City of York

Safeguarding Adults Board

SAFEGUARDING ADULTS REVIEW

Report into the circumstances surrounding the death of Mr Z.

Mark Tasker Independent Reviewer and Author

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1. Introduction

1.1 Statutory Framework relating to Safeguarding Adults' Reviews (SARs)

Under Section 44 of the Care Act (2014), Safeguarding Adults Boards (SABs) are required to commission Safeguarding Adults Reviews (SARs) in certain circumstances. Section 44 of The Care Act 2014 states:

The Safeguarding Adults Board must arrange for there to be a review of a case involving: An adult in its area who has care and support needs (whether the local authority was meeting any of those needs)

a) 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**
b) 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).
c) In delivering good practice in any area of safeguarding adults, it is important to identify what areas are working well and what areas safeguarding can be improved. The overall purpose of a Safeguarding Adults Review is to learn and improve.

The Independent Chair of the City of York Safeguarding Adults Board determined that the statutory criteria for carrying out a SAR were met in relation to the tragic death of an individual, who will be identified as Mr Z for the purposes of this report, and who died on 6th April 2019.

1.2 Background to the Circumstances of the Review

Mr Z was born on 10th January 1971. At the time of his death, he was living at an address in York. Mr Z had no known diagnosed physical health issues, but he had a long history of involvement with drug and mental health services and a diagnosis of schizophrenia. In 2010, he was diagnosed with longstanding anxiety and acute psychosis, secondary to cannabis.

On 20th March 2020 Her Majesty's Coroner concluded an inquest with an open verdict and the cause of death recorded as drowning.

Mr Z's case was referred for consideration of a Safeguarding Adults Review by the Named Nurse Safeguarding Adults from Tees, Esk, and Wear Valleys (TEWV) NHS Foundation Trust on 18th February 2020. On the 30th June 2020 the recommendation was approved by the Chair of the City of York Safeguarding Adults Board.

In summary, the grounds for this referral were as follows: Mr Z was a resident of York. He had care and support needs in relation to housing and social support. He had experienced a change in his circumstances, as the level of his parents' support had decreased. He was in receipt of support from mental health and substance misuse services. It was therefore felt that there was a need for further exploration of the multi-agency working approach to the safeguarding concerns surrounding Mr Z and the effectiveness of the arrangements.

Mr Z had two older brothers and his elderly parents provided a high level of social support to him on a daily basis. Sadly, his mother passed away overnight on 13/14th February 2019 and at the time of Mr Z's death, his father was in a care home.

2. Terms of Reference

2.1 Context

The terms of reference for the Review were developed by the City of York Safeguarding Adults Board. These highlighted that Mr Z was a 48-year-old male who had diagnosed mental health difficulties, as well as substance misuse issues. There is evidence in various records that Mr Z was believed to be the victim of 'cuckooing[1]' at his property in York. As a result of this criminal act (and alleged drug dealing), he was known to North Yorkshire Police, the City of York Council Housing Department and Adult Social Care in addition to the local Mental Health Trust (TEWV). Mr Z had approached these agencies asking for assistance to deal with the abuse he was experiencing at his property on many occasions. Sadly, he died by drowning on 6th April 2019.

The following points show the purpose of the Review in shaping the terms of reference:

a) To examine the circumstances prior to Mr Z's death, particularly the level of support he received from involved agencies and services.
b) Establish whether there are lessons to be learned about the way in which professionals, agencies and any other relevant persons work together in the City of York to safeguard adults at risk.
c) Review procedural effectiveness at both a multi-agency and individual organisation level.
d) Inform and improve local interagency practice and commissioning arrangements.
e) If agreed by the Safeguarding Adults Board, the author will work closely with the family in helping to shape and inform the review.
f) Identify good practice where evident
g) Improve practice by acting on learning and improving practice.
   Bring together and analyse the findings of reports from agencies to make recommendations for future action.

2.2 Specific questions the SAR will address and analyse

2.3 Time-Period Considered by the Review

The Safeguarding Adult Review covers the period January 2018 to April 2019.

[1] Cuckooing occurs when drug dealers befriend vulnerable individuals and turn their homes into a place to keep and sell drugs (known as trap houses). Drug dealers will often use violence, abuse, coercion, intimidation and bullying tactics to facilitate the use of the accommodation and the vulnerable person's co-operation.

2.4 Methodology

i. **Information Gathering**. Chronologies to be undertaken by the following agencies:

- City of York Council-Adult Social Care
- City of York Council-Housing Services
- Yorkshire Housing Association
- Tees, Esk, and Wear Valleys NHS Foundation Trust (TEWV)
- North Yorkshire Police
- Mr Z's registered General Practitioner
- Changing Lives (York) – A Drug and Alcohol Specialist Recovery Service.

ii. **Analysis by Agencies**. The agencies above to be also asked to make recommendations as to what actions they need to undertake to improve practice.

iii. **Learning event**. Practitioners and Managers will be invited to an event to establish the local context and inform the SAR.

iv. **Family Involvement**. If considered appropriate by the City of York safeguarding Adults Board, Mr Z's family will be invited to take part in the SAR in the following ways:

a) Invited to meet with the author to give their view of the events leading up to Mr Z's death
b) Invited to parts of the SAR process as determined by the SAR panel.
c) Invited to contribute to a final draft prior to publication.
d) Informed about publication stages, dates, and processes.

2.5 Timescale for Completion of the Review

It is envisaged that the SAR would be completed within four months of initiation from Sept 2020 to January 2021.

