SAFEGUARDING ADULTS REVIEW

Report into the circumstances surrounding the death of Adult Jake

Report produced by Richard Proctor Independent Reviewer and Author

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ACKNOWLEDGEMENTS

City of York Safeguarding Adults Board (SAB) would wish to place on record their sincere thanks to the mother of Jake who worked closely with the Board and Independent Author. She provided valuable information and an insight into the life of Jake which was used in shaping and informing this review.

The Safeguarding Adults Review would not have been possible to undertake without the co-operation and information supplied to the SAR Panel by those agencies who provided care and support for Jake. This contributed significantly in the production of the final report and helped to identify recommendations for improvement.

This report reflects the combined views of the SAR Panel who have invested their time, commitment and expertise throughout this process. The input and professional support provided by the Head of Service Adult Safeguarding and executive support officer of the City of York Safeguarding Adults Board were invaluable throughout this process.

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All names in this report have been anonymised for publication and dissemination.

1. Introduction

1.1 Statutory Framework

Section 44 of The Care Act 2014 states that the Safeguarding Adults Board must arrange for there to be a review of a case involving

a) an adult in its area with care and support needs (whether the local authority was meeting any of those needs)

b) 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

c) 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).

The decision to undertake a Safeguarding Adults Review in relation to the death of Jake was made on the 27th June 2018 by the Independent Chair of the Board, who following consideration of the case was satisfied the criteria to undertake such a review was met.

The timeline period for the review to consider was identified as being between the 1st October 2011 when Jake was being supported by Child and Adolescent Mental Health Services (CAMHS) for behaviours which were felt to be connected to his Asperger's syndrome up to and including the 28th May 2018 when tragically he was found dead in his flat after taking his own life by hanging.

1.2 Pen Picture

Jake was born in 1997.He was dearly loved by his parents, sister, family and friends.

The world and Jake were never wholly comfortable with each other but his beaming smile and enthusiasm for life when things went well were infectious.

In 2003 when 6 years of age, following the identification of behaviours believed to be associated with Asperger's Syndrome he began to be provided support by CAMHS (Child Adolescent Mental Health Services) which continued for several years. In 2013 when aged 16 years of age he was discharged from their care.

Despite the challenges he faced he was a highly gifted talented individual, performing well at his studies, subsequently gaining employment as an apprentice welder.

He studied engineering at York College and achieved the prestigious honour of becoming a Duke of Edinburgh Gold award winner through his involvement with Choose2 youth group.

Jake tragically took his own life in May 2018 and his loss was felt dearly by many. His foreman whom he worked for as an apprentice described the experience of his death as a feeling "of having lost the favourite tool from their toolbox".

His parents describe that Jake always shouldered more than his fair share of life's burdens where he felt other peoples pains keenly and would try to fix things for others.

They commented how he lived life on his own terms and shortly prior to his death had spent the day sea fishing with friends warmly describing this as the "best day of his life".

2.0 Service Involvement.

The review was informed by information provided by the following agencies.

Leeds and York Partnership Foundation Trust -LYPFT

Tees, Esk and Wear Valleys NHS Foundation Trust- TEWV

The City of York Council Early Help Team – CYC

York College-YC

North Yorkshire Police- NYP

York Teaching Hospital- YTH

MIND (Mental Health Charity)- MIND (Provider of Young Peoples Counselling Service, commissioned by CYC)

General Practitioner Practice- Vale of York Clinical Commissioning Group-CCG

Glossary of Names

GP 1 CCG General Practitioner.

YC1 MIND Counsellor.

3.0 Summary of significant events.

3.1 On the 23rd November 2011 Jakes parents met with LYPFT CAMHS (Child and Adolescent Mental Health Services) Consultant Psychologist regarding Jakes “risky behaviours”. These were detailed as hurting cats, playing with fire and upsetting his sister.

3.2 On the 12th December 2011 LYPFT CAMHS were informed by Jakes mother that he had tried to strangle himself with a tie whilst at school which was a believed response to the rejection he received from a girl.

In response a CAMHS therapist attended a school liaison meeting to discuss Jakes case. A plan was subsequently established for the school to support Jake with interaction with his peers.

3.3 On the 14th December 2011 the LYPFT therapist contacted Jakes mother. They discussed Jakes current presentation and provided contact information details of on call and emergency CAMHS.

3.4 On the 20th December 2011 the LYPFT CAMHS Consultant Psychologist contacted Jakes mother where it was reported Jakes mood was variable. This was recorded as within the context of someone with a condition of Asperger’s and poor self-esteem. It was agreed that Jake would be offered another appointment after the Christmas period.

3.5 On the 4th January 2012 Jake was seen alone by the LYPFT CAMHS Consultant Psychologist where Jake explained some of the reasons regarding his recent presentation and the strangulation attempt whilst at school which he attributed to being unhappy at home.

3.6 On the 1st February 2012 it was recorded by the LYPFT CAMHS Consultant Psychologist following information that was shared by Jakes school that his behaviour at school was escalating. A plan was established by the Psychologist to work with Jakes parents in relation to the issues at home.

3.7 On the 28th February 2012 the LYPFT CAMHS therapist met Jake at his school in relation to the recent incidents in relation to his escalating behaviour.

Jake informed the therapist that he was unhappy at home owing to the factors which he perceived to be unreasonable parenting, no freedom to be independent, a lack of things to do, that he had no friends and nothing to look forward to.

He requested that the therapist treat this information in confidence and not share the information with his parents. The therapist agreed to this with a condition that this would be overridden if there was a concern about his safety.

3.8 On the 7th March 2012 a meeting took place arranged by the LYPFT CAMHS Clinical Psychologist at Jakes school in relation to Jakes current educational progress. Present were the schools educational Psychologist, Jakes teacher and his parents. Agreed outcomes at the conclusion of the meeting included that the school would take on responsibility for Jakes behaviour whilst at school and his parents informed of both positive events and serious incidents involving Jake.
The holding of this meeting involving key stakeholders and relevant agencies with regards to Jakes wellbeing the review identifies as good practice.

3.9 On the 27th June 2012 the LYPFT CAMHS therapist sent a letter to Jakes parents in relation to securing his attendance at a summer group that supports young people who experience difficulties with social communication skills. This offer was accepted and positive feedback regarding Jakes involvement was later received by the LYPFT CAMHS therapist.

3.10 On the 5th August 2013 the LYPFT CAMHS Consultant Psychologist sent a letter to Jakes parents to inform them that following a review of Jakes case notes it was noted they had not seen Jake since 2012 and enquired if more appointments were required. The letter explained they understood Jake attended "Choose 2" which he enjoys and that if no contact is received his case will subsequently be discharged by LYPFT CAMHS.

https://choose2youth.co.uk/

3.11 On the 5th August 2013 GP 1 received a letter from CAMHS informing the GP that as Jake had not been seen for some time now, he was being discharged from the service unless contact was made before the end of that month. It was noted that Jake was attending "Choose 2" which is a Social Enterprise scheme working with children, young people and adults with disabilities and additional needs in York and North Yorkshire.

https://choose2youth.co.uk/

3.12 On the 13th May 2015 GP1 recorded in Jakes notes that he had a lactose intolerance condition which can make him initially aggressive then "sleepy".

https://www.nhs.uk/conditions/Lactose-intolerance/

3.13 On the 7th October 2015 Jake transitioned from childhood into adulthood as he reached his 18th birthday.

3.14 On the 24th August 2016 GP1 saw Jake at the practice in company with his mother. This was to undertake a review of Jakes Asperger's condition after it transpired, he had applied to the Driver and Vehicle Licensing Agency (DVLA) for a driving licence and had declared his medical condition as part of the process of completing the application form. GP1 recorded Jake had no physical impairment or significant mental health impairment. Whilst not formally recorded it was apparent from the information provided that GP1 assumed Jake had mental capacity in relation to his ability to make decisions on his own behalf.

https://www.gov.uk/asperger-and-driving

3.15 On the 22nd February 2018 GP1 saw Jake at the practice initially in the presence of his mother who shortly after arriving left the room. Information recorded by GP1 indicate Jake was happy to share most information regarding his medical condition with his mother, although GP1 observed that Jake was uncomfortable in sharing all the information. At this time Jake disclosed to GP1 that his mood was very “up and down” and that he felt trapped in this cycle of mood changes. He described his family environment as living at home with his father, mother and sister. He described having a troubled relationship with his father though spoke positively of his relationship with his mother. He explained he was employed as a welder but was now withdrawing into himself and whilst having a network of friends, he had recently experienced a relationship breakdown with a girl which had impacted upon him. He described having suicidal thoughts but that he did not wish this information to be shared with his mother.

