse, there was an apparent lack of multi-agency meetings taking place.

Had these meetings occurred, it was considered this may have benefitted in information being shared in real time, enabling strategies to be established to manage the cumulative risk posed and address issues for example such as James' disengagement with agencies."[26]

This observation seems appropriate for this case also.

The "What about the children?" report by Ofsted and the Care Quality Commission examines how Adult Mental Health and Drug and Alcohol Services consider the impact on children when parents or carers face such challenges. It recommends that:

"Local authorities, mental health services and drug and alcohol services should ensure that staff liaise with each other and agree a joint plan of action when parents or carers do not attend appointments with adult services."[27]

Marie was known to multiple services, yet professionals were unclear on referral responsibilities during her crisis episodes. The lack of coordination between services may have contributed to her disengagement and unmet needs.

Some agencies were unaware of Marie's cultural identity as a Traveller and so this was not discussed or considered as a factor that could influence her engagement or perceptions of services, despite national guidance[28] highlighting this as a key consideration in safeguarding practice. Multi-agency working would have assisted this.

North Yorkshire operates a Multi-Agency Safeguarding Hub (MASH) and follows the joint safeguarding adults policy and procedures shared between North Yorkshire and City of York. However, this review found no evidence that formal multi-agency case conferences were convened specifically to coordinate risk management for Marie as an adult with

[26] https://safeguardingadults.co.uk/learning-research/nysab-learning/sar-james/
[27] https://assets.publishing.service.gov.uk/media/5a81a56be5274a2e87dbebf7/What_about_the_children.pdf
[28] https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/360/360.pdf

complex needs. While multi-agency working was evident in relation to child protection, adult-focused case planning was fragmented. This suggests that existing structures may not be consistently utilised or sufficiently tailored for adults experiencing dual diagnoses, domestic abuse, and self-neglect. It is important to note that, unlike children's safeguarding, the legislative and policy framework for adults is different, and any equivalent to a MASH or lead professional system would necessarily look different and require national policy and funding decisions. Strengthening the use of multi-agency meetings for adults at risk could improve coordination and outcomes.

18. Professional curiosity and trauma-informed approaches

We know that Marie had experienced considerable trauma in her teens and into adulthood. Her eldest daughter had been conceived as a result of rape when she was 15, and her uncle then killed the attacker. Marie had recently decided to leave an abusive relationship but was living with his family, and her children were subject to care proceedings and living away from her.

Marie seemed to decline throughout the last year of her life, displaying increasingly concerning behaviours such as driving whilst under the influence of alcohol and cocaine, making multiple 999 calls, and regular substance use. It is unclear whether the background as to *why* Marie might be presenting in the way that she was, was considered, or whether her actions were taken on face value.

Put simply, when confronted with challenging behaviours, were professionals asking *What has happened to this person?* as opposed to *What is wrong with this person?*

19. Safeguarding interventions

While there were many safeguarding concerns being raised, these were primarily about the health and wellbeing of the three children. There were, however, missed opportunities to raise adult safeguarding concerns in respect of Marie:

Emergency Department (ED) and Mental Health Liaison Team communication:

- The Community Team at the CMHT was not made aware that Marie had taken an overdose on 04/03/2023 or that she had received emergency care over that weekend period.
- The liaison team did not submit a DATIX (incident report) to alert the Community Team of the self-harm incident or the safeguarding concerns for the children's welfare. This lack of communication meant that the Community Team was unaware of the overdose and could not offer increased support or follow-up.

Documentation and incident reporting:

- Contacts between the Mental Health Liaison Team, a ward on which Marie was pending admission to complete treatment, and the ED, were not documented on the Trust's care record system. This lack of documentation prevented the Community Team from being informed about Marie's attendance at the ED and the associated risks.
- There was no incident report created to show that Marie had attended the ED, which would have been crucial for ensuring that all relevant teams were aware of the situation and could respond appropriately.

The absence of safeguarding concerns raised specifically about Marie as a vulnerable person highlights the need for better communication and documentation practices between the general hospital and mental health clinicians to ensure that safeguarding concerns are promptly raised and addressed.