A report was submitted to the City of York Adults Safeguarding Board on 11th January 2021. The Board requested some additional work be undertaken on the role of the council's Adult Safeguarding and Housing Department response to Mr Z and a further report was sent on 4th February 2021. At a meeting between the Board's SAR Panel and the Author on the 4th of April 2021, it was decided that the period of time the Safeguarding Adult Review was to consider was to be extended back to 1st January 2018 and a new completion date set for end of July 2021. The panel also requested that some additional analysis be carried out on the information obtained from the Practitioners and Managers Event, which took place on 11th June 2021.

3. History of Prior Involvement with Mr Z

3.1 Although the period of Mr Z's life from 2007 to the end of 2017 is outside the timeframe to be considered as part of the review, the author considers that an understanding of the events during this period will help provide context regarding the events, which lead to Mr Z's tragic death.

3.2 Mr Z had been known to Mental Health Services since August 2007 when he was referred by his GP. He had been in treatment with Substance Misuse Services since 1995 with a long history of heroin dependence and use of cannabis / poly substances. He had

reportedly stopped using these but had remained under the care of the Substance Misuse Service for maintenance therapy.

3.3 In 2008, Mr Z reported that his housing was unsatisfactory, and this added to his problems because he felt threatened and unsafe in his flat due to his neighbours whom he believed were dealing street drugs.

3.4 It was also believed at that time that Mr Z was possibly the victim of 'cuckooing'. It was documented that he had allegedly been held hostage in his accommodation and had been 'running' drugs for the people who had taken over his flat. He was experiencing panic attacks and was reluctant to leave his property. Concerns were further raised by TEWV staff in November that year about the people in Mr Z's flat and the police were notified.

3.5 Also, in May 2017 Police submitted a safeguarding referral to City of York Safeguarding Team regarding concerns about Mr Z expressing thoughts of self-harm and suicide. Notes reveal that the information was passed to the Mental Health team.

3.7 In July 2017, a safeguarding concern form was submitted re neglect / acts of omission and self-neglect. Mr Z was having problems with neighbours who are violent towards him, and he avoids leaving the house. The referral states that the police are aware, it was identified that Mr Z had no CPN due to him not attending appointments but Mr Z states that he was not attending appointments due to a fear of leaving his accommodation.

3.8 On 12th October 2017, there was a safeguarding concern from the police- Mr Z was arrested on 10/10/17 for drug dealing; he said he was doing it under duress and dealers had moved into his flat. A search of the flat was carried out but they had left. The Local Authority safeguarding team contacted Mr Z who said he was not doing well but that he was OK. Mr Z was engaging with the Mental Health Team. His CPN advised they were working with him getting a move to another property because of the impact his location and others was having on his mental health. The referral was closed to safeguarding.

4. Summary of Agency Involvement with Mr Z between January 2018 and April 2019

Information was obtained from Single Agency and Multi-Agency Chronologies compiled by the agencies involved from case records.

4.1 Summary of TEWV Mental Health Trust Involvement

4.1.1 Mr Z received support and monitoring by means of mostly face-to-face visits at his flat during the entire review period, at least every two to three weeks. He received some additional telephone support. The frequency of visits increased when he was in crisis, such as when he was attacked by his neighbour. He was offered practical support regarding rehousing and bidding on properties. His mental health and any suicidal ideation was monitored and noted. Comments were recorded about his weight loss and poor dietary intake, as well as difficulties he was having with neighbours and other associates who were believed to be involved with drug use and dealing.

4.1.2 There was evidence of liaison with the police, housing and safeguarding and safeguarding referrals were made but not accepted on the grounds of them not being appropriate. At the Practitioners and Managers event, it was stated '*He was presumed to have mental capacity unless there was contrary information and then an assessment would be undertaken*.' There were no detailed accounts provided in the notes of capacity assessments undertaken.

4.1.3 Mr Z received a period of intensive support from approximately 5.12.18 until after Christmas 2018. At that time, his mother was very ill and he was worried about who would support him. There was a reported incident of Mr Z threatening to harm himself by means of a noose. At that time, an increase to his housing priority was declined. A safeguarding referral was made on 12th December 2018 and not accepted. Mr Z indicated that he would like to move to some form of supported living.

4.1.4 There was a further spell of particularly intensive support following Mr Z mother's death in February 2019. He continued to express suicidal ideas and expressed concern about his personal safety in his flat to the TEWV staff who were in contact with him.

4.2 Summary of Changing Lives Involvement

4.2.1 Mr Z attended the service approximately monthly for a clinical review and key worker session. At these appointments, he had a urine test and was usually weighed. It was often noted that he looked underweight and gaunt. Throughout the review period, he admitted to using crack twice weekly. His urine tested positive for this and other substances. In the notes, there was infrequent mention of other issues such as the support that was being offered by his parents and his housing situation. An offer of housing support was made at the visit on 12/10/18 but Mr Z declined. In the early part of 2019, there were occasions when Mr Z was unable to provide a urine sample and he discussed his concerns about his unwell mother and housing difficulties more frequently. There were occasional other issues noted such as Mr Z trying to cash his Lorazepam prescriptions in early, before they were due, and Mr Z's mother collecting his Methadone on his behalf.

4.2.2 When Mr Z did not attend his prescription and key work session on 29/3/19, staff checked with the local pharmacy if he had collected his Methadone prescription. They reported that he had not collected it on 26th, 27th and 28th March, which meant he was now 'off script.' This was highly unusual and led to him being reported missing.

4.2.3 There is evidence of liaison between Changing Lives, the local pharmacy, and the GP but not with any other partner agency.