He stated to GP1 he would not harm himself as he recognised the impact that would have on others.

He shared with GP1 his account of when he tied something around his neck whilst still at school and how a teacher had found him and cut him free. He emphasised he did not wish to repeat such an action but would prefer not to be here. Whilst the notes are non-specific as to the meaning of this statement the review for evidence to the contrary believe this to be a reference with regards to taking his own life.

GP1 confirmed that his medical records were confidential unless Jake gave permission for the information contained within them to be shared.

Jake agreed to GP1 sharing the information in relation to his suicidal thoughts with local mental health services.

GP1 contacted TEWV single point of access who requested GP1 submit a referral regarding Jake so an assessment could be made as to how best to support him.

GP1 was of the view that the risk posed to Jake at that time was low as whilst Jake had said he didn’t want to be here, he also said that he didn’t want to hurt himself as it wasn’t the right thing to do and planned to discuss Jakes referral to TEWV mental health services with him at his next appointment in two weeks.

The review has been unable to identify any referral following this appointment being made by GP1 to TEWV single point of access.

3.16 On the 25th February 2018 North Yorkshire Police (NYP) responded to an emergency telephone call made by a friend of Jake, requesting police attendance at a bridge in York where it was reported Jake was attempting to jump from it. Upon police attendance Jake was still in situate on the bridge and he agreed to accompany the NYP officer to the local hospital emergency department. Jake agreed for Jake's mother to be contacted who joined him at the hospital.

When presenting at the emergency department it was recorded Jake had expressed a wish to harm himself and that he had wanted to drown.

He was then assessed by TEWV Liaison Psychiatry where Jake disclosed previous involvement with CAMHS until he was discharged at 16 years of age and that he had a diagnosis of Asperger's. He reported having a history of suffering from anxiety and panic attacks together with a history of minimal self-harm.

TEWV Liaison Psychiatry established a management plan and provided a written care plan to Jake. This included attendance at the second look clinic.
He was signposted for age appropriate support advice, online self- help resources for anxiety management and self- help guides.
(Signposting is a phrase commonly used by services to provide patients with a first point of contact that directs them to the most appropriate source of help).
https://www.networks.nhs.uk/nhs-networks/releasing-capacity-in-general-practice/messageboard/1-active-signposting
Crisis contacts within TEWV were provided and the role of the service was discussed with Jake.
TEWV sent a letter to GP1 to provide notification of the assessment which was received the following day at the practice.
TEWV prior to discharge undertook a Psychosocial assessment which is described as a thorough and comprehensive evaluation of an individual patient's physical, mental, and emotional health, aimed at identifying personal factors that might explain an act of self-harm

https://www.nice.org.uk/guidance/qs34/chapter/quality-statement-3-comprehensive-psychosocial-assessments

Jake was discharged and returned home with his mother.

3.17 On the 26th February 2018 Jake's mother contacted York College where Jake attended as a student as part of his apprenticeship placement and spoke with the College Counselling and Mental Health Service. The purpose of the contact was to inform them of the incident on the 25th February 2018 as detailed at **3.16** above. The service explained Jake could access support by completing an online form and went on further to explain that the student mental health coordinator would need to see Jake to complete a risk assessment and establish a support plan upon his return to college. The aim being to ensure he was safe whilst in college and consider what support the service could provide for him.
It was established by the Mental Health advisor during their discussion with Jake's mother that Jake was unaware this personal information was being shared. The advisor explained to Jake's mother that Jakes permission and consent would be required to share this information with agencies and that he would need to attend the risk assessment and support plan meeting.
The advisor was informed by Jake's mother that a referral had been made to Adult Mental Health Service and that his GP was aware of his suicidal thoughts.

3.18 On the 27th February 2018 GP1 undertook a telephone consultation with Jake. Jake informed the GP that he had decided to take time off from work and that his mood was quite low. He was unable to provide clarity as to whether he was thinking of self-harming but assured GP1 he would not act upon any such thoughts. During the consultation he discussed he was speaking to a counsellor later that day, but it was unrecorded who the counsellor was or from which agency. He agreed to attend the practice to see GP1 after the weekend and would make contact if his condition deteriorated.

3.19 On the 28th February 2018 York College received a call from Jake's mother who raised concerns of possible bullying and coercion issues occurring on social media

between Jake and his college friends. This information was shared with Jakes head of study to raise awareness of this concern.

3.20 On the 3rd March 2018 GP1 saw Jake in the presence of Jake's mother at the practice. He expressed a desire to return to work as he was suffering from boredom consequently. He informed GP1 that following an argument with his father he had left the family home and was staying now with his grandmother. He confirmed that he had appointments booked with mental health services who had suggested to him that he may benefit from taking sertraline medication but was undecided as to whether he should. The reason why he was reluctant was unrecorded by GP1.

Sertraline is a form of antidepressant often used to treat depression.

https://www.nhs.uk/medicines/sertraline/

GP1 encouraged Jake to ensure he had the contact details of the Crisis Mental Health team recorded on his telephone so he could make contact if in crisis.

GP1 additionally provided Jake a "Not fit to Work" note for his employers.

3.21 Additionally on the 3rd March 2018 Jakes mother contacted York College asking if Jake could return to college expressing concerns regarding him missing work. She was informed that Jake could not be permitted to return until a risk assessment meeting had taken place following the disclosure by Jake's mother of attempting to take his own life on the 25th February 2018.

3.22 On the 5th March 2018 Jake attended TEWV mental health second look clinic in company with his mother and was seen by the TEWV registrar. It was recorded by TEWV that Jakes mood was "both up and down", that he had fleeting suicidal thoughts which he stated he would not act upon. The care plan established was that there should be a consideration that Jake commence taking anti-depressants which could be addressed when he next saw GP1.A further appointment with the registrar was booked and it was recorded that Jake's mother requires support as a carer. Risk assessment in relation to Jakes personal safety remained unchanged.

3.23 On the 12th March 2018 Jake was again seen in the presence of his mother by the TEWV registrar at the second look clinic. Jake consented to his mother being present.
His mood was recorded as remaining unchanged from his previous attendance.
Jake informed the registrar he had secured a flat as alternative accommodation, he had relationship issues with his father and had secured a counselling appointment with the City of York, Young Peoples counselling service. Jake continued to show resistance in commencing taking anti-depressant medication.
Information was shared with Jake of various services locally who support people with autism and Jake's mother was provided with information regarding support she may access as a carer.
No arrangements were made for mother to undertake a carers assessment as per the Care Act 2014.
http://www.legislation.gov.uk/ukpga/2014/23/section/10/enacted

3.24 Additionally on the 12th March 2018 a Risk Assessment meeting was held at York College by the College Counselling and Mental Health Service relating to Jakes anticipated return. Jake attended with his mother and repeated the information provided to the TEWV registrar regarding his moods and suicidal thoughts. Jake identified his mother and sister as his protective factors. Protective factors are referred to as things that contribute to mental health and allow a person to be resilient in the face of challenges.
It was established that Jake was currently being supported by TEWV Adult Mental Health Service
A risk management plan was created in collaboration with Jake and his mother to allow Jake to return to College. Weekly reviews of the plan and regular meetings with Jake were agreed would be undertaken.
The College agreed to Jake returning on the 19th April 2018 albeit Jake and mother had wanted him to return sooner.

3.25 Additionally on the 12th March 2018 Jake attended at the Young Peoples Counselling Service for an initial first contact appointment and was seen by a MIND Counsellor (YC1). All young People who wish to access the counselling are required

to have an initial ‘first contact’ appointment. During this appointment Jake was asked several questions by YC1 including questions in relation to self-harm and suicide ideation.
It was at this time that Jake disclosed to YC1 information regarding the incident on the 25th February 2018. Jake informed YC1 that he had been assessed by the Adult Mental Health Service Crisis team following the incident. YC1 decided that there was no need to contact his GP owing to Jakes involvement with the Crisis Team.
At the conclusion of the appointment it was agreed with Jakes consent that he would now be placed on the waiting list for counselling and to manage his expectations explained that there would be a delay before he was seen.

