1. Anne was in the wrong place to start with, the supported accommodation was not equipped to deal with her specific needs. This was identified in the Safeguarding Enquiry, but not highlighted in this SAR. The original Safeguarding Enquiry stated that there had been no formal assessment of need prior to Anne living at the supported accommodation. There should have been, and if it had been done, it would have highlighted that staff were not equipped to meet the requirements to administer medication in the way stated in her care plans from TEWV dated 2013/14. Staff also needed to be trained adequately to deal with overdose situations and to work with a person who was psychotic.
2. It was identified that Anne’s lifestyle created a problem with medication and necessitated the need for daily delivery/collection to minimalize stockpiling and the risk of overdosing. However it was never recognised that this action alone did not actually stop this. A robust structured removal of unused medication was needed. Equally although medication should be delivered/collected daily, the system did not appear to take into account holidays or days when Anne failed to collect her medication and therefore it would accumulate to more than the daily dose when it was eventually delivered/collected. We would suggest that Anne collected more than one daily dose on January 2nd 2018. We have asked repeatedly for evidence of exactly what was collected by Anne on 2nd January and as yet we have not had an answer from any party that has enquired into Anne’s death. Although TEWV indicated there was a need for a structured delivery and removal of medication on a daily basis, this was never achieved. It is interesting to note this requirement was removed from the TEWV Care Plan written in October 2015 when Anne was in the supported accommodation. This leads to two more unanswered questions:-
   1. Did TEWV believe that the supported accommodation were monitoring and supporting Anne with her medication (which we know they were not)?
   2. Did the GP think that the supported accommodation were monitoring Anne’s medication as he states that he was happy to prescribe blister packs of Diazepam due to the fact that Anne was in supported housing?
3. In our opinion, the author of the SAR takes it upon himself to state that Anne died on 4th January 2018, this was never established during the Coroner’s Inquest. We were told this date was used as it equated to when Anne was found dead. We have questioned this many times and have never had a proper medically based answer. However, in our opinion, there are strong indicators that we believe shows that Anne actually died on 3rd January. These are listed below:-
4. The last time Anne was seen speaking and physically moving was in the early hours of January 3rd 2018. The night watchman said she was looking for her cigarettes and medication. No one has questioned why she was looking for medication at this time but it is an indication of the chaotic lifestyle she lived prior to moving to the supported accommodation and obviously still continued to live.
5. There is a questionable welfare check done at 10.15am by two staff who apparently saw Anne asleep on her settee, although a staff member states he was lone working and wasn’t able to make a welfare check on the morning of the 3rd. It is interesting to note that neither staff who apparently made the check have been questioned or even named in any way.

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1. Anne did not appear at all on the 3rd even though she lived by routine. On that day she neither looked for a medication delivery nor went to collect it as was her normal routine.
2. The staff said Anne seemed asleep at 5.15pm on January 3rd when they did a welfare check, although there was no attempt to physically or verbally rouse her. We have always questioned how much anyone would be able to ‘see’ in a dark room given that it was 5.15 on a dark January evening. Why was there no attempt to physically or verbally rouse someone who had not been seen for over 12 hours and when last seen was not OK. What is a ‘Look for Life’ Policy in a home with residents that had the potential to overdose as well as mental health and substance abuse issues? We have asked for this policy and never seen it.
3. the night watchman on duty from the 3rd - 4th January noted that Anne had not put on her light, which was her usual routine during the night.
4. Despite the night watchman alerting staff, on the morning on the 4th January, that Anne had not followed her usual routine of putting her light on, did not make a welfare check.
5. It was never established during the Coroner’s Inquest what was the likely time that the fateful dose/s of Pregabalin and Haloperidol were likely to have been taken that caused Anne’s death.

# Therefore no one actually knows if Anne was alive on the morning of the 4th January 2018 and it would be more correct to state ‘found dead’ rather than ‘died’ 4th January 2018.

