North Yorkshire Safeguarding Adults Board

Safeguarding Adult Review – Gemma

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1. Introduction

Gemma[1] was a 38 year old white British woman who died in 2021. In late July, neighbours became concerned about a sour, strong smell coming from Gemma's flat. The Police entered the property and Gemma was found deceased. The Coroner concluded that this was a "drug-related death". The cause of death was cardiorespiratory arrest due to the effects of a combination of prescribed methadone, prescribed pregabalin and cocaine.

She had a background history of substance use disorders, adverse childhood experiences and domestic abuse, criminality, threats of suicide and mental health problems. Professionals also found it difficult to engage her into services.

A Section 44 referral for a safeguarding adult review (SAR) was submitted by North Yorkshire County Council Health and Adult Services as a result of concerns about the lack of a coordinated response, workers' understanding of working with people at risk of self-neglect and indicators of risk that were not escalated.

The SAB Learning and Review Group, which makes decisions on proceeding to a SAR, agreed that the case highlighted a number of areas of potential learning, and decided that that a SAR should be undertaken. This SAR considers a period from July 2020 until Gemma's death in July 2021.

A significant amount of time has passed since Gemma's death and, while looking at agency reports, it was clear that much may have changed since then, particularly as the period coincided with the Covid lockdowns. However, this report needs to consider the response during the review period. When action planning against the recommendations, agencies can determine how recent changes may have met the requirements highlighted in this report.

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.
- To improve practice by acting on learning.

[1] A pseudonym

- 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 Gemma from harm.

3. Independent Review

Mike Ward was commissioned to write the overview report. He has been the author of over thirty SARs as well as drug and alcohol death reviews and a member of a mental health homicide inquiry team. He worked in Adult Social Care for many years but in the last decade has worked mainly on developing responses to change resistant dependent drinkers.

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. Initial information was sought from agencies involved with Gemma by requesting chronologies and Individual Management Reports. More detailed information was sought from the involved agencies via an online Practitioners' Event in January 2025.

The following agencies were involved in the process:

- North Yorkshire Horizons (Alcohol and Drug Service)
- Tees, Esk and Wear Valleys NHS Foundation Trust (Mental Health Trust)
- Primary Care
- Yorkshire Ambulance Service
- North Yorkshire Police
- Harrogate and District NHS Foundation Trust
- North Yorkshire Council (Prior to April 2023 - North Yorkshire County Council)

Some of the information provided included information from outside the review's time period enabling a fuller picture of Gemma to be developed. All of the material was analysed by the author and an initial draft of this report went to the Review Panel in March 2025. Further changes were made over the next two months, and a final draft was completed in May 2025.

5. Family contact

An important element of any SAR process is contact with family. The author identified family members who might have been consulted; but contact has not been possible.

6. Parallel processes

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

7. Background and personal Information

Gemma reported that she had had numerous adverse childhood experiences. The details of these are not clear but it is known that her father left when she was 5 years of age, but that she did have some contact with him in her life. She had opiate and cocaine dependence from the age of 16. A CAMHS referral was made in 1995 and their assessment noted that Gemma was refusing to attend school, reported bullying, said that she had no friends, had low self-esteem and low mood.

As an adult, her personal life was also difficult, marked by the birth and subsequent removal of two children (May 2013, June 2016). It is likely that these two experiences had a real impact on her decline; her Drug and Alcohol Worker attempted to explore these issues but it was reported that she appeared unwilling to open up about this. At one point in the last year of her life she claimed, wrongly, to be pregnant and it was suggested that this claim may have been linked to those earlier traumas. Her history certainly highlights an individual struggling with considerable emotional pain and experiencing long term anxiety and addiction issues, compounded by high-risk domestic abuse.

However, staff who knew her described her as "*resilient*", "*very astute*", "*vivacious*", "*outgoing*", "*switched on*" and "*having real insight into her problems*". She was described by the Drug and Alcohol Service as "*loving artwork*".

At the age of 19 (2001-02), Gemma received an eight-month prison sentence for deception, due to trying to raise money for illicit drugs. In the subsequent years she had an extensive history of involvement with the Criminal Justice System. (She was also imprisoned in 2005 and 2017). In the period from her first conviction in February 2000 to her last conviction in January 2021, Gemma had 186 offences recorded resulting in 48 convictions including:

- 5 Offences Against The Person (2006-2021)
- 2 Offences Against Property (2004-2006)
- 78 Fraud And Kindred Offences (2000-2017)
- 62 Theft And Kindred Offences (2000-2019)
- 5 Public Disorder Offences (2012-2019)
- 31 Offences Relating To Police/Courts/Prisons (2000-2020)
- 3 Drug Offences (2014-2021)

Additionally, there are many documented instances where Gemma had tried to access additional prescription medications, often claiming medication had been lost or stolen under suspicious circumstances. Frequent changes in GP registrations to access medications were noted in 2011 and Gemma was removed from a GP practice in November 2011 after being seen on CCTV entering prohibited areas within the practice.

She also changed GP practice during the review period. However, this was most likley due to her moving home. Positively, this seemed to be in pursuit of a new start. However, this did not transpire.