3.26 On the 14th March 2018 Jake in company with his mother saw GP1 at the practice. Jake confirmed he was content with his mother being present but was concerned as he did not wish to hurt her feelings. He disclosed to GP1 he was obtaining a flat to reside in, that he wished he had jumped off the bridge and was no longer alive. He informed GP1 he had no current thoughts of harming himself but had met recently with his friends and seen a counsellor, none of which had made him feel any better. He quoted that all support he was offered always had a waiting list.

GP1 noted that Jake was tearful at which point his mother left the room.

GP1 recorded being concerned about Jake and his safety. It was agreed GP1 would inform Mental Health Services of this concern the following day, then discuss the outcome of this contact with Jake and his mother.

3.27 On the 15th March 2018 GP1 contacted TEWV Mental Health Crisis Team where GP1 reported his concerns that Jake was in crisis and evaluating whether he wishes to live or die.GP1 explained Jake was reliant upon his mother for support but held a desire to be more independent. GP1 recommended that Jake required a trial of anti-depressant medication and close supervision.

GP1 later contacted Jake’s mother to update her in relation to contact with the TEWV Mental Health Crisis Team.

The review deems the approach by GP1 in contacting TEWV to discuss Jakes case and then updating Jake's mother as good practice.

3.28 Additionally on the 15th March 2018 TEWV Crisis and Intensive Home Treatment Team (IHTT) undertook a "face to face" consultation with Jake at his grandparents' home where he was staying. The purpose being to assess both his mental health state and risk of harm.
TEWV recorded as part of the assessment that Jake had no clear intent at that time to harm himself though did have a plan though that it would be difficult to carry out. The plan detailed visiting a remote area in England where he would cut his wrists.
A Care plan was established which would see his case allocated to the TEWV Crisis & IHTT for a period of home treatment to assist with mood management and coping strategies. The plan detailed a review to be undertaken of his medication though the information provided to inform the review does not specify which medication was being referred to.
A generic intervention plan was established within the Care plan should Jakes crisis escalate though non-specific to Jake. This something that has since been addressed by TEWV as an improvement activity, following the Serious Incident investigation commissioned in relation to Jakes tragic death.
https://improvement.nhs.uk/resources/serious-incident-framework/

3.29 On the 16th March 2018 TEWV Crisis and IHTT undertook a "face to face" consultation with Jake at his grandmother's home to assess his mental state and risk. Jake informed them that he was impulsive and would not call his mother or the crisis team if he decided to take his own life.

3.30 On the 17th March 2018 GP1 saw Jake's mother on her own at the practice. She informed GP1 that it would be beneficial for Jake to return to work on a phased return. GP1 provided a phased return note to mother for Jake's employers.

3.31 Additionally on the 17th March 2018 Jake was seen at home by the TEWV Crisis and IHTT. It was recorded by TEWV that Jake engaged, responded

appropriately and had improved insight, though still held fleeting thoughts to take his own life.

3.32 On the 19th March 2018 Jake returned to York college to recommence his studies. A risk assessment and support plan that had been created were shared with Jake which he duly signed. He reported feeling anxious at returning to college and that he still held existing suicidal thoughts but had no intent or plan to carry them out. He did state he felt able to inform the college if he felt unsafe and able to seek their help if required.

3.33 Additionally on the 19th March 2018, TEWV Crisis and IHTT met with Jake and his mother at his grandparent's address. The purpose of the visit was to assess his current risk and mental health state. It was recorded he had low mood after returning to college that day and had additionally returned to work. It was recorded he held some suicidal ideation, had feelings of hopelessness, there was clear evidence of future planning, and his vulnerability was ongoing. A plan was established to appoint a Care coordinator with whom Jake could build a relationship with, the potential of Community Support Services would be explored and that his case would be referred to the Community Mental Health Team (CMHT). Jake confirmed he would contact his mother if his condition deteriorated and it was agreed that a medication review would be undertaken. Information in relation to carer support was provided to Jakes mother.

3.34 On the 20th March 2018 TEWV Crisis and IHTT submitted a referral to CMHT requesting urgently that Jake was allocated a care coordinator. TEWV Crisis and IHTT additionally visited Jake at his grandparents' home to assess his mental health state and risk. He denied having any thoughts or plans to harm himself.

3.35 On the 21st March 2018 TEWV Crisis and IHTT visited Jake at his grandparents' home to assess his mental health state and risk. It was recorded he continued to be vulnerable and his moods were variable albeit he had no plans to harm himself or others.

3.36 On the 22rd March 2018 TEWV Crisis and IHTT undertook a medication review with Jake in the presence of his mother. It was recorded some risk of suicide existed and that it was recommended that he commence taking anti-depressant medication. Mother expressed concerns to the practitioners that there potentially were traces of dairy in this medication which may aggravate Jakes autism condition.

3.37 On the 25th March 2018 TEWV Crisis and IHTT met with Jake and his mother who was present with his consent. The purpose of the meeting was to discuss the transfer of care to CMHT. Jake expressed concerns that he may be unable to meet with CMHT owing to work commitments. He stated he had no current thoughts of taking his own life but described having breakthrough thoughts on occasions. He requested that he did not have to provide historical information in relation to his condition which was respected by the practitioners. It was recorded that there was no evidence of risk to Jake and that a Multi-Disciplinary Team Meeting (MDT) would be held before Jakes case could be transferred.

TEWV Crisis and IHTT confirmed that they still awaited receiving information from the pharmacy in relation to potential traces of dairy in the anti-depressant medication which Jake had been recommended to take following his medication review.
Whilst unrecorded this review assumes Jake was not taking this medication currently.
No formal assessment of Jakes mental capacity as per the Mental Capacity Act 2005 was recorded as having been undertaken.
This review assumes that practitioners in accordance with Principle 1 of the Mental Capacity Act assumed Jake had mental capacity to make an informed decision in relation to the impact of not taking this medication.
http://www.legislation.gov.uk/ukpga/2005/9/contents

3.38 On the 25th March 2018 Jakes mother contacted GP1 to discuss her concerns in relation to what she described as “panic attacks” that Jake was experiencing. These she stated lasted between 2 to 10 minutes where his eye pupils would become dilated, he would have tremulous in his arms and make groaning noises. She additionally reported that Jakes employers had reported they had noticed he had an injury to his arm, the cause of which was unknown at that time.

3.39 On the 26th March 2018 TEWV Crisis and IHTT were advised by the Pharmacy that there was no contraindication in relation to the anti-depressant medication. Following this confirmation, they contacted Jake by telephone who agreed to start taking the medication and that TEWV Crisis and IHTT would organise the supply.

3.40 On the 27th March 2018 TEWV Crisis and IHTT visited Jake at his grandparents' home to assess his mental state and risk. He referred to suffering from anxiety attacks but did not report any thoughts of harming himself or others.
When the TEWV Crisis and IHTT discussed with Jake the issues in relation to taking the anti-depressant medication he informed them he did not wish to take them.
No formal assessment of Jakes mental capacity as per the Mental Capacity Act 2005 was recorded as having been undertaken in relation to Jakes capacity, to make an informed decision regarding the risk to himself of not taking this medication.
Neither was it recorded as to whether this was considered when assessing Jakes current risk.

3.41 On the 31st March 2018 TEWV Crisis and IHTT visited Jake at his grandparents' home. His current risk and mental health state were assessed as unchanged from the previous visit.

3.42 On the 5th April 2018 GP1 saw Jake and his mother at the practice. Jake reported continuing to have variable moods and "freezing" for up to an hour when in panic.
He informed GP1 that he would be staying overnight alone in his flat for the first time that evening and had mixed feelings in relation to this. He stated he usually felt worse when he was alone, but his mother felt that it was a good idea and if he wished she would sleep on his floor if required.
Both Jake and his mother reported being unsure if the support currently been provided by TEWV Crisis and IHTT was helpful.
Jake expressed his frustration at having to repeat his case history but then not provided with any coping strategies.
He did express hope in relation to his imminent transfer to CMHT, with the additional hope that they would be proactive in their response.