4.3 Summary of North Yorkshire Police Involvement

4.3.1 North Yorkshire Police had frequent direct contact with Mr Z. He was both a victim of crime as well as being suspected of being involved in drug dealing. Additionally, he was involved in two incidents of anti-social behaviour during the time of the review period. The Police also received and recorded intelligence about Mr Z's activities, the intelligence recorded, referred to drugs and possible exploitation. There are documented incidents of Mr Z being reluctant to report incidents where he was a victim and he withdrew complaints, apparently because he was fearful of making the situation worse. The Police carried out a

number of welfare checks on Mr Z during the review period, some at his request, some from concerned neighbours and some at the request of other agencies.

4.3.2 Intelligence was provided to the police on 1st May 2018 where it was reported that people were visiting Mr Z's flat uninvited and putting his tenancy under threat. It was noted that Mr Z was using heroin four times a fortnight and working with Changing Lives, and he was looking at going to Re-hab.

4.3.3 Mr Z was threatened by another resident on 9.8.18. The police carried out a vulnerability assessment and Mr Z obtained a low score.

4.3.4 Between late December 2018 and March 2019, the frequency of reports pertaining to people being at Mr Z's flat uninvited, exploitation and abuse increased. A welfare check was carried out, on 15/3/19, but Mr Z refused any follow up action. Mr Z was arrested for drug offences on 19th March 2019 and the chain of events commenced which led to his premature death.

4.4 Summary of Involvement from City of York Safeguarding Team

The Safeguarding Team received a number of referrals in relation to Mr Z during the review period, from the Police, TEWV staff and Yorkshire Housing. None were accepted and the case was closed following speaking to the referrer, making further enquiries and sometimes signposting to other services. There was one phone contact with Mr Z on 14/3/19, but following a discussion with apparently the referrer, who stated Mr Z had 'capacity,' the referrer was advised that no involvement from Safeguarding was possible.

4.5 Summary of Involvement from General Practitioner

Mr Z received both routine physical health care and mental health care from his GP throughout the review period. Mr Z mentioned he was in contact with his GP when he interacted with other agencies. The GP responded to requests from other agencies and proactively undertook a home visit to Mr Z following the death of Mr Z's mother in February 2019, on that occasion providing a short course of sleeping tablets.

5. Practitioners and Managers Event 11th June 2021.

This event was held virtually. Its aim was to further clarify the events leading up to Mr Z's tragic death and to allow those who provided care and support to Mr Z to come together, talk about their input and look at what can be learned about working together across organisations and systems to support those in most need of care.

Each agency was invited to give their views regarding their involvement. However, it is acknowledged that there were limitations in this event as it was held more than two years after Mr Z's death. Some of the views expressed were based on direct involvement with Mr Z and some from those with knowledge of the case records.

5.1 TEWV Mental Health Trust

5.1.1 Mental Health staff saw Mr Z on a weekly / twice weekly basis. He was presumed to have mental capacity unless there was contrary information and then an assessment would be undertaken. Staff tried to support Mr Z in obtaining a housing transfer, but this was difficult and staff were unable to understand why. Staff felt that Mr Z's problems and vulnerability were not recognised.

5.1.2 Mr Z was offered two properties; he refused the first as it was in a known drug area. He was in hospital at the time of the second offer and therefore was unable to respond in the required timescale. Staff felt there was a general disconnect between Housing and TEWV / CYC Safeguarding / CYC MH Team.

5.1.3 The view from meeting attendees was that there was no evidence of agencies or practitioners challenging each other or escalating issues. There was a need to examine pathways; and in cases of dispute or difficulty, there needed to be a method of escalating issues to an appropriate decision-making level.

5.1.4 TEWV staff were concerned about what happened at the CYC temporary supported housing service and felt that assumptions were being made about Adult Social Care involvement. It was possible that some practitioners thought that the housing service staff were part of Adult Social Care.

5.2 North Yorkshire Police

5.2.1 Mr Z had been known to the police since 1987 with a number of arrests relating to drug crime between 2008–2019.

5.2.2 Mr Z was initially very engaged and co-operative with the Police and with investigations that Mr Z had reported but then he would withdraw. In retrospect, it was considered this may have been down to people he was associating with and the pressure and fear he may have felt at the time. He tried to manage situations himself but would call police when things got out of hand.

5.2.3 In summary, when Mr Z co-operated and stated what risks he faced he had a positive response and support from the Police. Although it was suspected Mr Z was involved in illegal activity, including supply of drugs, officers viewed Mr Z as a victim and safeguarded Mr Z accordingly. Police highlighted the difficulty of balancing victim status with his offending behaviour; police could not overlook the crimes Mr Z was alleged to have committed.

5.2.4. A vulnerable risk assessment was carried out and a low score was assessed. It is possible that the assessment did not take account of all risk factors concerning Mr Z's circumstances. If Mr Z was assessed as High this may have prompted a multi-agency planning meeting to have been convened. No referral was made for the multi-agency planning meeting and it is unclear if an NCA (National Crime Agency) referral was submitted for victims of 'County Lines[2]'.

5.3 Changing Lives

5.3.1 Mr Z's first contact with Changing Lives was in 1995. Mr Z was seen on a monthly basis. It was stated he was a regular crack user but no evidence of heroin, although some drug tests showed evidence of opiates. It was stated this could have been Co-codamol. Mr Z always collected his prescription on time, and this is why concerns were raised in March 2019 when he missed three.

5.3.2 Mr Z never mentioned any concerns regarding his neighbours, assaults, County Lines or exploitation. Of greater concern, no agency mentioned concerns to Changing Lives. Changing Lives do liaise with police regarding County Lines but there was no liaison concerning Mr Z.

5.4 CYC Safeguarding Team

5.4.1 It had been identified that two separate records had been created for Mr Z under different spellings of his surname which clearly would not have helped staff to see the full picture.

5.4.2 There were six referrals from different agencies where there is no information regarding the action taken or outcomes.