The Mental Health Trust report ed that Gemma had multiple referrals to Mental Health Services between 2009 and 2021. In the review period there were also a few contacts with Adult Social Care Mental Health Practitioners. Various agencies record differing mental disorders associated with her, including bi-polar disorder, anxiety, depression and obsessive-compulsive disorder. However, in the review period she was only engaged with Primary Care as a result of depression and anxiety for which she was, at points, receiving anti-depressant medication.

More crucially, Gemma had repeated instances of self-harm / suicidality thoughout her adult life e.g. intentional overdoses were recorded in June 2002 and June 2003. This pattern continued into the review period and, as noted, she appears to have died of a drug overdose. It is unclear whether this was intentional or accidental although the death was ruled drug related, not suicide, by the coroner and Gemma's Mum feels strongly that it was accidental.

Substance use had been a feature of Gemma's life since her teenage years. Drugs such as morphine, methadone, diazepam, pregabalin, spice, cocaine and alcohol are all mentioned. She had a long engagement with the local Drug and Alcohol Services who were, at times, prescribing opiate substitute medications. She also seems to have been dependent on diazepam at points. During the review period, there was an attempt to support Gemma into detoxification and residential rehabilitation. This failed due to her using larger doses of diazepam than reported.

The other key feature of her life was that she was the victim of domestic abuse from her long term partner Neil[2]. Neil himself had mental health problems and Gemma seemed to be in a carer role for him at times. Nonetheless, Gemma reported domestic abuse incidents and domestic abuse was reported by third parties e.g. a neighbour in April 2021. This abuse certainly predated the review period, Gemma was discussed at MARAC (Mullti-Agency Risk Assessment Conference) in July 2018. It is not known whether Gemma suffered abuse from any earlier partners, although there were no concerns of abuse in her prior long term relationship from which her son was born.

During the year prior to her death much of what happened mirrored the pattern of earlier years. However, two key changes in her life occurred in this period. She moved to another town, in order to try and make a clean break. She also lost her grandfather which seems to have upset her deeply. These incidents both imply a loss of past contacts and may possibly be significant in the decline she experienced in 2021.

Her turbulent relationship with Neil continued but she was not discussed at MARAC in the review period. In August 2020, a separate incident of abuse was reported at the hands of other people. Gemma alleged that she was kidnapped by two drug dealers

[2] A pseudonym

who tied her up and placed her in the boot of a car. This was said to be due to her owing them money. She was eventually released and began the process of reporting this to a Police Officer who treated it with due seriousness. No other similar incident was reported.

Frequent engagement with a variety of services continued. For example there were seven Ambulance callouts during the review period mainly related to drugs and drug overdose but also to domestic abuse and her death. Just a month before her death, shop staff reported Gemma making threats in their store. Four crimes were recorded relating to theft and threats at different times and her partner Neil also became involved in making threats.

However, as has been said, in July 2021 she was found dead in her flat following a drug overdose.

8. Analysis

Gemma was a woman with multiple complex needs including physical health, mental health, substance use and domestic abuse. The next sections of this report address each of these issues. However, agencies are able to respond to each of these problems. The real challenge is how to respond to someone like Gemma that services found very difficult to engage into appropriate care.

Therefore, the central theme of this SAR is the need for a concerted and assertive response to a woman whose needs were very clear and had been clear for many years. As a result, the subsequent sections focus more widely on the response to vulnerable individuals like Gemma including:

- People that services find difficult to engage
- Tackling stigma and prejudice
- An assessment and screening tool
- Multi-agency management
- Assertive outreach
- Practical interventions with individuals that services find difficult to engage.

It finishes by considering:

- The use of the Care Act and the Mental Capacity Act
- Information governance
- The impact of Covid 19.

9. Tackling drug use disorders

9.1 Generic identification

At the most generic level, Gemma is a reminder of the importance of the need for robust drug and alcohol screening processes. Without data on the prevalence of drug and alcohol use, it will not be possible to build an appropriate response to the

individual; but it will also be harder to build a case for a general improvement in the approach to substance use disorders.

NICE Guidance states that best practice would ensure that a drug and/or alcohol screening tool is routinely being used at assessment by all relevant professionals, whether in Primary Care, Mental Health Services, Adult Social Care, Housing or any other appropriate adult service. NICE recommends the use of the AUDIT tool for alcohol[3] and the Department of Health advocates the use of the Assist-Lite[4] screening tool for drugs, although other tools such as the DUDIT[5] are available.

9.2 Tackling drug use disorders: a community pathway

Gemma had been known to Drug and Alcohol Services since release from Prison in 2015. During her time in custody she had undertaken a rapid detoxification from methadone but reported she had struggled with this and began using illicit buprenorphine[6] in the community. A prescription for buprenorphine was offerred to support Gemma as a harm reduction strategy. Between 2015-2017 Gemma remained engaged with the service, navigating significant life events, including the birth of her child who was later removed from her care and the loss of her grandfather.

In August / September 2020, Gemma was on a diazepam script and a methadone script and there was a plan for her to undergo an inpatient detoxification and move into a rehab unit. This plan did not work out and is commented on in 9.4 below. From that point forward Gemma's ongoing engagement with the Drug and Alcohol Service was characterised by use of a number of drugs (including spice and cocaine/crack) and sporadic disengagement. Ultimately, she did not engage in a programme of positive change.