Jake informed GP1 that he had decided currently not to take the anti-depressant medication despite this being recommended by TEWV Crisis and IHTT.
No formal assessment of Jakes mental capacity as per the Mental Capacity Act 2005 was recorded as having been undertaken in relation to Jakes capacity, to make an informed decision regarding the risk to himself of not taking this medication.
This review forms the view GP1 assumed Jake had the mental capacity to make this decision.
There was nothing recorded to demonstrate GP1 shared this new information regarding Jakes change of residence or his decision to refuse to take the anti-depressant medication recommended by TEWV Crisis and IHTT.

3.43 On the 6th April 2018 a home visit was undertaken with Jake and he was seen with his mother by TEWV Crisis and CMHT to undertake his transfer of care to CMHT.
The practitioners assessed Jakes risk and mental health state. It was recorded he was distressed, in a low mood and having plans and thoughts of taking his own life. The issues affecting him were recorded as a break down in social media relationships and concerns in relation to his friendship with a female.
It was recorded he had spent the preceding night alone at his newly acquired flat and had kept himself safe. During the visit it was confirmed to TEWV by mother that his family were able to provide safety support and she understood that should they believe Jake was at immediate risk of harm then they should contact the emergency services.
Mother later contacted TEWV to advise them of her concerns of the impact upon Jake in having to repeat information previously provided regarding his condition to practitioners.

3.44 On the 9th April 2018 Jakes mother contacted TEWV Crisis and IHTT to request that the newly appointed care coordinator from CMHT is an individual with autism experience and that they do not discuss his mental health history.

3.45 On the 10th April 2018 TEWV Crisis and IHTT visited Jake at his grandparent's address to assess his current risk and mental health. His risk was assessed as low.

Jake raised concerns in relation to accommodating meetings with the newly appointed CMHT care coordinator, owing to work commitments.

3.46 Additionally on the 10th April 2018 TEWV Crisis and IHTT identified a CMHT care coordinator with relevant autism experience to provide future support for Jake.

3.47 On the 19th April 2018 TEWV Crisis and IHTT visited Jake at his grandparents to assess his risk and mental health. It was recorded that Jakes risk had significantly reduced and that he now had plans in place for the future. Jake was informed his case was now being transferred to CMHT.

3.48 On the 23rd April 2018 the newly appointed TEWV CMHT care coordinator met Jake at his parents' home in the presence of his mother. When assessing Jakes current risk, the practitioner recorded there was no current risk and that he did not have any suicidal thoughts.
The practitioner agreed to make contact by telephone the following day to arrange a future appointment.

3.49 On the 24th April 2018 TEWV CMHT contacted Jakes mother by telephone to arrange an appointment with Jake on the 21st May 2018.

3.50. On the 26th April 2019 GP1 saw Jake at the GP practice together with his mother. After discussing Jakes current condition and the continuing panic attacks Jakes mother repeatedly kept questioning Jake about injuries to his arm in the presence of GP1. She offered to leave the room the review presumes in case Jake wished to speak with GP1 in confidence, an offer which Jake accepted.
Jake then showed GP1 superficial cuts to his right forearm which had apparently been attempted to be disguised by covering them over with black felt tip ink.
Jake then disclosed to GP1 that these were self-inflicted injuries which he had caused to himself whilst feeling low approximately 6 days ago. A feeling Jake confirmed he often had.
GP1 advised Jake to be more open to his mother and CMHT about his actions and feelings.
This information in relation to Jake self-harming was not shared with TEWV by GP1.

3.51 On the 9th May 2018 Jake attended at the Young Peoples Counselling Service for his first counselling session with a Youth Counsellor. (YC1).

Jake presented to the Counselling Service as a high functioning young adult who was coherent and assumed to have mental capacity by YC1.

In collaboration with Jake a counselling contract was established which addressed such issues as length and regularity of future sessions together with an opt out clause from both parties. It included an explanation regarding confidentiality, how and when information may be shared, together with seeking Jakes permission to share information if it was considered he may be at risk of significant harm.

YC1 completed a CORE (Clinical Outcomes in Routine Evaluation) assessment with Jake, a process used by the service to assess an individual's wellbeing, functioning, risk and problems.

https://novopsych.com/assessments/clinical-outcomes-in-routine-evaluation-core-om/

During this process Jake disclosed to YC1 when asked in relation to a specific question relating to suicide attempts that whilst he hadn't made plans, he had been prevented by his family from taking his own life when attempting to hang himself with a belt. Consequently, his family were making sure he wasn't on his own and that he stayed with grandparents or someone else at the flat. Additionally, his family had prevented him having access to belts, were supporting him and aware of his current feelings.

It subsequently transpired following Jakes death that it was four of his friends who have intervened to save Jakes life, his family unaware of this event until after his death.

Jake informed YC1 that he had regular 3 weekly appointments with his GP who was aware of the afore described suicide attempt and that he had the contact numbers for TEWV Crisis, should he require support when in crisis.

YC1 additionally provided Jake with information of a local "drop in" centre offering support for people 16 years and over who required support for mental health during the evening hours.

Jake during the session referred to his mother as being a protective factor and that as a distracting factor he went to the gym to help lift his mood, that he undertook artwork, was working and had an additional job washing pots.

Jake informed YC1 he had no current suicidal intent and was committed to keeping himself safe.
From the information provided YC1 formed the assumption that Jakes current level of risk was already known to his family and health professionals who were providing support to him. Consequently, no information in relation to the reported attempted suicide event was shared by YC1 with TEWV, GP1 or Jake's mother.
Jake after completing a goal achievement form used to identify his desired outcomes from counselling, identified a desire to discuss his feelings of depression and isolation.
Jake highlighted issues of concern with YC1 regarding a breakdown in his relationship with his father who was pressuring him to leave the family home and live in a flat, together with two unsuccessful relationships with females that had broken down.
He described how he felt lonely at times and feeling let down by friends who didn't contact him. He additionally raised concerns regarding the future transition from college to work.
YC1 discussed with Jake that when starting something new, there was always the potential to form new relationships and have new experiences which could be a positive experience.
The counselling session ended on an apparently positive note for Jake as he received a message from a friend to arrange a meeting with him.
YC1 recorded a note on Jakes record to consider how his Asperger's condition may impact upon the counselling relationship.
The review identifies such a consideration by YC1 as good practice in this case.

3.52 On the 21st May 2018 following a case management review, the Young Peoples Counselling Service made a decision that owing to the level of risk that Jake posed to himself that he would not benefit from counselling and it was planned to meet with Jake so he could be informed of the decision.

3.53 Additionally on the 21st May 2018 the newly appointed TEWV CMHT care coordinator with the requisite autism experience saw Jake together with his mother at his parents' home in order to assess his risk and mental health.

It was recorded that his mood was low and that he was physically tired. His current level of risk was unrecorded.
Jake was provided with contact details for his new TEWV care coordinator.

3.54 On the 23rd May 2018 Jake was seen by YC1 at the Young Peoples Counselling Service for what originally had been intended to be his second counselling session.
It was confirmed to YC1 by Jake that he had a prearranged appointment with GP1 and was in contact with a mental health worker whom he had seen two days previously.
YC1 recorded feeling assured Jake had appropriate support in place from mental health services, GP1 and his family.
YC1 then informed Jake of the decision to suspend his counselling as it was believed it was not the appropriate support he required at this time and did not wish to make him feel worse by discussing his feelings, which may upset him.
YC1 discussed sending a letter to GP1 to inform them in relation to this decision and Jake requested a copy of the letter to be sent to him also.
YC1 requested Jake stay to undertake some coping work, however Jake declined the offer stating he had undertaken this before and did not wish to repeat the exercise again.
No suicidal intent was disclosed to YC1 by Jake.
Jake then left the premises, YC1 recording that Jake appeared despondent.
YC1 then contacted Jakes mother to inform her of the decision to end the counselling in the belief that she was his main support if he was feeling upset.
The review identifies this as good practice.

3.55 On the 25th May 2018 a letter was sent to the GP practice from the Young Peoples Counselling Service to inform them Jakes counselling had ended. The rationale for the decision being Jake demonstrated high levels of risk, was experiencing impulsive suicidal thoughts, felt isolated and depressed and two weeks previously had tried to hang himself where his family had intervened. The letter was received by the practice on the 30th May 2018.

3.56 On the 28th May 2018 North Yorkshire Police attended at Jakes flat following receipt of a call from his mother reporting Jake had hung himself in his flat and she was unable to resuscitate him.