In addition, there is no evidence that a formal safeguarding referral under Section 42 of the Care Act was considered for Marie herself, despite her escalating risks. This left safeguarding processes focused almost exclusively on her children, with little equivalent consideration of her own status as an adult at risk.

The Anne SAR for North Yorkshire SAB recognised this as a concern beyond the Acute Trust. It recommended that *"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."*[29]
This same recommendation seems appropriate in the light of this current SAR.

20. Using the Mental Capacity Act

Marie was repeatedly assessed as having mental capacity regarding her care decisions. Mental Health Services determined she had capacity during interactions, including a Police custody assessment, where she was able to understand, retain, and weigh information for decision-making. Primary Care acknowledged a presumption of capacity but noted potential impairment due to slurred speech during a consultation, suggesting an assessment should have been conducted. The Police *"when encountering Marie in custody did encourage and engage [her] in developing her care plan, ensuring she was able to receive the help and support she needed and requested"* but recognised

[29] 'Anne' - Safeguarding Adult Review (NYSAB)

instances where her fluctuating capacity might have warranted referrals without consent.

On 4th March 2023, Marie was admitted to the ED following an overdose, with reduced consciousness. There was uncertainty regarding her capacity at discharge, as documentation did not clarify if she was assessed before refusing mental health intervention. A safeguarding referral was submitted for her children. The hospital has since implemented electronic records with capacity assessment prompts.

While the MCA was referenced across agencies, its application was inconsistent. TEWV and the Police largely assumed Marie had capacity without detailed reassessments, despite indications of fluctuating mental state. Primary Care highlighted a potential lapse in capacity assessment when her speech was slurred. The hospital records lacked clarity on whether Marie had the capacity to refuse mental health support before discharge. The lack of a structured approach to fluctuating capacity may have impacted the support she received.

Improvements, such as the Emergency Department's new electronic prompts for capacity assessment, suggest a recognition of gaps in practice. However, a more proactive and structured application of the MCA, particularly in cases of possible impairment or fluctuating mental health, may have allowed for earlier interventions and more tailored support.

21. Care and support needs – thresholds and the Care Act

Marie was referred by her community mental health care coordinator to the Living Well service within Adult Social Care in November 2022, following significant changes in her circumstances. Living Well provides preventative support for adults whose needs do not meet the statutory threshold for a Care Act assessment. On this basis, a formal Care Act assessment was not undertaken, and ASC's involvement remained limited to the preventative role offered by Living Well.

Marie was known to multiple services and presented with a range of complex and interwoven needs including mental ill-health, substance use, domestic abuse, housing instability, and social isolation. She experienced periods of crisis, disengagement, and declining ability to care for herself and her children, all of which may have amounted to self-neglect under the Care Act 2014.

In hindsight, a Care Act assessment would have enabled a more coordinated, person-centred response to her multiple vulnerabilities and could have triggered greater inter-agency planning, support, and monitoring.

While the decision not to progress to a statutory assessment was consistent with thresholds at the time, the case highlights the importance of:

- Ensuring that decisions about Care Act eligibility are clearly recorded.
- Reconsidering eligibility where risks escalate or needs become more complex.
- Using the Care Act framework proactively as a mechanism for bringing agencies together around adults with multiple disadvantage.

22. Cultural context – Traveller heritage and safeguarding practice

Marie was described by her mother as a "proud Traveller," and her cultural identity played a significant part in how she lived and engaged with services. It is therefore important that this review recognises the specific barriers faced by individuals from Gypsy, Roma and Traveller (GRT) communities in accessing support, especially in relation to domestic abuse, mental health, and substance use.

GRT communities are known to experience:

- Higher levels of stigma and discrimination when accessing public services;
- Low levels of trust in statutory services, including the police, social care, and health;
- Close-knit family structures which can sometimes compound isolation or limit disclosure in cases of domestic abuse;
- Cultural expectations around privacy, loyalty, and autonomy, which may inhibit engagement with external agencies.

