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# Safeguarding Adult Review

Executive Summary

# James

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## Introduction

## This Executive Summary presents the findings and subsequent recommendations from the Safeguarding Adult Review (SAR) in respect of ‘James’

## The North Yorkshire Safeguarding Adults Board and the Independent Author of this review would like to give their condolences to James’ family and friends.

* 1. **Background and circumstances leading to the review**
  2. On the evening of 11 December 2019, North Yorkshire Police discovered James self-ligaturing with the use of a rope attached to railings. Emergency first aid in the form of cardiopulmonary resuscitation (CPR) was applied and James was conveyed by Yorkshire Ambulance Service (YAS) to the local acute hospital, but tragically died the following day from his injuries.
  3. A subsequent coroner’s inquest identified that his cause of death was as a result of a hypoxic brain injury, an out of hospital cardiac arrest and by hanging.
  4. James was supported by several agencies in North Yorkshire both as a young person and as an adult in relation to issues including mental health, offending behaviour, substance misuse and episodes of self-harming. Shortly prior to his death, a referral was made for James by his GP to the Community Mental Health Team, requesting he be assessed given concerns about the risks of accidental death through self-harm and overdose.
  5. On 20 May 2020 Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) submitted a Safeguarding Adult Review (SAR) referral to the North Yorkshire Safeguarding Adults Board (NYSAB) for James’ case to be considered as to whether it met the criteria for a Safeguarding Adult Review (SAR) to be undertaken. After careful consideration, the Independent Chair of the NYSAB decided that the criteria to undertake a statutory review had been met and that a SAR should be commissioned.

* 1. **Statutory Framework**
  2. Section 44 of The Care Act 2014 states that the Safeguarding Adults Board must arrange for there to be a review of a case:

1. Involving an adult in its area with care and support needs (whether the local authority was meeting any of those needs)
2. if there is reasonable concern about how the Board, or members of it or other persons with relevant functions worked together to safeguard the adult; and
3. the adult has died and the board suspects that the death resulted from abuse or neglect. (Whether it knew about or suspected the abuse or neglect before the adult died.)
   1. Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to identifying the lessons to be learned from the adult’s case, applying those lessons to future cases.
   2. Although many of the events outlined in this report took place when James was a child, a SAR was the appropriate mechanism for reviewing his case, as he had reached the age of 18 by the time of his death.

## Who was James?

* 1. James was the younger of two boys and despite the feeling that he was very much loved did not enjoy the best start in life. His parents separated when he was a young boy, resulting in him losing all contact with his father. Attempts made by James in later life to re-establish contact were sadly rejected by his father. James’ older brother left the family home, leaving him to reside solely with his mother.
  2. As James became a teenager it was apparent that he and his mother lived separate lives, with James spending most of his time with his teenage friends.
  3. James did not always make the best choices in life: substance misuse and offending behaviour became regular features of his life. This led, eventually, to him serving a custodial sentence within a young offender institution.
  4. Sadly, James died at 18 years of age.
  5. Several professionals from a variety of agencies spent time with James. They reported enjoying working with him and saw him as **a funny, likeable, kind young man, who was far more capable than he ever gave himself credit for.**

## Terms of Reference

The Independent Reviewer was asked to ‘consider and reflect’ on the specific areas of enquiry following:

1. How effectively did services work together to safeguard the individual, in light of the known risks (e.g., offending behaviour, self-harm, substance misuse) and was there evidence to suggest that agencies shared a common understanding of risk throughout the scoping period (which has been agreed as being three years and 9 months prior to his death)?
2. Were the individual’s mental health needs, adverse childhood experiences (ACEs) and behavioural issues (possibly linked to ADHD and Autism) appropriately explored and assessed? What interventions and support were put in place?
3. Was the family actively engaged in assessments, planning and interventions in order to effectively support the individual?
4. How effectively were Children and Families Services (CFS) “step up and step down” processes managed?
5. How effective were the plans to support the individual moving into adult services?
6. How was the individual’s education managed and how was this linked in with other agencies for assessment and support?
7. Were there any areas of good practice?
8. **Key themes identified**

This section sets out the key themes identified during the review and the recommendations for improvement.

**Missed opportunities for holding multi-agency meetings to share information, assess and manage risk**

* 1. 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.
  2. It was recognised in this case that there was a potential for assumptions to be made (as James had attended the emergency department following an overdose) that a mental health assessment would have been carried out, but this did not always occur.
  3. It was identified that GPs often receive a significant amount of information from the hospital emergency department. This will not always be responded to promptly unless the requests for urgent action are highlighted and the GP’s attention is directed to the request. If the emergency department at the hospital is seeking an urgent response, this should be flagged so that the surgery is aware of actions to be completed, and urgent attention to the issue can be highlighted to the GP.
  4. It was identified that North Yorkshire Police now have specialist police staff who work closely with TEWV clinicians to promote the real time sharing of information about people presenting with mental health concerns in the locality.