Despite further attempts to resuscitate Jake, he tragically died, having taken his own life by hanging.

4.0 Methodology

SAR methodology is non- prescriptive within the Care Act with the overall aims that the review is conducted wherever possible in a timely and proportionate manner.

In this case the SAR panel deemed it appropriate to develop a Multi-agency Combined Chronology drawing on information from agencies who provided care and support for Jake, to seek to achieve a system wide overview of the case which may assist in identifying areas of practice for development and change.

In this case a systems model often utilised in undertaking Serious Case Reviews in Children's Safeguarding was broadly utilised, to identify factors that supported both good practice and what may have contributed to creating unsafe conditions where safeguarding practice may require improvement.

Such a model seeks to be collaborative in its approach where those directly involved in the case are centrally and actively involved in the analysis and development of the recommendations.

The process undertaken was as follows.

4.1 Panel Membership

A Safeguarding Adult Review panel was established consisting of senior managers nominated by their agency with no previous involvement in the case, and authority to effect change in their own agency, meeting on three occasions.

The Reviewer and Author of the Overview Report has been commissioned by City of York Safeguarding Adults Board to produce an independent report and was not involved in the delivery of identified services; line management for any service or any individual mentioned within the report.
The reviewer and author previously a Senior Police Officer before retirement, has experience of undertaking similar reviews in other parts of the United Kingdom together with working within a strategic multi-agency safeguarding environment.

The author and the SAR Panel agreed terms of reference as detailed below to guide and direct the review. They undertook responsibility to look openly and critically at individual and agency practice, to identify whether this SAR indicates changes could and should be made to practice and if so, how these changes will be brought about. Additional support in undertaking this review was provided by a specialist in relation to points of detail regarding autism.

Agency	Role
Independent consultant	Reviewer and author
City of York Council	Head of Service Safeguarding, Mental Health, Learning Disability and DoLS
NHS Scarborough & Ryedale Clinical Commissioning Group NHS Vale of York Clinical Commissioning Group	Designated Nurse for Safeguarding Adults
North Yorkshire Police	Safeguarding manager
Tees, Esk and Wear Valleys NHS Foundation Trust	Associate Director of Nursing (safeguarding)
City of York Council	Assistant Director Adult Social Care
City of York Council	Principal Social Worker
City of York Council	Public Health Specialist Practitioner Advanced
City of York Council	Assistant Director Children's Specialist Services
City of York Council	Early Help & Local Area Team Service Manager
The Retreat York	Service lead for Autism and ADHD

4.2 Terms of Reference

Specific areas for the SAR to focus on and key areas to be analysed:

1. Are there lessons to be learned about the way in which professionals worked in partnership to support Jake and his family and to safeguard Jake.
2. Given Jake's age, are there issues around his transition into adulthood and the support available?
3. How specialist services might be able to help inform the treatment of young people with autism?

The SAR was asked to additionally consider:

a) Were services easily accessible and responsive in meeting Jake's needs including support relating to autism?
b) Were services co-ordinated?
c) What evidence was there of communication and information sharing?
d) The timeliness of interventions for Jake and his family.
e) Risk assessment and risk management.
f) The extent to which Jake's mental capacity was considered.

4.3 Family Involvement

4.31 It was a priority for the panel to allow those closest to Jake, to have a voice in helping to shape and inform this review.

4.32 Subsequently the independent author and reviewer met with Jake's mother to capture her view of events and provide a valuable insight into his life.

4.33 In relation to Jakes **a**utism condition mother described after input from CAMHS whilst Jake was a child he was subsequently discharged. This she described as a feeling of abandonment, with no support or plan in place in relation to his ongoing care and support into adulthood. This she felt should have been established by Adult Mental Health Services.
She articulated how his condition of autism apparently went unnoticed by agencies as if it was an “invisible disability” and that she felt unsupported in accessing support to assist Jake in managing situations for example exam stresses and expectations of friendships.
She assumed agencies would know and recognise how people with autism may act and respond to certain situations but was disappointed to discover that this was not generally the case.
She identified the constant change of practitioners and having to repeat information of his history made Jake feel worse about his condition, reinforcing the message to him that he was autistic.

4.34 Regarding Jake’s attempts to take his own life, Jakes mother reported being unaware of any form of a crisis plan being established to manage the risk posed to Jake or if any Multi Agency meeting was ever held to share information in relation to his risk. The review has identified safety planning did occur following the attempt as detailed at **3.16** and a support plan established following the attempt as detailed at **3.2.**
She discussed informing Jake’s college of the events as detailed at **3.16** but felt disappointed in that initially the decision made by the college was to bar Jake from attending college rather than establishing a plan to manage the risks posed to enable him to continue attending. This decision she described had a detrimental impact upon Jake as he had to be active and had been encouraged to use the opportunities of attending college to build relationships.

4.35 Jake’s mother believed he possessed the Mental Capacity to make his own decisions and stated that he never took the prescribed anti-depressants as detailed at **3.20.**
Jake’s mother could not recall if powers in relation to the Mental Health Act were ever discussed or considered with either herself or Jake.

4.36 Regarding Jakes involvement with the CYC Young Peoples Counselling Service Jakes mother described finding the information in relation to this service in a leaflet on public display whilst at the hospital. This following Jakes attempt to take his own life as detailed at **3.16.**
She stated it contained no information regarding the services suitability for a person accessing the counselling who had an autism condition, but she felt it may be beneficial for Jake to attend.

4.39 In addition to a mother's role she also was Jakes informal carer and she reported feeling unsupported by agencies in undertaking this role. She reported never receiving any formal Carers Assessment as per the Care Act 2014 to identify any support she may require in undertaking this challenging role.
The review has identified that whilst there was evidence of her being informed of carer support networks no contact was made by TEWV with "City of York" ASC to enable a carers assessment as per the Care Act 2014 to be undertaken.
It is evident that others in Jakes family such as his grandparents, his younger sister and Jake's father all played a role in providing support for Jake. There is nothing to demonstrate how agencies considered this as an issue or how they may support them in providing care for Jake.
Recognising the significant contribution, mother played in supporting Jake it would have been good practice to ensure an assessment was undertaken to support mother in providing support for Jake in the role as carer.
http://www.legislation.gov.uk/ukpga/2014/23/section/10/enacted

Recommendation 1.
TEWV drawing upon the learning from this case should ensure carers providing support to patients are informed of their eligibility to access a "Carers Assessments" as per the Care Act 2014.

4.40 Jake's mother provided a description of the events leading up to Jake's tragic death. She spoke now upon reflection how she believed Jake had decided to make "his peace with the world" spending the day fishing with his friends which he described as the "best day of his life".

She attributed the reason he took his own life was because of a failed relationship with a girl. This following his discovery that photographs of the girl he believed had only been shared with himself, had been circulated to other male friends of the girl.

4.41 Following Jakes tragic death mother stated she felt unsupported by agencies and was not provided access to information in relation to bereavement services.

4.42 When asked if from her experiences she felt there was evidence of good practice that the review should consider, she highlighted the support Jake was provided at the Converge Centre in York where he undertook glass stain work, where here Jake spoke highly of one of the tutors. https://www.schoolandcollegelistings.com/GB/York/323077831176500/Converge-York

With regards to bereavement support she identified "IF U CARE SHARE FOUNDATION" an area of good practice, which is a suicide support service located in another area of the country.
https://www.ifucareshare.co.uk/

4.5 Documentary Review

- Relevant agencies provided chronologies of service involvement within the identified timeline.
- The chronologies were utilised to create a multi-agency chronology.
- Safeguarding Adults West and North Yorkshire and York Multi Agency Policy and Procedure 2018.
- The Care Act 2014.

- Mental Capacity Act 2005.
- Mental Health Act 1983.
- Think Autism Strategy

4.6 Learning Event – 4th September 2019.

4.61 The event took place with multi-agency staff participation from all the key agencies involved in providing care and support for Jake with exception of the GP practice who due to an oversight were not invited to the event.

The key objectives of the event were-

To establish:

a) What worked well?

b) What could we have done better?

c) What are the lessons we need to learn?

d) What are our recommendations for improvement?

4.62 The SAR panel identified the following four thematic areas of focus for the event.

a) Transition pathway child to adult. (CAMHS-AMHS).

b) Risk Management response to known suicide attempts.

c) Autism support, specialism and practitioner awareness.

d) Support for bereavement and family.