These cultural barriers are echoed in national research. The Women and Equalities Committee (2019) highlighted the need for local authorities to improve access to culturally competent support for GRT women, including through a single trusted contact. This recommendation takes on particular relevance in light of Marie's background and the support she may have needed but not received, where her cultural background may have impacted her ability - or willingness - to engage with services.

In Marie's case, it is not clear whether her Traveller identity was explored as a potential barrier to engagement. Although her mother provided helpful insight, there is no evidence that professionals reflected on how cultural norms might have affected Marie's willingness to access services, disclose abuse, or accept support. Indeed, it was

commented in the practitioners' workshop that some services were not aware of Marie's cultural heritage.

The Safeguarding Adults Board should satisfy itself that:

- Professionals receive appropriate training in cultural competence relating to GRT communities;
- There is access to culturally sensitive advocacy or liaison services where needed;
- Safeguarding responses are not based on assumptions about family structures, and that risks of abuse or isolation are fully explored, even where family members are present.

22.2 Kinship care and cultural expectations in GRT communities

Marie's children were placed in the care of her mother, their grandmother, who played a central role in their lives both before and after Marie's death. This arrangement reflects a common pattern within Gypsy, Roma and Traveller (GRT) communities, where extended family members often step in as kinship carers during times of crisis. Such arrangements are rooted in cultural expectations of family loyalty, duty, and community care.

However, despite the protective nature of this arrangement, Marie's mother disclosed during the review that she experienced financial hardship as a result of taking on full-time care for her grandchildren. She was forced to give up her paid employment and received limited formal financial or practical support. This reflects a broader issue in kinship care arrangements where the support needs of carers can be overlooked, particularly when those carers do not actively ask for help.

In GRT communities, women are often described as "stoic", expected to "get on with it" and manage hardship without complaint. There may be cultural shame associated with admitting struggle or asking for help, especially from statutory agencies. Combined with a mistrust of services among GRT communities, this may lead to hidden need, even in cases where carers are struggling financially or emotionally.

This raises the question of whether more proactive assessment of kinship carers' support needs - particularly financial support - should have been undertaken. This could include eligibility for Kinship Carer Allowances, welfare advice, or access to practical support services. While Marie's mother did not request additional help, it is important to understand that not asking does not equate to not needing, particularly in this cultural context where self-reliance is highly valued.

Future practice should consider the potential invisibility of hardship in kinship care settings, and services should be encouraged to sensitively explore support needs, even

in the absence of explicit requests. This would align with a trauma-informed, culturally competent, and family-centred safeguarding approach.

22.3 Cultural significance of personal belongings after death

During the review, Marie's mother shared that she was awaiting the return of items of Marie's clothing. It later emerged that the hospital had destroyed her clothing following her death rather than returning these items to the family. While this may have been done in line with hospital policy (e.g. due to contamination), there was no evidence of this decision being communicated to the family, and it has the potential to cause significant emotional distress.

In many GRT communities, there is deep cultural significance attached to a person's belongings after death. It is customary for all of the deceased person's possessions to be gathered together, and for each loved one to choose a meaningful item to keep. Once this has been done, the remaining belongings are often ceremonially destroyed in a final act of letting go. This practice is rooted in a strong tradition of honouring the person's spirit and ensuring closure for the family.[30]

Given this cultural context, the hospital's decision to dispose of Marie's clothing without consultation or explanation represents a missed opportunity to demonstrate cultural sensitivity and compassionate practice. It highlights the importance of culturally sensitive bereavement care, particularly in relation to end-of-life customs that may not be widely understood in clinical settings. While infection control or other concerns may require the disposal of items, open communication with the family is essential, especially when working with communities for whom such practices carry spiritual meaning.

Future training and guidance for hospital staff should include awareness of the bereavement customs of GRT communities and other culturally diverse groups to ensure that support offered in the aftermath of a death is respectful and inclusive.

23. Impact of Covid-19

There is no evidence that responses to Marie were affected by the pandemic.

[30] Lane, P., Price, J., & Spencer, S. (2023). "The Last Journey: The Funeral Rites and Cultural Needs of Gypsies and Travellers."