5.4.3 It was considered at the meeting that there was too much focus by practitioners on a move being the main problem and solution. There was also too much emphasis on the presumption that Mr Z had capacity. It was felt that there should have been more professional curiosity regarding whether he had capacity. If he was assessed as lacking capacity, other avenues would be opened, including the Court of Protection. There was a lack of explanation and rationale when assuming capacity.

5.4.4 It was felt that there was missed opportunities to safeguard Mr Z, namely a cause for concern meeting was not held, and the escalation process was not used. This was the case when, for example, on securing a move to a CYC temporary supported housing service the decision to terminate the contract was made following police arrest of Mr Z. Contact was made with TEWV, but the decision to terminate the contract by CYC was already made, and Mr Z had left.

5.4.5 The point was made that services need to support positive risk- taking, challenge each other as professionals, encourage professional curiosity and escalate concerns when

[2] County Lines is where illegal drugs are transported from one area to another, often across police and local authority boundaries (although not exclusively), usually by children or vulnerable people who are coerced into it by gangs. The 'County Line' is the mobile phone line used to take the orders of drugs. Importing areas (areas where the drugs are taken to) are reporting increased levels of violence and weapons-related crimes as a result of this trend.

necessary. The need for information sharing was emphasised as information was not always shared about Mr Z when it should have been. There was a need for multi-agency working via various mechanisms. There was suspicion raised by agencies regarding County Lines and Cuckooing present in Mr Z's case and these should have been triggers for discussion and multi-agency working.

5.4.6 Information supplied by the supported housing service was considered. The notes focus on the decision to exclude Mr Z just after the police visit. The decision was well documented, communicated, and 'accepted' by agencies. It was noted that there did not appear to be any challenge. Those present at the Practitioners and Managers Event questioned the decision to exclude Mr Z from the service when it appeared many other residents who had issues similar or as complex to Mr Z were permitted to stay.

6. Analysis

The analysis is based on the considerations set as part of the review's terms of reference.

6.1 Consideration 1 - were services easily accessible and responsive in meeting Mr Z's needs, including support for his safety concerns and his frequent rehousing requests?

6.1.1: The information indicates that Mr Z was able to access services relatively easily. Mr Z had access to practitioners' work numbers, including mobile numbers, for example, Mr Z was able to request meetings with mental health workers by text. There is evidence that agencies responded positively in providing support to Mr Z.

6.1.2: Agencies appear to have responded appropriately and effectively to events and Mr Z's presenting needs. Mental health and drug services undertook regular meetings with Mr Z and monitored his health and wellbeing. His weight was monitored and there were regular blood tests. Practitioners referred Mr Z to senior and more experienced colleagues such as consultants where necessary and appropriate. There was evidence of practitioners securing the help and support of other services, for example, GP surgery and mental health services in relation to prescriptions.

6.1.3: There were also good examples of services responding to requests from Mr Z for home visits and meetings, sometimes at very short notice, and those agencies identifying and highlighting concerns and taking appropriate action. For example, the police undertook prompt and robust welfare checks in response to calls from other agencies.

6.1.4: In relation to support around Mr Z's concerns about his safety and his frequent requests to be rehoused, it appears from the information that a great deal of support was provided in the main by mental health services, but there appeared to be several hurdles and obstacles for both Mr Z and practitioners to overcome. Short-term solutions such as emergency accommodation was considered (e.g., Sept 2018).

6.1.5: Accommodation problems and problems with neighbours/drug dealers were first highlighted in November 2008, following a GP referral to the Community Mental Health Team. During the assessment, Mr Z stated he felt his housing was unsatisfactory and this added to his problems because he felt threatened and unsafe in his flat due to his neighbours whom he believed were dealing street drugs. This continued to be an issue for Mr Z throughout his life.

6.1.6: It is clear that Mr Z's problems associated with his accommodation were of great concern not only for him but also for some practitioners, and as detailed in chronologies, considerable effort was put in to support Mr Z in his quest for a move. However, other practitioners believed Mr Z used the issues in order to achieve a move and that too much focus was placed upon rehousing. Mr Z's accommodation issues and problems with neighbours are well documented and there is no doubt they did not help his situation; they were an additional stressor for Mr Z and added to an already complex and chaotic situation.

6.1.7: It may be that if the accommodation issue had been resolved, it may have resulted in Mr Z's disengagement with the local drug scene and eased his drug related problems with consequent improvement in his mental health and wellbeing. This is debatable. Mr Z was very well embedded within the drug scene and his ties, associations and own needs may have drawn him back. However, that does not mean that agencies should stop trying and indeed a short-term solution was thought to have been found in Mr Z's placement at the temporary supported housing service.

6.1.8: The placement did indeed have a positive effect on Mr Z, but this was short lived as on his first day of placement he apparently returns to the drug scene with his associates and was arrested. It is unfortunate that Mr Z was excluded from his placement the next day, Mr Z's situation and problems were well known, and this short respite may have been a starting point leading to better outcomes. Agencies felt aggrieved that there was little discussion about this course of action and were presented with a decision, which had already been made, and they had little time to plan and respond. (When he was informed that the placement had been ended, Mr Z stormed out of the premises and agencies did not know where he had gone).

The Author has no recommendation to make in relation to Consideration 1.

6.2 Consideration 2 - what evidence was there of effective coordination between multi-agency service providers?

6.2.1: When responding to safeguarding issues it is important to ensure that there is effective co-ordination both within services and between agencies working with the adult at risk. Larger organisations can offer a number of services and it is important to ensure effective co-ordination within that organisation so that the most appropriate response can be identified and provided.

6.2.2: Co-ordination between agencies, whether on an inter-agency (often between two organisations) or multi-agency (several agencies involved) basis, can often be difficult for many reasons. It is often the case that a single agency takes the initiative in instigating the multi-agency response, and it may be that, that agency or another takes the lead role (perhaps an agency that has been specified as the lead one within multi-agency procedures or the agency with the greatest involvement with the adult).