One particular incident should be noted. After her return from the attempted rehab placement Gemma was on a diazepam detoxification in the community. This was then discontinued because she was not engaging with the programme as required and was using illicit depressants at the same time. This decision was clinically appropriate because of the risk of overdose when combining her ongoing prescribed methadone with uncontrolled doses of central nervous system depressants. She was also provided with harm reduction advice. However, the service itself recognises that after stopping the diazepam, it needed to provide more follow-up support to Gemma.

Beyond this, the service continued to work with Gemma and supported her moving home. However, it is recognised that this single agency approach was probably insufficient for Gemma and she needed a more integrated approach to meet her complex needs. This theme is explored further in section 12 below.

9.3 Brain damage

[3] Alcohol Use Disorders Identification Test (AUDIT) (auditscreen.org)
[4] ASSIST-Lite screening tool: how to use - GOV.UK (www.gov.uk)
[5] Drug Use Disorders Identification Test (DUDIT) | www.emcdda.europa.eu
[6] Buprenorphine, sold under the brand name Subutex among others, is an opioid used to treat opioid use disorder, acute pain, and chronic pain

There is growing concern that cognitive impairment, particularly acquired brain injury (ABI), is a factor in the presentation of many of the people who are subject to SARs. In 2022, Mark Holloway and Aly Norman highlighted this theme in their article *"Just a little bit of history repeating: the recurring and fatal consequences of lacking professional knowledge of acquired brain injury".*[7] Since then they report that they have found another 20 more SARs where the impact of an ABI upon functioning was not picked up and responded to.

At no point was Gemma seen as someone with a cognitive impairment, therefore, it is hard to take this theme too far. However, Gemma did experience domestic abuse. She had also been a female in the prison system: a group with rates of traumatic brain injury of up to 70%.

This review cannot re-diagnose Gemma, so the impact of cognitive impairment is unknown; however, this is a reminder of the importance of considering cognitive functioning with individuals who require safeguarding.

9.4 Tackling drug use disorders: residential rehabilitation

The ideal care pathway for Gemma would probably have been inpatient detoxification followed by a period of residential care/rehabilitation in a drug-free environment. Dame Carol Black's *Review of drugs part two: prevention, treatment, and recovery* (states)*: "Local commissioning of inpatient detoxification and residential rehabilitation has decreased substantially in recent years, despite evidence of their effectiveness and importance for people with particularly complex needs."*

Such a placement would have enabled:

- A time away from her home situation in a protective environment.
- A chance to properly assess her physical and mental health.
- The opportunity to address her drug use disorders and develop an appropriate long-term care plan.

It is positive to note that in August 2020, it was planned that Gemma would attend a rehab for a 28 day detoxification followed by a period of 12 weeks residential rehabilitation. Gemma was happy about going to the rehab and confirmed she was still using 30mg diazepam daily: a level from which she could be safely detoxed in the proposed unit.

In September 2020, a nurse from the Drug and Alcohol Service drove Gemma to the rehab – again a positive approach. Shortly after a call was received from the unit stating that Gemma had disclosed she was using more benzodiazepine than she had initially stated (between 70-100mg daily) and that it would be unsafe for them to carry out a detoxification. Gemma returned on the train and a prescription was arranged to be collected on her return.

It was reported that residential options were also discussed with her in mid-2021. However, this was not the right time for Gemma and the Covid-19 restrictions would have made accessing rehab more complex.

[7] *The Journal of Adult Protection*, Vol. 24 No. 2, pp. 66-89. https://doi.org/10.1108/JAP-10-2021-0036

This incident highlights two important themes:

- The reliance on voluntary sector providers for detoxification beds – these facilities do not have the medical support of a Hospital and therefore, understandably, have to be more risk averse in the degree of complexity they can manage. It is vital that the local treatment system has access to beds that can provide the required level of medical support.

- The importance of contingency planning in case of residential placement breakdown. It is likely that a significant proportion, if not the majority, of residential placements for substance users will break down. Therefore, ensuring that a plan exists in the case of early discharge would help ensure continuity of care, reduce the risk associated with gaps in service provision, and enhance overall safety for vulnerable individuals.

10. Domestic abuse

Domestic Abuse Services report that the earliest record of Gemma as a victim of domestic abuse is from July 2016. The perpetrator is believed to be Neil, the man she was still in a relationship with at the end of her life. Gemma reported that he had served a prison sentence for domestic abuse, although it is not clear that this was related to her. As in later periods, Gemma was difficult to contact and her case was eventually closed. Abuse is also reported across 2017 / 2018 and into 2020/21. Although there seems to be a gap in reporting between these two periods. She was discussed at MARAC in 2016 and 2018, although not during the review period.

It should be noted that Neil was himself a man with significant needs including a diagnosis of schizophrenia. Gemma appears to have seen herself as his carer, assisting him with such things as diet and fluid intake. (It should be noted that no Carer's Assessment was offered and no other agency sought or suggested a referral on her behalf).

In the review period there were numerous incidents of domestic abuse ranging from reports by neighbours of shouting between the couple through to physical injury to Gemma following an assault. She also reported problems with theft of her drugs or money. In April 2021, Gemma reported that she awoke to Neil smashing the home up because she had spilt some yoghurt: although later she downplayed the incident to attending Police Officers. The reporting of incidents markedly increases in the period running up to her death.

However, it needs to be noted that this review has largely seen the abuse from Gemma's viewpoint; there are indications that Neil might have reported things differently. For example, in mid-July 2021, Neil was arrested following an abusive incident and was given bail conditions which prohibited contact with Gemma. However, he then complained that she was contacting him, and she also requested that the bail conditions were lifted.