24. Key Learning Points

Marie's experiences highlight a series of interlinked systemic, procedural, and engagement challenges across multiple services. The key learning points are as follows:

24.1 Substance use and engagement

Existing engagement strategies do not always meet the needs of individuals experiencing complex trauma. A model that discharges people after a set number of unsuccessful engagement attempts may inadvertently exclude those who are most vulnerable and most in need of sustained, trauma-informed support.

24.2 Inconsistent use of safeguarding procedures

There were missed opportunities to raise safeguarding concerns specifically in relation to Marie (in addition to concerns about her children), particularly following overdose and other crisis events.

24.3 Domestic abuse and coercive control

The extent and impact of coercive control in Marie's life may not have been fully recognised, especially when she withdrew from services or retracted allegations. A stronger understanding of the dynamics of coercive control may have led to more consistent professional responses.

24.4 Mental Capacity Assessments

The application of the Mental Capacity Act appeared inconsistent and under-documented, particularly in the context of fluctuating mental health and substance use. This may have hindered timely and appropriate interventions.

24.5 Mental health and suicide risk

Marie's suicide risk does not appear to have been consistently reviewed, especially following major life changes such as the removal of her children. While her children were considered protective factors, this assumption was not clearly revisited after their care arrangements changed.

24.6 Multi-agency working

While child safeguarding procedures were well established, adult risk management was less coordinated. The absence of regular multi-agency meetings may have contributed to siloed information and a lack of shared understanding of risk.

24.7 Cultural awareness
Marie's Traveller identity does not appear to have been fully considered in how services were offered or delivered. This is significant given the well-evidenced barriers that Gypsy, Roma and Traveller (GRT) communities face in accessing statutory support, particularly in relation to health, safeguarding, and mental health.

24.8 Crisis response and emergency services
Some of Marie's distress calls were recorded as hoaxes. This classification, combined with a limited exploration of the wider context of these calls, may have contributed to missed opportunities for intervention.

24.9 Missed opportunities for assertive outreach
Although Marie was disengaged at times, there were late signs of help-seeking behaviour (including self-referrals shortly before her death) that may not have been fully recognised or followed up with assertive outreach.

24.10 Information sharing and follow-up care
In several instances, there was a lack of timely information-sharing between emergency departments and community mental health teams, including after overdose events. This limited the opportunity for coordinated proactive follow-up care.

24.11 Culturally sensitive end-of-life care
The absence of consultation around post-death procedures (such as the handling of personal belongings) may unintentionally cause distress for families, particularly those from communities with specific cultural bereavement traditions, such as Gypsy and Traveller groups. Greater awareness and proactive communication can help ensure that end-of-life care is delivered in a culturally respectful and compassionate way.

24.12 Professional curiosity and trauma-informed approaches
Marie's challenging behaviours were linked to historical and ongoing trauma. There was a lack of exploration into the underlying trauma influencing her disengagement and crisis behaviours.

25. Good practice

Many agencies made efforts to help Marie. Of note across agencies was excellent practice to safeguard the children with good multi-agency work to achieve this.

25.1 Children and Families Services

Children and Families Services played a crucial role in supporting Marie and her family during a particularly challenging period. Despite the difficulties involved, Marie engaged positively with the support offered, recognising the need for intervention to ensure the well-being of her children.

The service provided structured and ongoing support, including parenting assessment sessions, regular core group meetings, and Public Law Outline (PLO) meetings. A proactive approach was taken in coordinating Family Group Conferences to facilitate open discussions and collaborative decision-making. In addition, referrals were made to the Drug and Alcohol Service to address Marie's substance use, demonstrating a commitment to ensuring she had access to specialist support.

A key strength of the intervention was the positive and consistent relationship maintained between Marie and her Social Worker. This relationship fostered trust and engagement, enabling Marie to work constructively with professionals involved in her care. Effective communication between agencies including Mental Health Services, ensured a well-integrated approach to supporting both Marie and her children.