6.2.3: The importance of multi-agency working and co-ordination in safeguarding adults has been emphasised over the years. Multi-agency working and co-ordination provides for a much faster and consistent response to safeguarding concerns, a more effective assessment, management, and reduction of risk. It provides for a better understanding between professionals and greater efficiencies in processes and resources. There is evidence within the chronologies and reports reviewed by the author that appropriate co-

ordination took place within individual agencies, but no evidence of co-ordination between agencies.

6.2.4: All staff working with vulnerable adults or adults at risk need to be aware of their roles and responsibilities and what to do when they have concerns. Agencies and workers need to be aware of the importance of recognising key areas or events that should trigger multi or inter agency co-operation and co-ordination. This will often include the adults at risk but on occasions and in accordance with relevant legislation and guidance may require a response without the involvement of the individual.

6.2.5: A number of agencies had been working with Mr Z since 2007 / 2008 and certainly during the review period January 2018 – April 2019. Throughout this period, there were a number of opportunities where a multi-agency approach could have and should have been triggered. Key and significant events or episodes were taking place on a regular basis and individual workers or agencies did not appear to recognise that other agencies involved with Mr Z could have made an important contribution in the consideration of Mr Z's needs and offered collective support.

6.2.6: During 2018, Mr Z was having problems with neighbours, with his weight, his accommodation, and his associates. In early 2019, Mr Z's mother sadly died, and his father went into care, Mr Z himself highlighted how reliant he was on his parents for support, especially his mother. There were a number of reports of concern and referrals were made to Adult Safeguarding. Mr Z was viewed by all agencies as a vulnerable person and there was a suspicion that he was involved in County Lines and that his accommodation was regularly taken over by drug dealers, possibly from outside the York area. Although a sensitive area of policing, this was an occasion when, as recognised by the police themselves, a multi-agency problem solving meeting could have been held to ensure all agencies were able to share real-time information. This type of meeting can be called by any agency, but primarily by Community Safety Partners or equivalent.

6.2.7: Another opportunity for multi-agency co-operation / co-ordination was missed when Mr Z was excluded from the temporary supported housing service after his arrest in March 2019. This was an extremely significant time in Mr Z's life. All agencies involved with Mr Z had information about the issues currently being faced by him and his needs and the decision to exclude him seems to have been accepted by practitioners without challenge. It may be that a multi-agency meeting, possibly involving Mr Z may have assisted the decision-making and possibly led to a different outcome.

6.2.8: The benefits of such meetings have been well documented in the various national guidance available on safeguarding adults. Information can be shared, practitioners questioned and challenged, options explored, and support and responses can be co-ordinated.

6.2.9: As stated above agencies and practitioners must be aware and alert to the importance and benefits of multi-agency working and co-operation.

Recommendation 1: The City of York Safeguarding Adults Board may wish to consider whether the guidelines concerning multi-agency working and co-ordination need to be reviewed and reissued to partner agencies.

6.3 Consideration 3 - what evidence was there of communication and information sharing between agencies?

6.3.1: The ability to have purposeful conversations with different members involved in adult safeguarding can really enhance the support offered to the adult at risk in ensuring effective, timely communication and information sharing, as well as collaborative working. Communication and information sharing must not be seen as a 'tick box' task; it must be purposeful, meaningful and agencies must follow up and engage with the recipient. This is often achieved through telephone or email on-going communication but can often require face-to-face meetings.

6.3.2: Adults have a general right to independence, choice and self-determination including control over information about themselves. In the context of adult safeguarding, these rights can be overridden in certain circumstances including the need to share information to safeguard adults at risk of abuse. There was evidence in Yorkshire Housing chronology where on 17th September 2018 Yorkshire Housing became aware of an alleged assault and concerns for Mr Z's safety and wellbeing. Mr Z was encouraged to contact the police; he said he would not as he was fearful of repercussions. Yorkshire Housing contacted the police, requested a welfare check, and reported the assault.

6.3.3: The information reviewed in this case highlights that there is a great deal of evidence of single agency and some inter-agency communication and information sharing. There are a number of good practice examples of staff and practitioners within an agency discussing Mr Z's case with colleagues and senior staff, including at meetings such as 'TEWV Huddle' meetings. Within the police a number of departments and units had contact and involvement with Mr Z and there was good evidence of information sharing between departments so that staff and officers had access to all necessary information.

6.3.4: Information sharing is fundamental to good practice in safeguarding adults. The information to be shared must be the right information; it must be shared at the right time and with the right people. Research has shown that information sharing is an area of practice, which many professionals find extremely difficult.

6.3.5: As highlighted above practitioners were effective at sharing information when particular needs were identified. Mr Z was vulnerable and clearly, an adult at risk and as a consequence, the sharing of appropriate information takes on a greater significance. Mr Z's case was complex and involved many practitioners from a variety of organisations and agencies. No one single agency had an overall view of what life was like for Mr Z and when making decisions which may impact on the safety and wellbeing of Mr Z. Agencies and practitioners should have access to all the available facts and information.

6.3.6: It can be difficult for practitioners to know exactly when and what information should be shared and with whom in safeguarding adults' cases. There were some opportunities when inter agency information sharing may have been enhanced but there was no evidence available to suggest this took place, e.g., Mr Z's weight loss problems, his being prescribed nutrient shakes and his possession of protein powder.

6.3.7: Possibly more worrying is that there is little evidence of the regular sharing of information to safeguard Mr Z, for example the drug service were totally unaware of the problems being experienced by Mr Z from his neighbours and associates and the suspicion of exploitation, even though the service had regular meetings and contact with the Police.