**Recommendations for improvement**

* 1. **Drawing on learning from this case North Yorkshire Safeguarding Adults Board and North Yorkshire Safeguarding Children’s Partnership should (through the application of their respective assurance processes) ensure that, where agencies have identified multiple safeguarding concerns relating to an individual, multi-agency meetings are held to promote information sharing and assess and respond to the cumulative risk posed to the individual.**
  2. **Drawing on learning from this case Harrogate and District NHS Foundation Trust should ensure (when requesting urgent action from a GP following an individual presenting at the emergency department following a self-harm or overdose event) that these are flagged to alert the GP surgery to the urgent nature of the request.**

**How best to support James’ mum**

* 1. It is apparent from the information provided to this review that on several occasions James’ behaviour caused his mother significant concern and she struggled to cope. The Youth Justice Board guidance identifies that high quality relationships between parents and their children are vital for effective work in managing offending behaviour. It recommends that the impact of parenting on offending behaviour should be considered and interventions such as parenting programmes introduced.
  2. TEWV reported that their serious incident investigation identified that they could have been more effective in supporting James’ mother. Where it was reported that James’ mother appeared to struggle, she may have benefited from support as both his mother *and* carer. It was considered that the perceived lack of support may have been attributable to the absence of multi-agency working as identified.

**Recommendation for improvement**

* 1. **North Yorkshire Safeguarding Adults Board should seek assurance that the areas of learning identified by the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) Serious Incident investigation have been embedded in TEWV operational practice.**

**Challenges in identifying a pathway for a learning disability assessment**

* 1. Professionals shared their frustration at the lack of clarity as to what services were available to undertake a learning disability assessment, which resulted in several referrals being made to various services by a number of agencies. It was further noted that it was extremely challenging to request a learning disability assessment for someone in adulthood with the emphasis apparently on proving the existence of a learning disability before being able to refer an individual for assessment. It was highlighted that James may not have received the required care and support he needed owing to the lack of a diagnosis.
  2. It was reported that there is no current commissioned service for learning disability assessments for 16 to 18-year-olds in North Yorkshire but the Humber and North Yorkshire Health and Care Partnership intends to undertake a mapping exercise of Children’s Services to identify gaps in provision.
  3. In relation to the assessment of mental capacity it was considered that, when someone presenting having self-harmed or having taken an overdose and clinicians are considering mental capacity, the presence of a learning disability would be taken into consideration when undertaking the assessment.

**Recommendation for improvement**

* 1. **Drawing on learning from this case, North Yorkshire Safeguarding Adults Board and North Yorkshire Safeguarding Children’s Partnership should highlight to the Humber and North Yorkshire Health and Care Partnership the current gap in service delivery for the provision of learning disability assessments for 16 to 18-year-olds in North Yorkshire and apply appropriate challenge in resolving the issue.**

**Repeated self-harm episodes with apparent escalation of severity shortly prior to James’ death**

* 1. In the weeks leading up to James’ death the review found his self-harming and suicide attempts escalated. TEWV Crisis received a report from James’ mother saying that he had taken an overdose of tablets. After initially refusing treatment, James agreed to attend the hospital with Yorkshire Ambulance Service, but self-discharged before he could be assessed. Yorkshire Ambulance Service contacted NYCC Adult Social Care Emergency Duty Team after being advised by TEWV to do so, as they could not support James. Yorkshire Ambulance Service (YAS) were advised by the Emergency Duty Team that they should apply the principles of the Mental Capacity Act.
  2. The SAR assumes this advice related as to whether James had the mental capacity to make an informed decision regarding admission and treatment at hospital. Yorkshire Ambulance Service assessed James to have mental capacity to make this informed decision and subsequently no assessment of his mental health was undertaken.
  3. On 9 December 2019 North Yorkshire Police received information that James had taken an overdose and shortly before had taken a young person by force, threatening the individual with a machete. Photographic images shared with North Yorkshire Police showed apparent self-inflicted cuts to James’ chin and lower body. The existence of the se self-inflicted injuries were identified by HDFT while James was at hospital. Although James had a history of self-harming (predominantly through overdosing) this was the first occasion during the timeline of the SAR that it was identified he had self-inflicted cuts to his body and face (albeit James’ mother had previously referred to concerns of such self-harm behaviour).
  4. It is apparent this change in severity of self-harm behaviour went unnoticed by agencies and/or practitioners as a potential escalating risk factor and no safeguarding concerns were raised by either agency. The NHS guidance regarding self-harm identifies a clear link between self-harming behaviour and suicide.
  5. The North Yorkshire Pathway of Support for Children and Young People with Self-Harming Behaviour or Suicidal Ideation provides clear definitions of severity and the impact of self-harming behaviour. It details a Thrive assessment model that may be used by professionals to help guide the appropriate response should behaviour escalate.
  6. The existence of this pathway should be promoted across the North Yorkshire Safeguarding Children’s and Adults Partnerships so as to increase awareness of how to assess and respond to escalating risk factors associated with individuals who self-harm.