1. We were given the impression that the SAR would reach further than the Safeguarding Enquiry, but we feel that essential documents were not referred to. We feel the SAR, in the way that it is written, promotes the 'innocence' of the supported accommodation provider, TEWV and the GP amongst others by blaming Anne for her illness and the way she struggled to cope. We trusted these organisations with our daughter, to help her with her problems, and they failed her and her children. At the end of the Safeguarding Enquiry of 2019 we were led to believe any questions that we felt were left unanswered would be answered during the process of the SAR. We left the professionals who attended the Enquiry Meeting a lot of questions, a number for each organisation involved with Anne. As the SAR, we now know, does not investigate, we were wrongly informed that our questions would be answered, but it served the purpose of shutting us up at the time. We waited for the SAR to show that there were organisations and individuals that were accountable, and in that, some justice, would have be served. We know now we were wrong to expect this outcome.
2. We believed the SAR would expand on and highlight these failings and then possibly make recommendations that were more specifically related to Anne’s death and the agencies involved. We would state that recommendations actually equate to failings. Failings are identified and as a result of these failings recommendations are made. We would suggest that the majority of the recommendations in the SAR are so fundamental that these basic practices should have long been in place showing a good working practice. As the recommendations are fundamental parts of Safeguarding it illustrates that, in our opinion, for many years the people of North Yorkshire have been failed. Especially the people of North Yorkshire with mental health issues. For a SAR in 2020 to make a recommendation about using the CPA more efficiently when this type of approach has been in existence since

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1990 is deplorable and really the reader should question how many other lives have been put at risk through this failing.

1. We cannot believe that serious concerns were not raised about the actions of staff in the supported accommodation during the 2nd, 3rd and 4th January. To do this would have meant diligently studying the Care Plans from TEWV, the Risk and Management plans from the supported accommodation and the statements written for the Coroner . In our opinion the author has omitted the contents of the Risk and Management Plans for Anne, that state that the CPN should be made aware of any deterioration in Anne's mental Health. This is pivotal in Anne's death, as it shows a basic lack of safeguarding towards Anne as this was not done, and not to be highlighted in a Safeguarding Review seems a startling omission.

Within days of Anne's death we were of the opinion that the supported accommodation were covering something up and they didn't want us to see Anne's Risk and Support Management Plans. When you read them you can see why as they detail what to do if Anne presents as she did on January 2nd. They did not act on these plans as they had done in the past. If the plans had been acted on the fate of Anne may have been different. The author does not seem to question why staff were able to follow the guidance of Care Plans and Risk Management Plans when Anne's mental health and presentation had concerned them at the supported accommodation in the past, but were not able to follow the guidance in January 2018. It is our opinion that Anne’s mental health had deteriorated on the 2nd January and that an assessment by her CPN or Crisis Team was needed on the 2nd /3rd of January to ensure that Anne’s needs were met, this was not done. This is not even questioned by the author, yet he refers many times that Anne had capacity, how does the author know this for certain in relation to the 2nd /3rd/4th Jan 2018?

1. We feel the overall tone of SAR puts the blame on Anne for her death. There is no evidence that suggests that on the 2nd Jan 2018 Anne obtained any illicit substances. There is no evidence that any illicit substances were found in Anne's possession or her flat post death. The only medication Anne obtained on 2nd January 2018 was picked up by herself from the pharmacy. We still do not know how much she picked up that day and have been asking this question since 2018. The repeated mention of Anne's 'dealing' within the SAR is misdirection and not relevant to the circumstances surrounding her death. It appears to desperately look for examples of Anne’s illicit use of substances therefore showing her in a poor light and absolving staff from any safeguarding neglect.
2. We were told that if any changes were to be made to the draft SAR we would need to provide evidence, yet reading through this report we have questioned several times where is the actual evidence/ proof of statements made within it? There also seems to be areas where certain facts are not as laboured as others, for example there is little reference to Anne’s diagnosis of schizophrenia. This diagnosis is more specific and relates directly to the paranoia Anne was suffering from shortly before she died. We feel this is misleading and overall the SAR appears extremely contradictory in places, giving a confusing picture to the reader. For example, the reasons for Horizons to discharge Anne in the September 2017, were they aware of her suspected growing abuse of prescribed medication? In part of the report it states they were and yet in another part they were not.
3. We feel the SAR has failed to fully recognise/acknowledge that the events /circumstances that led to Anne being found dead was over a 48 hour period.
4. We would question the conclusion of the SAR regarding Hindsight and preventable death. We would state that there were things such as the Support and Risk Management Plan, advice given from the Crisis Team, CPN 2, GP1, and any previous training that failed to be utilised. Therefore it becomes a failing or an inaction on behalf of the provider. It was a