6.3.8: All staff, in all agencies who work with adults at risk, should understand the importance of sharing safeguarding information and the potential risks of not sharing it.

Recommendation 2 - The City of York Safeguarding Adults Board may wish to consider whether any work needs to be undertaken in ensuring partner agencies and stakeholders are aware and understand the importance attached to information sharing.

6.4 Consideration 4 - were services offered to Mr Z in a timely manner?

6.4.1: The importance of appropriate and timely intervention in an adult's health and wellbeing and in safeguarding adults from abuse, harm and exploitation is crucial and has been well recognised for a number of years. The earlier a problem or issue is identified then the better the prospect of achieving a positive outcome.

6.4.2: The demands on all services are increasing and resources available are challenged on a year-by-year basis. Appropriate and timely intervention when coupled with attempts to identify the root cause of the problem can promote health, welfare, development, and safety and plays a great part in preventing problems developing later.

6.4.3: Based on the available information, the review author is of the opinion that single agency / organisation interventions were generally appropriate and timely. When problems were identified, action was taken, for example, in responding to Mr Z's changing physical and mental health needs and support in trying to achieve social changes in particular his accommodation issues.

6.4.4: It is clear that staff were committed to supporting Mr Z and in responding to and addressing his needs. As highlighted previously mental health and drug services undertook regular meetings with Mr Z and constantly monitored his health and wellbeing. His weight was monitored and there were regular blood tests, Mr Z's GP undertook regular checks and local pharmacies monitored his prescription collection.

6.4.5: When issues arose, there was evidence of good practice in responding to those issues, for example, there were a number of incidents were agencies highlighted a cause for concern regarding Mr Z and appropriately contacted police for welfare checks to be undertaken. In March 2019, the Substance Misuse Service highlighted that Mr Z did not attend his keyworker and prescription appointment. The service called the local pharmacy and they advised Mr Z had not collected his prescription on 26th, 27th and 28th March and was therefore 'off script.' Contact was then made with the Mental Health Service and the Police, culminating with Mr Z being classified as a missing person.

6.4.6: There was good evidence of agencies making appropriate safeguarding referrals to Adults Safeguarding but very little evidence relating to what happened with these referrals and the outcome being recorded and shared with the agency that initially made the referral.

6.4.7: Although most concerns can be effectively responded to and addressed at a single agency intervention level, some interventions require the support of many other agencies and often-in safeguarding adults' cases in order to achieve the best outcome for the adult at risk other agencies help is critical. As highlighted previously, there was some evidence of inter-agency co-operation but very little evidence of multi-agency co-ordination or co-

operation, which, in safeguarding terms, did have an impact on agencies being able to identify and implement the most appropriate safeguarding interventions.

6.4.8: An important part of safeguarding is ensuring that all agencies adopt a culture where challenge is considered appropriate, beneficial and a positive response. Where there are disagreements or practitioners are unhappy with other practitioners (whether within their own agency or another agency) actions or decisions, they should be encouraged to challenge those actions and decisions. Practitioners and agencies who are the subject of the challenge should also be encouraged to receive the challenge in a positive and professional way. Where challenges cannot be resolved then the issue should be quickly escalated to appropriate line managers for resolution.

6.4.9: As highlighted in the Practitioners and Managers event, it was felt that there were missed opportunities when the escalation process was not used, for example in the decision to terminate Mr Z's contract at the temporary supported housing service. It was also highlighted at the practitioners and managers event that staff should have access to a 'Pathway' which outlines the appropriate process for dispute resolution with details of managers who are able to appropriately respond and resolve issues and problems.

Recommendation 3 - The City of York Safeguarding Adults Board may wish to consider reviewing the advice and guidance provided to partner agencies regarding challenging each other's decisions and how to escalate concerns in case of dispute.

6.5 Consideration 5 - how were risks assessed and managed in relation to Mr Z?

6.5.1: An extremely important part of adult safeguarding is the identification, assessment and management of risk, which focuses upon and establishes the likelihood and consequences of abuse or neglect. Risk is a normal everyday experience and as with all adult safeguarding, risk management must be applied in a manner that promotes empowerment, is proportional, and aims to prevent harm.

6.5.2: When assessing risk, practitioners should have access to as much information they can and in particular an understanding of any previous harm that has occurred, as this will help in establishing facts, put events into context and also help with the identification of the possible impact of the harm or neglect.

6.5.3: It must be remembered that the assessment and management of risk is primarily the responsibility of the adult unless they lack capacity or are so intimidated or controlled by others that they are unable to protect themselves.

6.5.4: Practitioners will undertake various forms of risk assessment and management on a day-to-day basis both formal and assessing risk is part of the roles and responsibility of all practitioners who work or have contact with vulnerable adults or adults at risk of harm, from initial identification of harm to a full formal risk assessment.

6.5.5: In certain situations, for example where there is a likelihood of serious harm, practitioners from different agencies may have to work together in partnership to share information, consider options for intervention and be accountable for their individual and collective contributions in mitigating the risks.

6.5.6: In this case it should be remembered that Mr Z's everyday life was filled with additional challenges, not only relating to his mental health and drug addiction but also from his neighbours, drug associates, lifestyle, and exploitation.

6.5.7: Within the time frame of the review there was a great deal of evidence contained within the information regarding some agencies risk assessment and management of Mr Z's circumstances, most of which were clinical assessment and management concerning his mental health and risk relating to self-harm, suicide, and drug use. Mental health workers considered risk on a regular basis, identified, and recorded a plan to address those risks. Police undertook assessments of risks after incidents and had a model to help them categorises the risk based on the information considered at the time (VRA).