**Recommendation for improvement**

* 1. **North Yorkshire Safeguarding Adults Board and North Yorkshire Safeguarding Children’s Partnership should seek assurances partner agencies know of the North Yorkshire Pathway of support for children and young people with self-harming behaviour or suicidal ideation, together with encouraging its use within operational practice.**

**Disengagement with agencies who were trying to support James.**

* 1. It was identified by practitioners that James’ lack of engagement with agencies was a recurring theme. On several occasions, he self-discharged from hospital before he could be assessed by mental health practitioners, and disengagement with the Child and Adolescent Mental Health Service (CAMHS)following prearranged appointments was observed.
  2. It was considered agencies may have been able to exploit established relationships (such as the one held with his Youth Justice Service worker) to create another inroad to gain his confidence, so support for the issues of concern may be provided.
  3. It was identified that now, the TEWV Crisis Team would contact anyone in the same situation as James who had reported having taken an overdose within 72 hours of the overdose event. This protocol was not in existence at the time of James’s death. Contact in such situations would now involve engagement with close family members. Such follow up contact allows the individual time to reflect and process what occurred with the potential of being more open and transparent in discussing their feelings.

**Substance misuse**

* 1. James’s GP medical records showed that he was being supported in relation to substance misuse issues in 2017 and 2018, but there were no official notifications from services to indicate the success of these interventions.
  2. The SAR identifies it would have been beneficial for this information to have been shared with the GP, so that they had an awareness as to whether the work had been successfully completed or whether substance misuse concerns still existed. This work the SAR understands had been undertaken by the YJS substance misuse officer.
  3. A child and family assessment was completed by Children and Families Services, which identified concerns regarding criminal behaviour, substance misuse and potential vulnerabilities to James potentially being a victim of child criminal exploitation. Consequently, a Child in Need plan was agreed to help address the concerns. James was reluctant to engage with Children and Families Services, which complicated their efforts to provide him with support, although his mother did consent to the support being offered. Children and Families Services recognised the requirement to work closely with Youth Justice Service and attended a custody resettlement panel, so that multi-agency planning could take place with the aim of achieving a sustainable resettlement for James following his time in custody.
  4. It was recorded that James’s substance misuse issues were being addressed by the Youth Justice Service substance misuse worker
  5. James was seen by CAMHS at the acute hospital emergency department James’ mother described his behaviour as “out of control”. She also had suspicions he was abusing substances. Whilst referrals were made to Children and Families Services and the Youth Justice Service worker updated, there is no evidence of a referral being made to seek an assessment or support for James from substance misuse services. There is a local Young People Drugs and Alcohol Service provided on behalf of NYCC and a referral to this service by CAMHS could have been made to seek support for James with his suspected substance misuse issues.

**Recommendation for improvement**

* 1. **Drawing on learning from this case the North Yorkshire Safeguarding Children’s Partnership and North Yorkshire Safeguarding Adults Board should seek assurances on the quality of the information available to practitioners in relation to the Young People Drugs and Alcohol Service including how support for individuals with substance misuse issues can be accessed through its referral pathway.**

**Transitional safeguarding**

* 1. The time of James’s transition into adulthood coincided with a period of stability in his life that is evidenced by Youth Justice Service recording that they were pleased with his progress at that time.
  2. Based on the current picture, where James was apparently doing well and the support already in place for him, the decision not to refer James to adult safeguarding would be deemed as appropriate by the SAR.
  3. Whilst James may not have met the required thresholds for interventions to be considered by adult safeguarding this SAR has identified that on occasion, he lived a chaotic lifestyle with the potential need for support and guidance from professionals.
  4. Since 2015 NYCC has had an established “Living Well” service where coordinators work with people in need, to reduce loneliness and isolation together with supporting individuals to live an independent life. The coordinators work with people who may be on the borderline of requiring health and social care support to access their local community provision and resolve issues for people, including preventing hospitalisation.
  5. There is no evidence to show Youth Justice Service or Children and Families Services making a referral to the “Living Well” project that could have provided additional support to James as he transitioned into adulthood.