This period raises a number of questions about the management of domestic abuse.

Gemma was referred to the IDVA service via external agencies and via a helpline call from Gemma. However, the IDVA was unable to engage Gemma: she did not respond to attempts made to contact her to provide support including safety planning. This does raise questions about whether a response to an individual like Gemma which is based on voluntary engagement over the telephone is going to be sufficient. Is a more assertive and coordinated response needed? This is discussed below (section 12).

Perhaps the most notable feature of the review period is the lack of referrals to MARAC. This gap is acknowledged by most of the agencies involved with her. It is hard to understand why this did not occur, but it is possible that everyone felt that, given her involvement with multiple agencies, this would be done by someone else.

The same can also be said about the use of the DASH (Domestic abuse, stalking and harrasment) risk assessment. This does not appear to have been completed during this period and is a very obvious gap.

The other question raised about this period was whether the imposition of the bail conditions that excluded Neil from contacting Gemma was actually unhelpful and, more crucially, contributed to the negative state in which she died. This is a very difficult decision. However, it does highlight the potential for unintended consequences associated with an apparently simple decision when taken in the context of a very challenging situation and again highlights the importance of muti-agency working.

10.1 Abuse by others

Police reports show that on one occasion during the review period, Gemma was targeted by drug dealers to whom she was in debt. They kidnapped her, tied her up and put her in the boot of a car. They later released her. Subsequently, her debt continued to escalate to £400 and she was concerned about potential harm as a result.

These patterns of threats and violence are a familiar part of the illegal drug scene and there are examples of women being driven to suicide by these threats. However, there is no evidence in Gemma's case that this was anything more than a one-off incident. Nonetheless, it is flagged for completeness and to highlight another traumatic aspect of her life.

NB – the Police Officer to whom Gemma reported this incident responded in a very positive and supportive manner; this was particularly good practice because the Officer was working on traffic duty. The Police note this positive intervention but also note that the Supervising Officer did not respond in a similarly positive fashion.

11. Mental Health

11.1 General

At points in her life, Gemma reported having bi-polar disorder, anxiety, depression and obsessive-compulsive disorder. However, in the last year of her life her only

diagnoses are anxiety and depression, and she is receiving pregabalin[8] and sertraline[9] (from July 2021), from her GP. It is unclear whether bi-polar disorder or OCD were ever diagnosed. In the last days of her life, her GP prescribed zopiclone to help her sleep. This was not reported to be present in her bloodstream at death.

As a result, she does not appear to have been significantly involved with either NHS or Adult Social Care Mental Health Services in the last year of her life. In March 2021, following an overdose, she was referred to the CMHT and assessed, but said she did not want to engage with them. She was again referred to the CMHT by her GP in April 2021. However, she did not attend the appointment, and despite her GP attempting to follow this up with her she did not rebook.

In summary, the Mental Health Trust state that *"numerous attempts…were made to offer her appropriate mental health support, but at the point of assessment she declined it/did not attend appointments."* Following her death a root cause analysis was undertaken by the Trust, it identified that *"there was scope to improve joint working and communication between Hospital Trusts, the Mental Health Trust, Primary Care and Drug and Alcohol Services in relation to risk management and treatment options."*

The Trust also acknowledge that there was no Trust Multi-Disciplinary Team (MDT) discussion after each non-attendance or prior to sending an offer of service letter. This is also seen as a missed opportunity for a multi-agency approach. Furthermore, Gemma's GP was not informed of her non-attendance at either appointment.

However, the central concern regarding her mental health is her pattern of suicidality.

11.2 Suicidality

As described above, prior to the review period, there was a longstanding pattern of suicidality or self-harm. For example in May 2020, Gemma separated from her partner and attempted to take her own life by consuming 100 diazepam tablets along with half a bottle of vodka and ringing her Drug Worker stating that she would jump off a bridge.

In the last four months of her life several incidents were reported:

- March 2021 - Gemma took an overdose which led to hospitalisation
- April 2021 - Gemma said she had thoughts of self-harm but no plans to act
- June 2021 – Her partner called an Ambulance because she had taken 7-8 x 150mg pregabalin over the course of 1 hour.

In July 2021, there was an increase in the references to suicide:

- 19 July 2021 – Gemma was brought into Hospital having been found by Police with a 65ml empty methadone bottle and apparently 16 missing gabapentin[10] tablets. Despite being unresponsive when the Ambulance attended, by the time

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[8] To treat anxiety

[9] An anti-depressant

[10] Used to treat partial seizures, nerve pain and restless leg syndrome.

she arrived at Hospital she was fully conscious but agitated (distressed with staff and requiring a security presence to maintain safety).

- 21 July 2021 - Neil reported that he had received a text from Gemma saying *'Why are you making me suffer, I'm going to kill myself and I won't be here in two hours'.* Police managed to get hold of Gemma and she said: *'if I was going to kill myself do you think I would be telling you'*.
- 21 July 2021 – She spoke to a Pharmacist regarding a problem with a prescription; she became agitated and stated *'I will not be here tomorrow'* before leaving the Pharmacy. When spoken to by the Drug and Alcohol Service she said if she was going to do something to herself, she would just *'do it'*.