4.63 Following the discharge from LYPFT CAMHS, the "TEWV Framework for improving the experience of autistic adults using TEWV Services" was discussed as it was felt of relevance to this case.

TEWV practitioners described how knowledge gaps in relation to autism were now being addressed through mandatory training being delivered within mental health services.

The framework details 5 key aims one of which is described as ensuring there is a consistent, high quality transition plan for young people with autism, when they move from child into adult services.
The framework has been informed by the national autism strategy, Fulfilling and Rewarding Lives, in 2010, and then updated by the version, Think Autism, in 2014.
The framework identifies that approximately half of all adults with autism will experience mental health problems at some stage of their life.
https://www.gov.uk/government/publications/think-autism-strategy-governance-refresh-2018

The TEWV framework describes a three-level approach to autism training. Level one is basic autism awareness training, which all staff are required to complete. Level two training is for clinical staff who are likely to encounter patients with autism. Level three training is more in-depth training for people who are responsible for making decisions with or about the service for autistic people.
A lack of availability of TEWV staff with awareness of autism when supporting Jake was highlighted by this review and an issue of concern raised by Jakes mother.
There is a recognition in the framework that as resources are relatively small that training should be prioritised in relation to front facing mental health teams including Crisis and CMHT resources, all of whom were involved in providing support for Jake during the period of this review.
The City of York SAB should closely monitor the progress of the TEWV training delivery plan and seek evidence how it is improving outcomes for autistic adults experiencing mental health problems.

Recommendation 2.

The City of York SAB should closely monitor the progress of the TEWV delivery training plan and seek evidence how it is improving outcomes for autistic adults experiencing mental health problems.

The framework describes how not every young person with autism will be automatically transferred to the adult mental health team and decisions made on a "case by case" basis dependant on need.
It was considered by those in attendance at the event owing to Jakes high functioning presentation it was unlikely he would be transitioned into Adult Mental Health Services and was apparently doing well when transitioning into adulthood.

https://www.tewv.nhs.uk/content/uploads/2018/09/Autism-Framework-March-18-FINAL.pdf

4.64 Regarding risk management response to known suicide attempts, practitioners identified that there was a safety management plan established which was regularly reviewed on an ongoing basis.

Practitioners described how Jake was often reluctant to discuss risk. TEWV confirmed they adopted the Triangle of Care approach to assist in managing the risks posed to Jake. This was evident through the regular involvement and engagement with Jake's mother whilst they provided support for Jake.

The "Triangle of Care Pathway" is a therapeutic alliance between service user, staff and carer that promotes safety, supports recovery and sustains wellbeing. This approach enables carers to share information with mental health services in relation to concerns they may hold in relation to a patient, that can be duly considered by mental health services in assessment of risk and formulation of response plans.

https://www.tewv.nhs.uk/about-us/how-we-do-it/

The review identifies the use of such an approach as good practice in this case.

Issues in relation to when and how to share information were identified by some practitioners as challenging when considering the reported incident of self-harm made to GP 1 and the suicide attempt whilst Jake was at his flat as disclosed to YC1.

This issue should be addressed through the implementation of **Recommendation 7.**

It was identified by practitioners that there is significant pressure upon mental health services in York, owing to an increase in demand.

It was highlighted by the Young Peoples Counselling Service representatives that they have seen an increase in referrals from TEWV for counselling they view to be inappropriate for counselling, owing to perceived high levels of risk posed to the individuals concerned.

Recommendation 3.

The City of York SAB should seek assurance from TEWV as to how referrals made to the Young Peoples Counselling Service are quality assured, to ensure high risk cases that require support by Adult Mental Health Services are not inappropriately referred for counselling.

It was noted by participants at the learning event that several agencies held information in relation to risk, but at no stage was there any multi-agency strategy meeting or discussion held to share information.

The Joint Multi Agency Safeguarding Adults Policy and Procedures for West Yorkshire, North Yorkshire and York promote effective multi-agency working and the sharing of information to safeguard "Adults at Risk".
https://www.safeguardingadultsyork.org.uk/media/1125/joint-ma-safeguarding-adults-policy-procedures-final-approved-april-2018.pdf

Recommendation 4.
The City of York SAB should communicate to the safeguarding partnership the value of multi-agency working and the sharing of information to safeguard "Adults at Risk" as described in The Joint Multi Agency Safeguarding Adults Policy and Procedures for West Yorkshire, North Yorkshire and York.

Practitioners felt it would be beneficial to increase awareness to the safeguarding partnership of the heightened interconnected risk factors involving Autism and suicide.
The City of York Suicide Safer Community Strategy was felt to be a good vehicle to ensure this information was promoted across the safeguarding partnership.
https://www.york.gov.uk/downloads/file/16179/york_suicide_safer_community_strategy

Recommendation 5.
The City of York SAB should work in collaboration with public health to communicate the potential heightened risk to people with autism in relation to suicide, to the safeguarding partnership.

4.65 In respect of autism support, specialism and practitioner awareness as detailed previously, mandatory training is being delivered within TEWV Mental Health

Services through the TEWV Framework for improving the experience of autistic adults using TEWV Services.

4.66 When the Independent Author met with Jake's mother, she identified her experience being that Jakes condition of autism went unnoticed by agencies as if it was an "invisible disability". She described wishing to be supported in helping Jake manage situations such as exam stresses and the expectations of the outcomes of relationships with others, but this was never provided.

4.67 The practitioners identified that in their knowledge there is no commissioned adult autism services in the City of York which could provide the support as described by mother.
The City of York all age Autism strategy 2017-2021 reports to have been developed in consultation with residents of the city. It details that there is a strategic board made up of representatives of health and social care organisations, education, the police, charities, people with autism and their families and carers.

The strategy identifies 6 principles in that.
1.People with autism and their families and carers are at the centre of everything we do.
2. Focus on people's strengths to overcome barriers.
3. Guidance, information and support is easily available.
4. The right support at the right time.
5. Increased awareness of autism across the City.
6. Living in your community and being included.
The strategy is endorsed by the City of York Council, but it does not detail who the strategic board is governed by or accountable to.
With the diverse cross section of membership and in line with the principles of the strategy, the City of York SAB should share the learning from this case with the board to influence the strategy and future commissioning arrangements for adults living with autism in the City of York.
http://www.york.gov.uk/download/downloads/id/14181/all_age_autism_strategy_2017-21.pdf

Recommendation 6.

The City of York SAB should share the learning from this case with the All Age Autism Strategic Board to seek to influence the strategy and commissioning arrangements for adults living with autism in the City of York.

4.68 The experience of support provided to the family following bereavement was shared with practitioners.

Practitioners identified the Major Incident Response Team (MIRT) should have been the resource the family were referred to, so appropriate support was provided.

The MIRT form part of North Yorkshire County Council and the City of York Council's 24-hour emergency response service. They offer practical and emotional support for anyone who find themselves involved in traumatic or life-changing incidents.

It was recognised through learning from this case that there was a requirement to promote the existence of this service and how to access support across the safeguarding partnership.

https://www.york.gov.uk/info/20149/emergencies/928/major_incident_response_team

When responding to such tragic death deaths it was identified a requirement existed for agencies to take leadership and ensure a coordinated response is delivered to meet the needs wherever possible of bereaved families are met.

Recommendation 7.

The City of York SAB should assure itself that in similar cases to these that agencies can deliver a coordinated response in addressing the needs of bereaved families and promote awareness of the Major Incident Response Team and the process of accessing its support.

5.0 Analysis

This analysis is based upon the written information provided to this review and upon enquiries and discussions held with Jake's mother, practitioners and autism specialist.

Term 1

Are there lessons to be learned about the way in which professionals worked in partnership to support Jake and his family and to safeguard Jake.

5.1 In 2011 whilst Jake was at school he was identified as having "risky behaviours". Consequently, the CAMHS Consultant Psychologist held a meeting with the school education psychologist and parents to consider how they may work together to address these concerns. The review identifies this multi-agency working and involving his family as good practice.

5.2 Subsequently later in 2011 following Jakes attempt to take his own life whilst at school**,** the CAMHS therapist attended at Jakes school where it was agreed that in partnership with the school that they would provide additional support for Jake so he could build relationships with his peers. The review identifies this multi-agency working as good practice.