**Recommendation for improvement**

* 1. **Drawing on learning from this case the North Yorkshire Safeguarding Children’s Partnership should seek assurance that the Children’s and Young People’s Services are aware of the Living Well offer and eligibility criteria and, using assurance mechanisms, ensure that the option of signposting to the service is considered as part of transition planning.**

**Response to James’ frequent attendance at the hospital Emergency Department**

* 1. HDFT provided school nursing services to James and reviewed James’ presentations at the emergency department following reports of overdose. It is apparent that each of these attendances was dealt with in isolation and the cumulative risk of the increasing attendance in relation to overdose did not receive an appropriate level of consideration.
  2. A “Frequent Attender” meeting was held by HDFT in relation to James’s regular attendance at the emergency department. However, there was no apparent outcome or actions from this meeting recorded in HDFT records to evidence a risk plan being developed owing to James’s frequent attendance and the associated risks he presented with.
  3. As a result of the learning identified from this SAR, HDFT are reviewing the selection criteria for cases put forward for review at the Frequent Attender meeting. They are considering that cases involving children and adults of transition age who are aged between 18 years and 21 years will be considered at this meeting if, on two occasions, they present having attempted to take their own life or self-harmed through a significant overdose.

**Recommendation for improvement**

* 1. **Harrogate and District NHS Foundation Trust should ensure when reviewing cases at the Frequent Attenders meeting that it considers multiple attendances, attempted suicide and significant overdose events from a cumulative risk perspective, so as to ensure that frequent attendance and the risks posed to the individual are being appropriately considered and managed.**

**Greater understanding of the TEWV urgent referral pathway for individuals requiring urgent mental health support**

* 1. During a pre-arranged appointment with his GP James disclosed being in a “bad place” in relation to his mental health and how he had previously attempted to take his own life. James provided the GP with a handwritten letter that detailed his feelings and he requested help. In response, the GP submitted a referral letter that was sent electronically to the TEWV Community Mental Health Team - five days following the appointment. The time from appointment to the referral being submitted included the two weekend days and had been marked as a routine referral.
  2. Taking account of the concerns highlighted in the letter relating to James’ mental health and disclosures made of recent attempts to take his own life, the SAR would have anticipated an urgent referral being made to TEWV Crisis Resolution and Home Treatment Team by the GP. This team provides community specialist assessment for individuals over the age of 16 who need urgent mental health care.
  3. Drawing on learning from this case, pathways of referral between agencies and mental health crisis need to be better understood, so as to enable urgent mental health care to be provided when needed.

**On occasions, a lack of professional curiosity displayed by practitioners in this case**

* 1. Assessments provided as part of this review indicated a lack of professional curiosity in relation to James’ family relationships. Whilst the complexity of James’ family situation was documented within records, this was never fully explored by practitioners. This resulted in the potential impact of adverse childhood experiences (ACEs) upon James’ mental health, and how to respond accordingly, were not apparently considered.
  2. A lack of professional curiosity displayed by practitioners is a recurring theme often identified in both safeguarding children and adult reviews.

**Recommendation for improvement**

**North Yorkshire Safeguarding Adults Board and North Yorkshire Safeguarding Children’s Partnership should develop practitioner guidance to help them apply professional curiosity in safeguarding practice.**

1. **Good Practice**
   1. The following areas of good practice have been identified during the course of review:

* The seconded Youth Justice Service specialist teacher supported James to attend the local college, so as to secure his attendance in education.
* Joint working occurred to complete necessary assessments regarding the improvement of James’ relationship with his mother and the risks posed to him through child criminal exploitation
* Youth Justice Service proactively provided briefings for its staff. This following learning identified regarding the challenges individuals with communication difficulties face in using video link when passing sentence.
* Youth Justice Service officer continued to support James during his childhood and following his transition into adulthood.
* Youth Justice Service Officer accompanied James to an appointment with his GP and requested that James be subject to a learning disability assessment. This stemmed from concerns about James’ current IQ assessment.
* GP submitted a mental health referral to TEWV Community Mental Health Team, detailing James’ previous ACEs to provide context of the potential trauma he experienced in childhood.
* Youth Justice Service Substance Misuse Officer provided support to James in attending an appointment with his GP regarding Hepatitis B vaccinations to protect against infection and concerns regarding stomach disorders.
* GP secured James’ consent to share information with his mother in relation to the identification of risk should his self-harm behaviour escalate.
* TEWV applied the principles of the Triangle of Care by involving James’ mother in establishing a safety plan so as to manage the risks posed to him through self-harming.
* Youth Justice Service and Children and Families Services held a joint multi-agency meeting to plan James’ transition into adulthood, evidencing effective planning and relationship-building.
* Youth Justice Service seconded specialist teacher (in an attempt to secure James’ attendance within education) provided support to him by giving James a lift to college.