6.5.8: It is not known when undertaking these assessments whether information, if any, from other agencies was sought or provided. It is the responsibility of the practitioner undertaking the assessment to consider the need to involve other agencies. It is accepted that in many single agency assessments, for example, clinical assessments, then the need for other agencies' involvement is low. However, for other types of risk assessment, the involvement of other agencies can enhance decision-making and improve the chances of obtaining a better outcome for the individual.

6.5.9: In some instances, because of the situation and circumstances it may be appropriate to undertake a more formal safeguarding assessment of risk. When undertaking such an assessment it is crucial to have access to as much available information as possible, including and especially information from partner agencies working with the individual. This is often undertaken as part of a professionals meeting when a holistic view of the risk posed can be shared and assessed and an appropriate decision made.

6.5.10: As highlighted previously, it is important that all staff working with adults at risk are aware of the need for and importance of multi-agency working. A vital part of multi-agency working is the ability to identify, assess and manage risk on a multi-agency level. In this case, Mr Z had drug and mental health issues, he had been threatened and assaulted by neighbours, was involved in criminality relating to his drug use and was at risk of criminal exploitation. He was frightened and there was evidence relating to the possible use of knives to protect himself. He reported thoughts of suicide; he was unhappy with his accommodation and had little family support other than from his elderly mother and father. From the information available to the review, there appears to have been no formal multi-agency safeguarding assessment of risk having taken place.

6.5.11: Assessments and decisions were being made about Mr Z in a particularly challenging context and environment. Agencies will collate and have access to their own information that may help in thought processes, analysis and evaluation. Information sharing between partners as part of a safeguarding assessment process is important and essential and should be encouraged by the SAB and partner agencies. Concerns about sharing information should be acknowledged and addressed, by good communication with practitioners on both a single agency and multi-agency basis.

It may be that professionals can be better supported in their assessment and management of risk, especially any formal assessment regarding safeguarding risks. Consideration and review of the single / multi-agency processes that are currently employed, particularly those, which involve ensuring that partner agencies and stakeholders are aware and understand the importance attached to the consideration of the information held by other agencies in assessing risk.

Recommendation 4 - The City of York Safeguarding Adults Board may wish to review and reissue guidance to partner agencies concerning the requirement to share information concerning risk factors held by single agencies in safeguarding situations.

6.6 Consideration 6 - was the issue of Mr Z's mental capacity addressed?

6.6.1: An adult's ability to make their own decisions is an important aspect of protecting that individual from harm or neglect. Where an adult is unable to make their own decisions because of illness or disability such as a mental health problem, dementia, or a learning disability then their ability to protect themselves from harm, neglect or exploitation may be greatly affected. It is therefore important that when practitioners from all agencies or organisations are supporting a vulnerable person, who has problems associated with mental illness, substance, or alcohol misuse, are aware, understand, recognise, and appropriately respond to someone who may lack capacity.

6.6.2: When considering mental capacity in this case we must reflect on the circumstances, context, and Mr Z's behaviour at the time of the various significant events during 2018/19 leading up his tragic death and Mr Z's ability to make or not to make a decision.

6.6.3: Mr Z was supported throughout the review period by a number of services including GP and mental health services and was seen by various professionals including drug abuse and police professionals. Mr Z experienced a number of significant life events during the review period and was under a great deal of stress.

6.6.4: The information highlights that Mr Z was suffering from mental health and drug issues and was receiving support from services. He was also concerned about his safety, especially in relation to his accommodation. He was fearful of his neighbours and had problems with drug associates. In early 2019, his mother had passed away and his father was in care.

6.6.5: During the review period January 2018 to April 2019 and from the information reviewed, it appears that no person or professional raised concerns about Mr Z's mental capacity and there is no information or evidence that any form of mental capacity assessment was undertaken during the review period. During the practitioners and managers event, it was noted that some professionals adopted the stance that mental capacity was presumed unless there were concerns to the contrary when an assessment would be undertaken.

6.6.6: From the available information, it appears issues around capacity were considered when obtaining consent from Mr Z was needed to share information, especially in relation to referrals and to informing the police about assaults and attacks on Mr Z's person. In addition, an entry in the chronology from Adult Safeguarding states that during a telephone conversation with Mr Z's CPN, the CPN stated that in their work with Mr Z capacity was considered and checked. In an entry from the police re an incident on 21st March 2019 it stated that Mr Z has given consent and officers have assessed he understands and can retain information. Entries from Yorkshire Housing highlight that they consider capacity to consent but often decided that it was not applicable, as no information sharing was required.

6.6.7: As previously stated Mr Z's capacity to provide consent did not appear to be an issue for professionals, and many professionals took the stance that if there were no presenting issues then capacity was not a problem. However, there were instances when Mr Z was presented with certain choices and at the time professionals acquiesced to Mr Z's wishes. In the Practitioners and Managers Event, concern was raised that practitioners were placing too much emphasis on the presumption that the person has capacity. It was suggested that there should be more professional curiosity regarding whether or not the individual has capacity. If the individual does not have capacity, then it may be appropriate to make an application to the Court of Protection. In notes, staff should explain their rationale when assuming capacity.

Recommendation 5 - It is recommended that the City of York Safeguarding Adults Board emphasise the need for all staff in partner agencies working with vulnerable adults to be fully appraised of legislation and guidance relating to mental capacity and decision-making.

6.7 Consideration 7 - did Mr Z receive effective support for his substance misuse problems?

6.7.1: Reports identified that Mr Z had been an illicit drug user for a number of years and was supported by drug services in York. He received medication to help him deal with his addiction and this was managed and reviewed on a regular basis by both the drug service and Mr Z's own GP. Mr Z admitted using illicit drugs whilst receiving his medication and blood tests proved positive for illicit drug use.