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failure to utilise previously acquired information and more importantly the Support and Risk Management Plan for Anne by staff of the supported accommodation on 2nd and 3rd January, when they had been able to do so in the past.

1. The definition of hindsight is ‘Understanding of a situation or event only after it has happened’
2. Staff of the supported accommodation demonstrated that they had an awareness of what was happening and hindsight is another misdirection. The following events are examples that illustrate the awareness of staff.
3. They made a welfare check on the 2nd Jan at 5.30, albeit an extremely poor one, concern was raised that Anne did not seem at all right. But they failed to inform the CPN 2, as written in Anne’s Support and Risk Management Plan, regarding this very item, therefore endangering her life. They also failed to utilise information given to them concerning overdose they had previously obtained from the GP 1, and of course any previous training they had had that was pertinent to the case and the post they were employed to do.
4. Staff told Anne to contact the Crisis Team which indicated they realised Anne’s mental health was deteriorating/ had deteriorated. But they failed to contact the CPN 2, as written in Anne’s Support and Risk Management Plan, regarding this item, therefore endangering her life.
5. The senior practitioner in conversation with CPN 2 on the 3rd /1/2018 failed to give the CPN2 a full picture of the event of the 2nd /1/2018, She omitted information about Anne’s mental health deteriorating , her paranoia/psychosis. She also failed to follow advice given from GP1 and the Crisis Team regarding overdose and deterioration of mental health. By failing to give the whole informed picture the senior practitioner failed to utilise the Support and Risk Management Plan for Anne further endangering her life. By failing to make a proper check for life during welfare checks, either by physical or verbal arousal, she endangered life.
6. Staff further showed an awareness to the ongoing situation as welfare checks were supposedly made at 10.45 and 5.15 on the 3rd Jan 2018, albeit they were extremely poor, no attempt to physically or verbally rouse, relying on a ‘look for life’ policy which apparently the supported accommodation had in times of overdose and was presumably approved by NYCC, the regulatory body.
7. In times of overdose a person seeming asleep or breathing is not an indication that all is well. Considering the Charity running the home has/ had a long history of working with people always at risk from overdose it is amazing that a look for life policy was a practice that was seen as befitting the residents of the supported accommodation. The ‘look for life’ policy endangered resident’s lives, and most certainly did in Anne’s case. This cannot go down within the element of hindsight. It is a fundamental failing, lending itself to the fact that the supported accommodation was ‘an accident waiting to happen ‘. It does however question how staff thought that they dealt with a situation of overdose. We know that in mid-2017 they were given information about overdose situations. There seems to be a distinct failure to utilise information given, or even utilise common sense, during the 48 hour period that this SAR relates to. Staff had managed to follow procedures correctly before, so hindsight can be ruled out and negligence pencilled in. We would question was it new staff that were on duty who were not up to par with training in such matters, did lone working add to this or was it a lax attitude and staffing levels due to it being the Christmas /New Year period ?
8. The senior practitioner failed to pass on information to the night watchman on the 3rd, which then led to him not being overly concerned about Anne’s change in night time routine. The

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fact her light is not put on in the early hours did concern him enough to mention it to staff in handover.