Although the involvement of Children and Families Services was understandably difficult for Marie, they note that she remained open to the support provided and worked collaboratively with professionals and family members to maintain the safety and stability of her children. A strong multi-agency network was evident throughout, characterised by good communication and proactive intervention. This collaborative approach enabled Marie to sustain positive relationships with key professionals, including her children's social worker and her children's school headteacher. The coordinated effort across agencies highlights effective multi-agency working and demonstrates the value of strong partnership approaches in safeguarding and family support.

25.2 Mental Health NHS Foundation Trust

The Community Team Care Coordinator demonstrated best practice in supporting Marie through structured and proactive interventions. They provided ongoing emotional support, helping her manage distress while maintaining regular contact. Coordination between agencies was effectively facilitated through the children's safeguarding team and the Child Protection Plan, ensuring a well-integrated approach to care.

A key strength of the Community Team's approach was their flexible and patient-centred engagement strategy. Staff worked closely with Marie to maintain consistent contact and

encourage appointment attendance, offering a responsive and adaptable approach that included ad hoc home visits when needed.

25.3 Primary Care

The role of the GP team in Marie's care demonstrates strong clinical awareness and a proactive approach to safeguarding. Recognising the risks associated with prescribing dependence-forming medication, they considered how Marie's social circumstances and mental health challenges influenced her substance use. This case highlights the importance of assessing the broader context in which a patient presents - factors such as socioeconomic disadvantage, social isolation, stressful life events, and co-existing physical or mental health conditions can significantly increase the risk of harm.

Best practice was evident in the GP's approach to risk management. They implemented risk-reduced prescribing strategies when Marie's medication-seeking behaviour escalated, ensuring that her treatment remained safe and appropriate.

26. Summary of learning

Although described by professionals and family as spirited, loving, and devoted to her children, Marie experienced overlapping challenges including domestic abuse, substance use, mental ill-health, and the removal of her children. She was known to multiple services, but support was often fragmented, short-term, or focused on a single presenting issue. While there were periods of concern and intervention, these did not always translate into coordinated or sustained responses.

Marie's identity as a Traveller woman adds important context. Cultural stigma around substance use and mental health may have made it harder for her to ask for help, and services may not have fully recognised the cultural barriers she faced in doing so.

Marie's experiences reflect the ways in which trauma, cultural identity, social exclusion, and system-level gaps can intersect. No single agency appeared to hold a full understanding of her needs or circumstances. This review reinforces the importance of multi-agency working that is joined up, culturally competent, and responsive to complexity.

Marie's story reminds services of a need to evaluate how they work with those individuals whose trauma may manifest as disengagement, whose cries for help may appear chaotic, and whose lives do not fit neatly into traditional service models. Her case

reinforces the importance of seeing the person behind the behaviour - and recognising that those most in need are often the hardest to reach.

27. Recommendations

Recommendation A: Cultural competency framework

The SAB should seek assurance that a framework to support culturally competent practice with GRT communities is available to staff and is embedded within practise and training.

Recommendation B: Embed and align trauma-informed practice across all safeguarding partners

The SAB should seek assurance that trauma-informed practice is embedded across all safeguarding partner agencies. This should include ensuring access to appropriate training and supervision, and that existing programmes are strategically and operationally aligned.

This aligns with the SAB's April 2025 Priorities, in particular Priority 3: Confident Practice, which highlights the importance of practitioners working in a trauma-informed way.

Recommendation C: Improve Mental Capacity Assessments in crisis settings

The SAB should seek assurance that there is guidance on how to use the Mental Capacity Act in a consistent and structured way in situations involving fluctuating mental state.

Recommendation D: Build Assertive Outreach principles into existing services

The SAB should assure itself that assertive outreach principles are embedded within existing frontline services such as the Drug and Alcohol Service, Living Well teams, and Mental Health Teams.

Recommendation E: Domestic abuse and suicide link protocol

The SAB should seek assurance from commissioning services that a protocol exists which supports professionals in recognising and responding to the intersecting risks of domestic abuse and suicide.

This should include guidance on risk assessment, information-sharing, and referral pathways across agencies.