5.3 In March 2012 the CAMHS Clinical Psychologist held a meeting with Jake in the presence of his parents to consider Jakes progress. Also, in attendance was Jakes teacher and the school education psychologist. The agreed outcomes of this meeting were that the school would take on responsibility in managing Jakes behaviour and his parents provided with updates in relation to positive and serious incidents. The review identifies this multi-agency working with Jake and his family as good practice.

5.4 On the 21st February 2018 as detailed at **3.15,** Jake in the presence of his mother saw GP1. GP 1 recorded in the notes that Jake was happy for information to be shared with his mother in relation to his health.

Whilst unspecified in the GP records, it was apparent GP1 identified mother as a protective factor in helping keep Jake safe. Their actions reflected the basic principles of the Triangle of Care Pathway in creating a therapeutic alliance between themselves, Jake and his mother as carer. Such an alliance provides the carer an opportunity to share information with the GP, for example escalating risk factors which may be used to inform and assess risk.

This approach taken by GP1 is identified by the review as good practice.

https://professionals.carers.org/sites/default/files/thetriangleofcare_guidetobestpracticeinmentalhealthcare_england.pdf

GP1 saw Jake alone following his mother leaving the room. Here he disclosed to GP1 that his moods were changeable, and he held occasional suicidal thoughts. GP1 obtained Jakes consent to share this information with TEWV Adult Mental Health Services although he specifically requested his mother was not informed.

GP1 subsequently contacted TEWV and was requested to submit a referral in relation to Jakes needs for support. This so an assessment could be undertaken, and a decision made how best to support him. Nice guidance recommends all adults presenting in primary care with symptoms of depression are offered support through a stepped-care model. This provides a framework in which to organise the provision of services, and supports patients, carers and practitioners in identifying and accessing the most effective interventions. In stepped care the least intrusive, most effective intervention is provided first. If a person does not benefit from the intervention initially offered, or declines an intervention, they should be offered an appropriate intervention from the next step which may include a referral for a specialist mental health assessment.

https://www.nice.org.uk/guidance/cg90/chapter/1-Guidance#care-of-all-people-with-depression

The review has been unable to identify such a referral being submitted by GP1 to TEWV.

Some 4 days later, on the 25th February 2018, Jake attempted to take his own life by attempting to jump from a bridge.

Recommendation 8.

The City of York SAB drawing upon learning from this case should seek assurance from commissioners that GPs in York, are reminded of the requirement that when adults present with depression, they are offered a stepped approach in line with NICE guidance.

5.5 On the 25th February 2018 North Yorkshire Police responded to the report of Jake attempting to jump from the bridge. Upon attendance with consent they transported Jake to the local Emergency Hospital Department where he was seen by the TEWV Crisis Mental Health Team based within the hospital. Following assessment by the TEWV Liaison Psychiatry a written care plan was created and Jake was discharged into the care of his mother. The review deems the response by agencies to safeguard Jake on this occasion was appropriate in the circumstances.

NICE Guidance quality markers identify that local arrangements should exist to ensure crisis resolution and home treatment teams are accessible 24 hours a day, 7 days a week, regardless of diagnosis.

The support provided by the TEWV Crisis Mental Health Team to Jake whilst at the hospital shows adherence to this quality marker.

https://www.nice.org.uk/guidance/qs14/chapter/Quality-statement-6-Access-to-services#quality-statement-6

5.6 On the 15th March 2018 following Jakes visit to the GP practice as described at **3.26,** GP1 contacted TEWV Mental Health Crisis Team and submitted a referral requesting support for Jake.

TEWV responded by arranging to meet with Jake within 4 hours of the referral.

This enabled TEWV to meet Jake in person to assess his risk and mental health state. Consequently, a plan was established for home treatment to be provided including support in relation to his mood management, coping strategies and a medication review. The review deems the response by GP1 and TEWV as appropriate in the circumstances.

5.7 On the 26th March 2018 TEWV following liaison with the Pharmacy were able to confirm that there was no contraindication in relation to the anti-depressant medication prescribed for Jake regarding it containing traces of dairy or soya. This enabled TEWV to update Jake and provide reassurance regarding this finding. This resulted in Jake agreeing to commence taking the medication to manage his condition, albeit according to his mother he never took it.

Term 2.

Given Jake's age, are there issues around his transition into adulthood and the support available?

5.8 On the 5th August 2013 in circumstances as described at **3.10** Jakes parents were contacted by LYPFT CAMHS. They informed them, as Jake had not been seen since 2012 unless further support was required then he would be discharged. There was no further recorded contact made with parents by LYPFT CAMHS and a letter informing GP1 of his discharge sent to the GP practice.

From the information provided to inform the review there was nothing to indicate additional support from LYPFT CAMHS was required at that time with regards to Jakes mental health.

5.9 As detailed at **4.33** Jake's mother describes her experience of Jake being discharged from CAMHS as one of feeling abandoned, with no support or plan in place in relation to his ongoing care and support moving into adulthood.

She articulated that Jakes condition of autism apparently went unnoticed by agencies as if it was an "invisible disability".

Whilst it was LYPFT CAMHS who discharged Jake, TEWV now the current provider for mental health services in York have developed an Autism Strategy with one of its

five main strands being that “there should be a consistent, high quality transition plan for young people with autism when they move from child into adult services.”

It states that not every young person with autism will be automatically transferred to the adult mental health team. Each case will be considered on an individual basis depending upon need.

It details as one of the goals of the strategy is that transitions should be planned well in advance with discussions held with the young person and their family.

The review recommends drawing upon learning from this case that the City of York Safeguarding Adults Board should seek assurance from TEWV of the effectiveness of this strategy in relation to young people with autism when transitioning into adulthood.

https://www.tewv.nhs.uk/referrers-professionals/strategies/autism-strategy/

Recommendation 9.

The City of York Safeguarding Adults Board should seek assurance from TEWV of the effectiveness of the Autism Strategy for young people with Autism, when transitioning into adulthood.

Term 3.

How specialist services might be able to help inform the treatment of young people with autism?

5.10 As described at **4.33** Jake’s mother identified the constant change of practitioners and having to repeat information of his history, had the impact of making Jake feel worse about his condition and reinforced the message to him of his autism condition.

Discussions with an autism specialist identified to support the review, highlighted the challenges autistic people have with forming relationships and the impact of constant change may cause them to feel devalued.

5.11 As described at **3.44** Jake's mother made a request to TEWV when they were considering a change of care coordinator, that the appointee be a practitioner with autism experience. This request was met by TEWV, 42 days later. Not all professionals that had contact with Jake had received formal training in relation to autism. There were two identified TEWV professionals, who supported Jake, whom had previous experience of working with people who have autism.
TEWV additionally have a consultant psychiatrist lead for autism that was available to provide support and advice for staff whilst TEWV were supporting Jake.
Additionally, TEWV are considering the appointment of clinical leads in autism in each of its locality areas.
As described at **4.63** the "TEWV Framework for improving the experience of autistic adults using TEWV Services" is prioritising front facing Adult Mental Health staff in delivering training to raise awareness of the impact of autism to practitioners.

5.12 As identified at the learning event there are no commissioned adult services for people with autism. Information detailed in the City of York All Age Autism strategy 2017-2021 identifies that approximately 1% of the population have autism.
The review has identified that whilst GP1 had received general mental health training, they had no specialist training in relation to autism.

5.13 The Young Peoples Counselling Service receive no specialist mandatory training in relation to autism, though may attend autism awareness training voluntarily as part of a counsellor's professional development.
The counselling service were aware of Jakes diagnosis and prioritised working with him to attempt to establish a psychological contact between himself and the counsellor. The service views the development of a therapeutic relationship as an important factor.
Jake self-referred into the counselling service following the discovery of information about the service whilst at the hospital and was initially accepted for counselling but later the counselling was suspended owing to his perceived level of risk. Jake's mother described Jake viewed this decision to suspend counselling as another

rejection for help. When he was informed of the decision by YC1 they described Jake as being visibly despondent.

Whilst the review does not question that the counselling service had nothing but good intent in attempting to support Jake through counselling, it would have been beneficial for YC1 to have a greater awareness of working with autistic people in particular a recognition of the challenges they face in building relationships.

The cessation of this counselling relationship as described by Jakes mother and the recorded response of how Jake responded by YC1, demonstrated he was distressed by the decision and it is believed impacted negatively upon him.