1. The senior practitioner, further shows an awareness that there had been an ongoing situation for Anne, again showing that this was not a case of hindsight. She rings the area manager about making a welfare check, there was absolutely no need to do this as their accommodation policy allowed for welfare checks, if there was concern for the resident, and they had done previous checks in the last 48 hours. Why did she feel the need to make a welfare check on the 4th at this time 12.00 midday. She proved by her actions this was not hindsight.
2. Preventable Death?
3. We feel Anne’s death (in the way that it happened) could have been prevented if staff had followed her Support and Risk Management Plan, primarily by contacting CPN2 with a properly informed picture of Anne from the events of 2nd Jan 2018, followed advice the from the GP1, the Crisis Team, any training that staff had pertinent to the situation. Staff could have rung the emergency services including the Crisis Team. Had any of these courses of action been followed and Anne had still died then it could be said that Anne’s death was not preventable. But the staff at the supported accommodation did none of the above not even drawing on their own risk plan and this we feel makes the home culpable and neglectful and Anne’s death preventable. Why have a plan of Risk and Support if it is not utilised when it is needed?
4. If this catalogue of events cannot be seen to be the cause of Anne’s death, as it hasn’t been by two Safeguarding Enquiries, then one wonders what chance others have in the same situation when looked after by staff deemed to be more than adequate by North Yorkshire County Council. The lack of accountability leads to a lack of Justice for Anne.
5. To us the SAR is nothing more than a regurgitated version of a couple of previous reports, being highly selective of what was chosen to highlight, and repeating flawed information. We questioned the SIR at the time but as it had been published they stated we could add an addendum in response, we never felt that this was adequate but it was the only avenue left open to us. We did, however, write an addendum, but did question if anyone would ever read it
6. That is an appropriate point to finish this addendum with our knowledge that a previous addendum to a report was not utilised allowing factual errors to be transferred from one report to another and thereby giving an erroneous background to the subject of the SAR. Like the SAR we will leave the reader with some recommendations that we believe can be derived from Anne’s tragically short life.
7. Proper and meaningful assessments should be made on entry to care provision to ensure a client’s needs can be fully met. Reason - This did not happen in Anne’s case
8. A care provider should be able to demonstrate the ability to fulfil the role of a rehabilitation provider if they take on this role. Reason – the supported accommodation took on this role after Anne had a detox
9. A care provider should liaise with the parents of a client to get a balanced picture of the client’s history. Reason - Anne found it hard to acknowledge some aspects of the past and therefore withheld it.
10. A care provider should demonstrate the ability to promote contact with children in a planned and constructive manner. Reason – the supported accommodation wanted to re-

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establish contact between Anne and her girls without an understanding of the previous history nor an idea of how to build contact in small steps

1. A care provider should liaise with the Carer’s of a client’s children to ensure they have up to date information relevant to any plans they have for their client. Reason – the supported accommodation supported Anne to apply for contact through the court, but if they had contacted us they would have known it was better to delay this action by some months rather than building up false hope for Anne.
2. Care Providers should liaise with children’s services to check that any suggestions they make to a client are in line with the feelings of children’s services. Reason – the supported accommodation supported Anne to make an application for contact with her children without considering the implications of this action.
3. Improve liaison between care provider other organisations eg TEUV and a client’s family. Reason – get a balanced picture of the history of a client rather than a one sided one
4. Cohesive prescribing between medical staff who can prescribe for a client. Reason – at one time 3 people were prescribing for Anne without any liaison between each other
5. Cascading of information to interested parties from Tasking Group. Reason – meetings were held and information about Anne did not get passed on to all professionals working with her.
6. Proper and meaningful assessments to be made on clients before a moving to independence begins. Reason – Anne was being found a place to live independently without her physical and mental health being taken into account.
7. If there is a need for daily delivery/collection of medication there should be a robust plan to remove medication that has not been used. Reason - In Anne’s case there was a need for this due to prior overdose situations which could be due to her state of mind or due to chaotic lifestyle – Anne could take medication multiple times in one day or not at all due to not being aware of time, both due to being forgetful and not being mindful.

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