Recommendation F: Review and adapt engagement policies

The Safeguarding Adults Board should seek assurance from Public Health Commissioners and providers of drug and alcohol services that engagement and assessment protocols are evidence based, facilitate engagement and robust risk assessment, and are appropriately reviewed and audited, with particular attention given to how they deliver flexible, tailored interventions and deliver effective support for all people who experience harmful substance use.

This assurance should take into account the forthcoming redesign of substance use services, including the planned multiple disadvantage offer across housing, substance use and social care mental health, to ensure that the learning from this SAR is embedded within the new model and aligned with North Yorkshire's substance use strategy.

Recommendation G: Strengthen use of multi-agency case conferences

The SAB should seek assurance that multi-agency case conferences for adults with complex needs are used consistently, and that this work is explicitly linked to the existing MASH and the Joint Safeguarding Adults Procedures. This should take account of the work currently underway across HAS and Localities to review MDT arrangements, to ensure that the learning from this SAR informs that review.

The SAB should also seek assurance that frontline agencies, such as NHS mental health services and the Police, understand their role in convening such meetings when risks to adults escalate, and that these are clearly linked into the existing MASH and Joint Safeguarding Adults Procedures.

Recommendation H: Review Emergency Department pathways for mental health crisis

The SAB should seek assurance that in line with NICE Clinical Guidelines CG133 and NG225, Emergency Department pathways ensure follow-up is initiated within a defined period (48 - 72 hours) after attendance at ED for self-harm, overdose, or mental health crises.

Recommendation I: Coordination of Care for Adults with Complex Needs

The SAB should seek assurance from partner agencies about the arrangements currently in place to ensure effective coordination and oversight of care for adults with complex needs receiving input from multiple services. This should reflect the distinct statutory framework for adult safeguarding, recognising that approaches to coordination will differ from those used in children's services.

This should be aligned with the forthcoming Adult Social Care restructure, which is intended to enhance capacity and skills for working with people with complex needs, and offers a timely opportunity to embed learning from this SAR.

Recommendation J: Improve identification and use of Care Act Assessments

The SAB should seek assurance that professionals consistently consider both Care Act assessments (s.9) and safeguarding enquiries (s.42) for adults with complex needs, particularly where risks are escalating due to self-neglect, fluctuating mental health, domestic abuse, or disengagement from services.

Appendix

Key Lines of Enquiry

1. *Responses to risk, including safeguarding processes and information sharing*
    - Were risks around domestic violence appropriately identified and responded to?
    - Were safeguarding referrals made when risks were identified and were these responded to appropriately?
    - Did professionals identify and respond to self-neglect concerns?
    - Was professional curiosity evident in the professional involvements with Marie and family?
    - Were opportunities missed to identify and offer support for suicidal ideation throughout the chronology period?
    - Is there evidence that an effective multi-agency response (with effective information sharing) was provided for Marie?

2. *Access and pathways into services*
    - Were referrals made at reasonable/appropriate times?
    - Should Marie have been offered an assessment under the Care Act 2014? Was the Living Well service most appropriate for her?
    - Was a 'Think Family' approach used by Children's Services to support Marie and her family (and identify the support they needed)?
    - Was information effectively shared by professionals, to enable all services to have a full picture of Marie, particularly as her general wellbeing declined towards the end of the chronology period?
    - Was support available to help Marie make and maintain initial contact with new agencies? For example referrals to domestic abuse and substance use organisations?

3. *Medication management*
    - Were Marie's medications reviewed regularly? Was due consideration given to all the prescribed medications (and the impact of these) at reviews?
    - Was professional curiosity and risk assessment evident when Marie requested additional medications due to loss/theft of the originals?
    - Were there suitable controls around the prescribing and reissue of medication?

4. *Hospital attendances and discharge processes*
    - Were opportunities missed to safeguard Marie when she chose to self-discharge from A&E the day before her death?
    - Was information on risk shared appropriately to ensure she received adequate and timely follow-up in the community?

- Was due consideration given to mental capacity, and to Marie's overall mental state, at point of discharge?

5. *Covid 19 pandemic*
    - Is there evidence that response to Marie were affected by the pandemic and is there any learning to be taken from this?

6. *Good practice*
    - Are there examples of good practice from this case which could support learning in similar situations?