1. **Recommendations**

*Whilst some of the recommendations explicitly refer to events that occurred within Harrogate and District NHS Foundation Trusts, the learning is applicable to all North Yorkshire Safeguarding Adult Board’s partner NHS Tru*s*ts*.

1. Drawing on learning from this case North Yorkshire Safeguarding Adults Board and North Yorkshire Safeguarding Children’s Partnership should (through the application of their respective assurance processes) ensure that where agencies have identified multiple safeguarding concerns relating to an individual, that multi-agency meetings are held to promote information sharing and assess and respond to the cumulative risk posed to the individual.
2. Drawing on learning from this case Harrogate and District NHS Foundation Trust should ensure that, when requesting urgent action be undertaken by a GP following an individual presenting at the emergency department following a self-harm or overdose event, these are flagged to alert the GP surgery as to the urgent nature of the request.
3. Drawing on learning from this case North Yorkshire Safeguarding Adults Board and North Yorkshire Safeguarding Children’s Partnership should highlight to Humber and North Yorkshire Health and Care Partnership the current gap in service delivery for the provision of learning disability assessments for 16 to 18-year-olds in North Yorkshire and apply appropriate challenge in resolving the issue.
4. Harrogate and District NHS Foundation Trust, when sharing information with GPs regarding “Frequent Attender” patients, should provide more detailed information with regards to cause and effect of attendance.
5. North Yorkshire Safeguarding Adults Board should seek assurance that the areas of learning identified by the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) Serious Incident investigation have been embedded in TEWV operational practice.
6. Drawing on learning from this case North Yorkshire Safeguarding Adults Board and North Yorkshire Safeguarding Children’s Partnership should raise awareness to agencies of the circumstances when information is required to be shared to safeguard children and adults at risk as detailed within the “One Minute Guide” for information sharing.
7. Drawing on learning from this case the North Yorkshire Safeguarding Children’s Partnership and North Yorkshire Safeguarding Adults Board should seek assurance from HDFT as to the effectiveness of their current 0-19 offer. This is relation to providing support for individuals who may be presenting with mental health, substance misuse and self-harm concerns.
8. Harrogate and District NHS Foundation Trust should ensure when reviewing cases at the Frequent Attenders meeting that it considers multiple attendances, attempted suicide, and significant overdose events from a cumulative risk perspective, so as to ensure that frequent attendance and the risks posed to the individual are being appropriately considered and managed.
9. North Yorkshire Safeguarding Adults Board should seek assurances that partner agencies know of the Tees, Esk and Wear Valleys NHS Foundation Trust urgent referral pathway for individuals over the age of 16 years who require urgent mental health care, and how to access it.
10. North Yorkshire Safeguarding Adults Board and North Yorkshire Safeguarding Children’s Partnership should seek assurances partner agencies know of the North Yorkshire Pathway of support for children and young people with self-harming behaviour or suicidal ideation, together with encouraging its use within operational practice.
11. North Yorkshire Safeguarding Adults Board should audit partner agency compliance against the requirement of the West Yorkshire, North Yorkshire and York Joint Multi Agency Safeguarding Adults Policy and Procedures to have systems in place that enable the early identification, assessment, and review of risk through timely information sharing and targeted multiagency intervention.
12. North Yorkshire Safeguarding Adults Board and North Yorkshire Safeguarding Children’s Partnership should develop practitioner guidance to help them apply professional curiosity in safeguarding practice.
13. Drawing on learning from this case the North Yorkshire Safeguarding Children’s Partnership and North Yorkshire Safeguarding Adults Board should seek assurances on the quality of the information available to practitioners in relation to the Young People Drugs and Alcohol Service, including how support for individuals with substance misuse issues can be accessed through its referral pathway.
14. Drawing on learning from this case the North Yorkshire Safeguarding Children’s Partnership should seek assurance that the Children’s and Young People’s Services are aware of the Living Well offer and eligibility criteria and, using assurance mechanisms, ensure that the option of signposting to the service is considered as part of transition planning.
15. North Yorkshire Safeguarding Children’s Partnership should seek assurances from partner agencies on the robustness of the referral and escalation mechanisms to support the welfare of children who are missing from education.