Ultimately, Gemma died of a drug overdose. Whether this was related to her suicidality, is both unknown and unknowable. However, there is evidence from the drugs field that many apparently accidental deaths involving drugs are actually set against a past history of suicidality. Indeed, people may reach the point where they no longer care about their lives and are consequently so reckless in their drug use that it leads to overdose.

Irrespective of the ultimate cause of her death, Gemma was a high risk for suicide. Depression, substance use, being the victim of domestic abuse, the loss of a family member, isolation and past incidents of suicide or self-harm are all indicators of a heightened risk of suicide. On any reasonable assessment of her suicide risk she would have rated as highly vulnerable.

This risk was well known to all the agencies who encountered her. The challenge is that there does not seem to have been a constructive plan to manage this risk. The necessary approach is considered in the next sections.

12. People that services find difficult to engage

The fundamental challenge with Gemma was not that she was a drug user, mentally unwell, considering suicide or a victim of abuse. The real challenge was that services did not create a constructive and coordinated approach to engage her into the care she needed for those problems.

Gemma's situation suggests the need for a new framework for these challenging individuals. This cannot be applied to every service user, but is certainly required for the most risky and vulnerable. Gemma clearly fell into that category.

Gemma highlights the need for a published, multi-agency procedure to guide professionals in dealing with non-engagement by individuals with complex needs. This will need to cover:

- a framework that helps practitioners to flag and escalate these clients
- a multi-agency framework to which this client group can be escalated
- assertive outreach capacity
- professional attitudes to complex clients
- guidance on how to practically intervene with individuals that services find hard to engage.

These themes are explored in the following sections of the report.

12.1 A framework for flagging these individuals

The simple problem at the heart of Gemma's care is that agencies did not flag her as someone who needed a more rigorous approach – despite her complex needs being very obvious from even the briefest review of her history. Repeated incidents did not seem to generate growing concern but rather were treated as one off incidents.

A more rigorous approach cannot be applied to every client who disengages from services. Only those having the greatest impact on themselves, family and local services will be able to be targeted. Therefore, determining who to escalate will be supported by the development of a framework which will guide and support practitioners to determine which vulnerable individuals require a more assertive, multi-agency response.

Such a framework will also provide assurance to the Safeguarding Adults Board that appropriate action is being taken.

12.2 Multi-agency management

No agency or worker appears to have attempted to set up a multi-agency meeting or to have escalated her into a multi-agency framework during the review period. A number of agencies specifically commented that a multi-agency approach would have been helpful with Gemma. In any procedure, once individuals are identified, it will be necessary to have a mechanism for escalating and managing them in a multi-agency context. This escalation might be either to an existing multi-agency group, e.g. multi-agency risk management or safeguarding forums; or to a specific client group-focused multi-agency forum which can act as the focal point for work on, for example, complex drug users and dependent drinkers. These frameworks will benefit individuals by enabling clear and positive inter-agency liaison and multi-agency working.

Whichever route is chosen escalation into a multi-agency group will be beneficial. Therefore, such a pathway should be a part of any guidance on working with this group.

12.3 Assertive outreach

Gemma would probably have benefited from an assertive outreach approach which attempted to build a relationship and understand what lay behind her challenging behaviour. An assertive outreach approach is built on the recognition that, with complex individuals, agencies are going to need to sustain the relationship rather than expecting the individual to be able to do that. This will require an approach that is:

- Assertive – using home visits
- Focused on building a relationship
- Flexible – client focused – looking at what the client wants
- Holistic – looking at the whole person
- Coordinated – linking with other agencies
- Persistent and consistent.

Once professionals have a better understanding of what lies behind Gemma's pattern of non-engagement, they can begin to think about ways in which these needs can be better addressed. This is an area for local service development.

It has been reported that since 2021, the Drug and Alcohol Service has appointed 'MDOM' (multiple disadvantage outreach model) Workers who work with individuals experiencing numerous complex issues and have the ability to support them on a less formal, outreach, basis. It was further reported that this will expand into a North Yorkshire Council-led multiple disadvantage service.

12.4 Professional attitudes

It is important to acknowledge that people like Gemma can be very challenging to work with, particularly because they appear to have a very negative attitude towards their own well-being. This can lead to cases being closed and care discontinued. However, there is a difference between recognising the individual's negative attitude and allowing it to drive interventions.

It is positive that in the review period there was only one identifiable example of negative attitudes towards Gemma. This was from a supervising Police Officer and is in marked contrast to a lower rank Officer who treated Gemma's concerns about the kidnap incident with great respect.

What cannot be determined is whether the general failure to develop a more coordinated approach was because agencies and workers had a sense that Gemma's behaviour was "normal" for her or because of a fatigue with attempting to address her needs. However, the relevance of this issue was confirmed by a number of attendees at the Practitioners' Event.

This highlights an important aspect of motivational approaches. Despite her self-destructive behaviour, Gemma continually showed a desire to change and improve her life. Moving house was a part of that. She talked about her interest in having a dog. When offered tramadol she refused because she was concerned that she would become addicted. She was also frequently seeking help from agencies.

This highlights a key theme of motivational interventions: that people are not in a binary state of either "wanting to change" or "not wanting to change" ("in denial" or "not in denial"). People's attitudes to change are much more complex and at times will be conflicting. This highlights the importance of positive attitudes and reaching out to build up the motivations to change. Constant service closures and inconsistent responses will reinforce the individual's negativity.