6.7.2: Reports also demonstrate Mr Z's continued involvement within the drug environment and it is clear the police were actively involved in responding to drug issues involving Mr Z. Mr Z's mental health issues and drug use made him vulnerable to exploitation. Mr Z had a number of associates both from within and outside York who were also involved in drugs and the supply of drugs in York. Mr Z's house appears to have been used as a base for drug related activities, to the annoyance of neighbours, some of whom threatened and attacked Mr Z. He was seen by the police as both an offender, regarding his possession, usage and supply of drugs and a victim of criminal exploitation, which made trying to find appropriate remedies extremely difficult.

6.7.3: It is surprising to learn (from the Practitioners and Managers event) that the drug team who were working with and supporting Mr Z had no knowledge of Mr Z's issues and problems in the community. This information may have been useful to the drug team in supporting Mr Z and it is possible that the drug team will have assisted in identifying appropriate options and the best outcomes.

The Author has no additional recommendation to make in relation to Consideration 7.

7. Conclusion

7.1 This is a tragic case of a life cut short, a life which over a long period of adulthood was plagued by mental ill-health and drug abuse, the latter of which involved criminal activity, assaults, abuse, and exploitation.

7.2 This review received documentary information from partners to the City of York Safeguarding Adults Board. There has been a detailed, thorough, and robust exploration of the multi-agency working approach to the safeguarding concerns surrounding Mr Z through an examination and analysis of these documents. It must be noted and acknowledged this review took place during a period of unprecedented demand because of the COVID 19 pandemic and national and local efforts to combat the virus.

7.3: As a consequence of these efforts to fight the virus and HM Governments national lockdowns, Tier system and local restrictions, the review had to be by means of primarily a review of documentation related to Mr Z's care. Where the SAR author needed more information, questions were posed to relevant agencies and those agencies promptly responded. A virtual meeting was held between the author, practitioners, and managers from key agencies who had worked with Mr Z. No contact has been made by the SAR author with Mr Z's family at this time and it may be that the City of York SAB think it is necessary and appropriate that this should take place.

7.4: It is right and a positive response to Mr Z's tragic death that the City of York Safeguarding Adults Board has commissioned a Safeguarding Adult Review. It is extremely important that the City of York Safeguarding Adults Board has an opportunity to review how partners and other agencies and organisations worked together and learn any lessons. Reviews must be seen by all agencies and practitioners as a positive response to an event or series of events and not as something, which is seen as a naming, shaming, or blaming mechanism.

7.5: Partners should be encouraged and in certain circumstances (such as part of a SAR or other such case review) required to undertake their own individual agency management review. All agencies and organisations as part of their safeguarding practice should undertake internal reviews of cases, whether this is done as an ad-hoc operational team review of specific cases or part of an annual review or audit process. Alternatively, as a specific response to a serious incident, such as in this case, where Tees, Esk and Wear Valley NHS Trust undertook a thorough and robust serious incident review. Often when partners undertake a management review or equivalent, lessons learned for the agency or organisation can be identified and action plans developed to ensure lessons are appropriately incorporated into practice. The SAB should ask the agency or organisation to update the SAB as to progress of the action plan.

7.6: In this case, agencies and organisations working with Mr Z did everything they could do to support Mr Z. Individual agencies responses and interventions were largely appropriate and effective in relation to not only addressing and responding to Mr Z's health and wellbeing. This was in spite of the challenges faced by agencies and organisations with the very strong and powerful pull factors keeping Mr Z involved in the drug environment and context of the area of York where he lived.

7.7: It must be recognised that practitioners were working with a challenging case and events were rapidly changing over a short period. However, key moments such as Mr Z's deterioration and isolation following his mother's death and his father being taken into

care, Mr Z's involvement and relationship with neighbours and drug users and the use of his flat as a possible base for drug suppliers and his removal from the emergency accommodation following his arrest, subsequently being classed as a missing person, represented missed opportunities for a more co-ordinated multi-agency response.

7.8 Based on the information available the author does not believe there was anything agencies could have done to prevent Mr Z's tragic and untimely death. However as indicated above there were a number of missed opportunities where partners could potentially have made a difference.

7.9 The author would like to thank the City of York Safeguarding Adults Board, members of the Safeguarding Adult Review Panel, all partner agencies, practitioners, and managers who contributed to this review for all their help and support.

8. Recommendations

8.1: The City of York Safeguarding Adults Board may wish to consider whether any work needs to be undertaken in ensuring partner agencies and stakeholders are aware and understand the importance attached to multi-agency working and co-ordination.

8.2: The City of York Safeguarding Adults Board may wish to consider whether any work needs to be undertaken in ensuring partner agencies and stakeholders are aware and understand the importance attached to information sharing.

8.3: The City of York Safeguarding Adults Board should consider reviewing the advice and guidance provided to partner agencies regarding multi-agency challenge and escalation process.

8.4: The City of York Safeguarding Adults Board may wish to review and reissue guidance to partner agencies concerning the requirement to share information concerning risk factors held by single agencies in safeguarding situations.

8.5: It is recommended that the City of York Safeguarding Adults Board should seek from partner's assurance that staff are fully aware and understand legislation and guidance around mental capacity.

9. Glossary of Acronyms

CPN – Community Psychiatric Nurse

CYC – City of York Council

CYC MH Team – City of York Council Mental Health Team

LA – Local Authority

MDT – Multi-disciplinary team

NYP – North Yorkshire Police

PPN – Public Protection Notice

SAB – Safeguarding Adults Board

SAR – Safeguarding Adults Review

TEWV – Tees, Esk and Wear Valleys Mental Health Trust

VRA – Vulnerability Risk Assessment

YH – Yorkshire Housing