Whether attitudes impacted on Gemma's care or not, as an individual, Gemma highlights that any renewed approach to complex clients will need to ensure that sigma and professional attitudes do not impact.

12.5 Practical interventions with substance users that services find difficult to engage

To bring this whole process to life, it will also be necessary to provide practitioners with guidance on what one-to-one techniques work with individuals that they find hard to engage. This is an under-developed field. Useful techniques are likely to encompass:

- Professional curiosity
- Harm reduction
- Motivational interventions
- The allocation of dedicated time

Professional curiosity - *'the capacity and communication skill to explore and understand what is happening within a situation rather than making assumptions or accepting things at face value'.* This is an apparently under-used approach nationally. The recent *LGA / ADSS - National analysis of SARs* highlighted that in 44% of SARs, professional curiosity was reported to be clearly missing (it was only positively commented on in 3% of SARs).

This is a gap in Gemma's care. A consideration of the impact of domestic abuse, trauma and drug use on her decision making would have helped drive appropriate interventions. This will require professional training, managerial supervision and challenge as well as ongoing messaging about this issue.

Harm reduction – A range of harm reduction techniques have been identified for this client group. This is likely to encompass approaches such as encouraging and supporting good nutrition, safer sex and maintaining personal safety among others.

Motivational interventions - With people like Gemma, professionals will need to build motivation rather than expecting her to have her own motivation. MI recognises that approaches to substance users based on persuading, challenging or confronting people are unlikely to be successful and may actually entrench people in their defences. Instead, practitioners need to encourage and support work on small changes that then build confidence to make bigger changes. Practitioners should have training in these approaches and be using them with this client group.

Time – Above all, positive interventions will require the investment of time to build a trust-based relationship which can then influence what the person does. This will require a consistent and persistent approach from practitioners.

The importance of this whole approach was summed up by the Drug and Alcohol Service IMR which commented that: *"The review identifies potentially missed opportunities for services to provide a more integrated approach to support Gemma's mental health. Gemma reported that her mental health had deteriorated during her diazepam detox, this could have been a crucial time to increase support and interventions. Although Gemma did not express any suicidal ideation and often spoke positively about future plans such as moving home and getting a dog, the period of detox presented clear vulnerabilities which possibly warranted a more proactive response. Strenghthened inter agency working between GP and (the Drug and Alcohol Service) could have ensured additional mental health support during this challenging period."*

The Mental Health Trust also comments that: *"There was a missed opportunity for mental health services, acute services and drug and alcohol services to take an interagency approach and communicate openly to attempt to address Gemma's social and mental health needs."*

13. Safeguarding and other Adult Social Care interventions

Gemma was an adult with the appearance of care and support needs and two safeguarding concerns were raised about her during the review period. In addition she was referred to Living Well and received support with practical aspects of her move to a new area. However, she does not appear to have had a Section 9 assessment of her care and support needs.

The first of these two concerns was raised by a Nurse Practitioner in mid-April 2021. Gemma had been the victim of violence and theft from her partner. The information gathering was completed the next day. Four days later a manager initially decided that Gemma required ongoing support from Adult Social Care; but then said that the case would be closed because Gemma was happy with the support she had.

The second concern was raised in mid-July 2021 by Housing as a result of further domestic abuse. This was just before her death. Again, inquiries were swiftly made. At this point, Neil had been arrested and was not allowed to see Gemma. Therefore, Gemma's view was that no further action was required, and the safeguarding was closed.

It is easy to question both these decisions with the benefit of hindsight, knowing what happened next. However, if we put that information to one side, both these situations return us to the question of whether these episodes are being seen in isolation or whether they are seen as part of an ongoing, and possibly increasing, pattern of vulnerability which therefore requires escalation into a more robust, multi-agency framework as set out above.

Agencies have acknowledged that there were also a number of missed opportunities to raise safeguarding concerns. The Ambulance Service, Acute Trust, Police and Drug and Alcohol Services all acknowledge such opportunities. This theme of missed opportunities emerges in other local SARs e.g. the Anne SAR and the Elaine SAR. This does not necessarily imply a failure to follow the recommendations in those SARs, because Gemma's death occurred before Elaine's death. Instead it should be seen as reinforcing the importance of the messages emerging from those SARs.

14. Using the Mental Capacity Act

Agency reports mention Gemma's mental capacity at several points. The prevailing view seemed to be that she had the mental capacity to (presumably) care for herself. The Acute Trust commented at one point that: *"Capacity not in doubt and on initial attendance a detailed report is given as to why they did not doubt her capacity."*

Given her pattern of self-harm and substance misuse, it might be possible to raise questions about the use of concepts such as executive capacity or fluctuating capacity. Nonetheless, there is no evidence in the notes to suggest points at which this might have been useful. Therefore, this report simply notes that consideration of mental capacity was not a particular feature of her care.

15. Note on information sharing

The IMRs raise concerns about information sharing at five points. These are all individual incidents and there is no suggestion that this is part of a wider pattern. Nonetheless, these are noted here to ensure that they are addressed.

- When Gemma moved home, her new GP practice requested her records from her previous practice. These had not been received at the time of her death. It was suggested that her records may have been too large for electronic transfer. However, the paper copy does not seem to have been transferred either. This was still being pursued during this review.

- Primary care also highlight a number of other concerns about the lack of, or quality of, information sharing by other agencies. Information received following an Emergency Department attendance was very limited. An outcome letter was not received following a CMHT referral in April 2022. Concern was also expressed about information received from the Drug and Alcohol Service.

- The Emergency Department notification form to Primary Care was unclear as it stated the admission was for poisoning/overdose. 'Pregablin od' was noted under the *narrative/medications/actions* section and the GP took this to mean that Gemma was taking pregablin '*omne in die'* (once daily) and not that she had taken an overdose of this. The use of abbreviations created a possibly troubling misinterpretation.

- In the review period there is a report that there were weapons in her property. This information does not appear to have been referred appropriately or widely shared.

- Perhaps the most concerning issue is that during the period leading up to her being found deceased, a welfare check on Gemma was cancelled because of third party reporting that she had been seen. This was not the case. The Police emphasised the importance of ensuring that such information was robustly verified – the ABC approach - *Assume nothing, Believe no one, Check everything* - was emphasised.

16. Note - Covid 19

The entirety of the period under review was during the Covid-19 restrictions. This is likely to have had an impact on Gemma's care and it is possible to identify a greater use of telephone contact with her. However, it is not possible to draw a line between

challenges in her care and the Covid restrictions. Therefore, no comments have been made on Covid's impact.

Key Learning Points

Gemma was a 38 year old white British woman who died in 2021. The Coroner concluded that this was a "drug-related death". She had a background history of substance use disorders, adverse childhood experiences and domestic abuse, criminality, threats of suicide and mental health problems. In particular, professionals found her difficult to engage into services.

At the most generic level, Gemma is a reminder of the importance of the need for robust drug and alcohol screening processes both to aid individual care and build a case for a general improvement in the approach to substance use disorders. NICE recommends the use of the AUDIT tool for alcohol and the Department of Health advocates the use of the Assist-Lite screening tool for drugs, although other tools such as the DUDIT are available.

In August 2020, it was planned that Gemma would attend a rehab for a 28 day detoxification followed by a period of 12 weeks residential rehabilitation. However, immediately after admission, Gemma was asked to leave because she had disclosed she was using more benzodiazepine than she had initially stated and, therefore, it would be unsafe for them to carry out a detoxification. This incident highlights two important themes:

- The reliance on voluntary sector providers for detoxification beds – these facilities do not have the medical support of a Hospital and therefore, understandably, have to be more risk averse in the degree of complexity they can manage. It is vital that the local treatment system has access to beds that can provide the required level of medical support.
- The importance of contingency planning in case of residential placement breakdown.

The earliest record of Gemma as a victim of domestic abuse is from July 2016. In the review period there were numerous incidents of domestic abuse ranging from reports by neighbours of shouting through to physical injury to Gemma following an assault. She also reported problems with theft of her drugs or money.

Gemma was referred to the IDVA Service via external agencies. However, the service was unable to engage Gemma: she did not respond to attempts made to contact her to provide support including safety planning. This does raise questions about whether a response which is based on Gemma's engagement with a phone call is going to be sufficiently robust.

She was also not referred to MARAC during the review period. This gap is acknowledged by most of the agencies involved with her. It is hard to understand why this did not occur, but it is possible that everyone felt that, given her involvement with multiple agencies, this would be done by someone else. The same can also be said about the use of the DASH (Domestic abuse, stalking and harrasment) risk

assessment. This does not appear to have been completed during this period and is a very obvious gap.

Prior to the review period, there was a longstanding pattern of suicide or self-harm. Ultimately, Gemma died of a drug overdose. Whether this was related to her suicidality, is not known. Irrespective of the ultimate cause of her death, Gemma was a high risk for suicide. Depression, substance use, being the victim of domestic abuse, the loss of a family member, isolation and, of course, past incidents of suicide or self-harm are all indicators of a heightened risk of suicide that were associated with Gemma.

On any reasonable assessment of her suicide risk she would have rated as highly vulnerable. Moreover, this risk was well known to all the agencies who encountered her. The challenge is that there does not seem to have been a constructive plan to mitigate this risk.

The central issue with Gemma is the challenge of engaging her into the interventions that would help her. Therefore, there is a need for a system or structure that allows practitioners to identify and flag vulnerable or risky individuals with complex needs that services are finding difficult to engage. Gemma was very well-known to services and had a long history of risk and vulnerability. However, services failed to initiate a coordinated approach to her. An agreed structure will allow a more targeted and assertive approach to be used, including:

- **a framework for flagging these individuals -** The simple problem at the heart of Gemma's care is that agencies did not flag her as someone who needed a more rigorous approach. Such an approach cannot be applied to every client who disengages from services. Only those having the greatest impact on themselves, family and local services will be able to be targeted. Therefore, determining who to escalate will be supported by the development of a framework which will guide and support practitioners to determine which vulnerable individuals require a more assertive and multi-agency response.
- **an identified multi-agency framework to which this client group can be escalated -** this escalation could be to either an existing multi-agency group, e.g. multi-agency risk management or safeguarding forums; or to a new specific client group-focused multi-agency forum which can act as the focal point for work with, for example, complex dependent drug users and drinkers. This will benefit individuals by enabling clear and positive inter-agency liaison and multi-agency working.
- **assertive outreach capacity** - Gemma would probably have benefited from an assertive outreach approach which attempted to build a relationship with her and understand what lay behind her challenging behaviour. This is built on the recognition that, with complex individuals, agencies are going to need to sustain the relationship with the person, rather than relying on individual motivation.
- **work to challenge stigma and prejudice** - it is not possible to prove that any of the challenges that Gemma faced were due to, or were worsened by, negative worker attitudes including stigma or prejudice. Nonetheless her brief history does raise questions about whether professional attitudes to people with drug use disorders and similar presentations change the response that they receive.

- **guidance on how to practically intervene with individuals that services find hard to engage -** useful techniques are likely to encompass: professional curiosity, harm reduction, motivational interventions and allocating sufficient time.

Gemma was an adult with care and support needs and it appears that two safeguarding concerns were raised about her during the review period. Both were closed very swiftly. It is easy to question both these decisions with the benefit of hindsight. However, more pertinently they raise the question of whether these episodes are being seen in isolation or whether they are seen as part of an ongoing pattern of vulnerability which therefore requires escalation to a multi-agency framework as set out above.

Agencies have acknowledged that there were also a number of missed opportunities to raise safeguarding concerns. The Ambulance Service, Acute Trust, Police and Drug and Alcohol Service all acknowledge such opportunities. This theme of missed opportunities emerges in other local SARs e.g. Anne SAR and Elaine SAR. This should be seen as reinforcing the importance of the messages emerging from those SARs.

The review identified a number of concerns about information sharing which need to be addressed by individual agencies.

17. Good practice

Many agencies made efforts to help Gemma. Most professionals appear to have worked appropriately with her within the framework of their individual disciplines. In particular, the review focused on the period of the Covid-19 restrictions and it is clear that agencies continued to work and maintain services during that difficult period.

However, specific points of good practice did emerge:

- A Police Officer on traffic duty encountered Gemma in the aftermath of her "kidnapping" by two drug dealers. The Officer treated this situation with commendable seriousness and tried to build a positive response.

- The Drug and Alcohol Service worked hard to engage and support Gemma and worked with her through some very challenging phases of her life.

18. Recommendations

Recommendation A

North Yorkshire's Public Health Team should:

- have a long-term programme to roll out drug and alcohol screening tools across all relevant professionals in accordance with NICE guidance.

- Work with local voluntary and statutory sector providers to ensure that beds for planned substance use disorder detoxifications are not solely available in third sector units to ensure that more complex detoxifications can be undertaken in an NHS Hospital or equivalent with the required level of medical support.
- ensure that referrers are developing contingency plans in preparation for potential residential placement breakdown.

Recommendation B

The North Yorkshire Domestic Abuse Board and/or the Community Safety Partnership should consider whether an IDVA Service response which is based on telephone contact with the individual is going to be sufficiently robust; and ensure that the DASH risk assessment and referrals to MARAC are routinely being considered with clients like Gemma.

Recommendation C

The North Yorkshire Safeguarding Adults Board should ensure that there is ongoing training and messaging on the indicators of a heightened risk of suicidality including domestic abuse and substance use disorders.

However, the central issue with Gemma is the challenge of engaging her into the interventions that would help her. The following recommendations address this theme.

Recommendation D

The Safeguarding Adults Board should ensure that there is a framework which will guide and support practitioners to determine which vulnerable individuals require a more assertive and multi-agency response.

Recommendation E

The Safeguarding Adults Board should ensure that there is a clearly identified multi-agency framework to which this client group can be escalated.

Recommendation F

The Safeguarding Adults Board should work with Public Health and the Integrated Care Board commissioners should work with key providers to ensure that assertive outreach capacity is available to support complex individuals.

Recommendation G

The Safeguarding Adults Board should work with Public Health and Integrated Care Board commissioners to ensure that assertive outreach capacity is available to support complex individuals.

Recommendation H

The Safeguarding Adults Board should assure itself that partners provide guidance and training on practical interventions with individuals that services find hard to engage e.g. professional curiosity, harm reduction and motivational interventions.

Recommendation I

The Safeguarding Adults Board should continue to assure itself that partner agencies are regularly reminding staff of the importance of raising safeguarding concerns, particularly in the context of people with substance use disorders.

Appendix 1 Terms of reference

GENERAL:

- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which professionals and agencies work together to safeguard adults at risk.
- To inform and improve local inter-agency practice.
- To improve practice by acting on findings and learning
- To produce an overview report which analyses the findings of individual reports from agencies and makes recommendations for future action.

SPECIFIC TO THIS CASE:

- How effective was the communication and joint working between agencies during the period under review and were there any missed opportunities for information sharing or joint working?
- What were the systems for risk assessment and how were reviews of risk conducted and managed? Did any review take account of any change(s) in the person's circumstances?
- How effective was the person's care plan? Did the plan operate within the policies and procedures for each agency? Did the plan meet her identified needs? How was the plan implemented?
- Was there clear leadership for her care?
- To what extent was the person, her family or other advocate involved in the planning of her care?
- Were there missed opportunities for intervention to protect her?
- Were concerns about her care escalated either to a multi-agency framework or to senior managers?
- Were legal frameworks such as the Care Act, Mental Capacity Act, Mental Health Act of others used and used to the best effect?
- How well were her substance use disorders managed? What other approaches could have been used?
- Were any mental health needs appropriately managed? What other approaches could have been used?
- Was she the victim of abuse or exploitation and, if so, was this addressed appropriately?