Recommendation 10. 10. The City of York SAB drawing upon the learning from this case should develop a programme of Autism awareness training which may be accessed by practitioners from across the safeguarding partnership in York.

Additional Considerations.

a) Were services easily accessible and responsive in meeting Jake's needs including support relating to autism?

5.14 It is identified Jake had regular appointments with GP1 over the course of the review timeline. GP1 responded to both Jakes general health needs and reviews in relation to his Asperger's condition.

When Jake had an appointment with GP1 in the circumstances as detailed at **3.15** where he reported having low moods and suicidal thoughts, in response GP1 contacted TEWV Single Point of Access who requested that GP1 submit a referral to TEWV so an assessment for Jakes needs could be undertaken. There is no evidence to demonstrate such a referral was ever made on this occasion.

There were subsequently further appointments and a telephone consultation with Jake and GP1 over the coming weeks.

These resulted in GP1 contacting TEWV to share concerns in response to deteriorating mental health expressing fears that Jake may act impulsively in relation to his thoughts as to whether "he lives or dies".

GP1 additionally discussed concerns with Jake in relation to him taking the recommended anti-depressant medication, together with promoting he keep active through attending the gym.

In response to Jakes mental health GP1 encouraged him to ensure he had the contact numbers for TEWV Crisis on his mobile phone in case he required help when in crisis.

GP1 was responsive to Jake's mothers desire for him to return to work as she felt it would assist him and consequently provided a return to work note.

Following contact by Jake's mother who raised a concern in relation to Jake experiencing what were described as episodes of "panic attacks", GP1 responded by requesting mother that she record one of the episodes so further analysis could be undertaken.

GP1 further recorded in Jakes notes of the requirement to take bloods together with considering if an ECG (electrocardiogram**)** and referral for a neurology investigation was required in relation to these attacks.

https://www.nhs.uk/conditions/electrocardiogram/

When GP1 saw Jake and advice was sought in relation to the use of "Nytol" to aid with sleep, GP1 confirmed the use would be appropriate.

https://www.nytol.co.uk/

At the final face to face appointment with GP1 as detailed at **3.50** Jake shared information with GP1 in relation to the causation of cuts to his right forearm disclosing apparent self-harm, the wounds having been attempted to be disguised by inking over the injuries. Jake admitted causing the injuries 6 days previously (20th April 2018) describing that he regularly feels low.

In response to this disclosure GP1 advised Jake he should be open with his mother and TEWV mental health services in relation to self-harming.

NHS guidance describes "self-harm as when somebody intentionally damages or injures their body. It's usually a way of coping with or expressing overwhelming emotional distress. Sometimes when people self-harm, they feel on some level that they intend to die. Statistics demonstrate in excess of 50 percent of people who die by suicide have a history of self-harm".

https://www.nhs.uk/conditions/self-harm/

No contact or referral to TEWV mental health services was made by GP1 following this disclosure or consent sought from Jake for the information to be shared with TEWV or his mother. This issue is considered further within the analysis section relating to information sharing.

5.15 LYPFT CAMHS saw Jakes parents on two occasions in 2011 in response to their concerns in relation to his behaviour. The concerns documented included playing with fire, hurting animals and causing upset to his sister. CAMHS responded by agreeing to work in partnership with the educational psychologist at Jakes school.

Following Jakes reported unsuccessful attempt to take his own life whilst at school CAMHS worked in partnership with the school who agreed to provide extra support for Jake to build relationships with peers. Advice was provided of on call mental health support should concerns escalate and a requirement existed to attend the hospital emergency department to seek overnight admission to a paediatric ward.

In 2012 following an appointment with Jake and his parents, Jake reported that he was bored and unhappy at home. In response it was agreed following further reports of behavioural issues at school that CAMHS Psychologists would work with Jakes parents regarding these issues. There is no information recorded to confirm if the work with Jakes parents was actioned.

In relation to the behavioural issues CAMHS responded by arranging a meeting with Jake, his parents and the school educational psychologist. This resulted in an action plan being established as detailed at **3.8**.

CAMHS further contacted Jakes parents to inform them of a summer support group course for young people who have difficulties with social communication skills. Jake attended the course receiving positive feedback in relation to his contribution.

https://choose2youth.co.uk/

5.16 TEWV AMHS (Adult Mental Health Services) responded to Jakes attempt to take his own life by jumping from a bridge by engaging with Jake following his

attendance at the hospital emergency department. Consequently, they established a management and written care plan to cater for Jakes needs at that time. The plan detailed arranging a “second look” clinic appointment to review Jakes Mental Health and provided advice of a young person’s counselling service who offer support and guidance for people under the age of 25.

http://www.yorkmhdirectory.co.uk/organisation/castlegate/

Additionally, online guidance regarding anxiety management was provided and AMHS Crisis Contact details should Jake require support.

In circumstances as described at **3.22** Jake attended at the second look clinic. In response to Jakes variable moods and fleeting suicidal thoughts, a recommendation was made to consider the commencement of a course of anti-depressants.

A subsequent second look clinic was held as detailed at **3.23.**
In response to Jakes Asperger’s condition the TEWV registrar provided information in relation to accessing services to help people with his condition develop their social skills. Consideration of Jake attending at an emotional regulation/distress tolerance group was discussed though it was of note there was a waiting time of 9 weeks to access this service.

Following the submission of a referral to TEWV by GP1 highlighting concerns relating to Jakes low moods and increased risks of suicide TEWV Crisis and IHTT responded by meeting with Jake to assess his current risk and mental health state as detailed at **3.28**.

In attempting to meet Jakes needs a “Care Programme” was undertaken by TEWV which is a package of care to help people with their mental health.
https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/
This package of care included providing a period of home treatment to assist with mood management and how to use coping strategies. A review of Jakes medication was referred to in the plan though was non-specific as to which medication was being referenced.

Over a period of the next 37 days Jake was seen on a face to face basis by TEWV Crisis and IHTT on 12 separate occasions. Additional regular phone contact usually via his mother took place in order to provide support to Jake and monitor his progress. On the 19th April 2018 Jakes care was transferred from TEWV Crisis and IHTT to CMHT.
Upon transfer it was recorded by TEWV that Jakes assessed risk had significantly reduced.

5.17 TEWV CMHT met with Jake on a face to face basis on two separate occasions. On the first occasion it was in response to reports of Jake suffering panic attacks, a recommendation from CMHT to contact the GP for support was made.

On the final occasion CMHT met with Jake prior to his death they appointed a Care coordinator with autism experience, this in response to mother's request as described at **3.44.** and 42 days after the request was made
A review of the referral made to CMHT identified insufficient information being recorded to demonstrate Jakes specific needs in relation to autism support.
Following an internal review undertaken by TEWV following Jakes death it identified as an area of improvement that TEWV ensure they are aware of a service users individual needs when allocating care coordinators.
It is recommended that the City of York SAB should seek assurance as to the progress of the recommendations as detailed in the TEWV Serious Incident Review report.
Recommendation 11. The City of York SAB should seek assurance as to the progress of the recommendations as detailed in the TEWV Serious Incident Review report.

5.18 NYPs only interaction with Jake whilst alive was in responding to a report of him attempting to take his own life by jumping from the bridge as described at **3.16.**
After ensuring Jake was safe with his consent, they conveyed him to hospital ensuring he was seen and assessed by the appropriate health professionals.

5.19 CYC in response to Jakes request of counselling arranged to meet with him so a first contact meeting as detailed at **3.25** could take place.

Following Jakes disclosure to YC1 in relation to attempting to take his own life by jumping from the bridge YC1 responded by confirming with Jake he was being supported by TEWV crisis, although they did not contact TEWV to confirm that this was the case.
To manage Jakes expectations YC1 responded by explaining there were current waiting lists for counselling.

At Jakes next counselling session as detailed at **3.51** Jake disclosed to YC1 that he had recently attempted to take his own life by hanging himself with a belt but had been prevented from doing so as his family had intervened to save him.

No response by YC1 was forthcoming in relation to this disclosure or checks made to confirm this information was known to agencies and the family. The information was not shared with TEWV or Jakes family. YC1 forming the assumption the information was already known to them, albeit this was not the case.
Investigations following Jakes death confirmed that four of Jakes friends had intervened to save his life, this information though never disclosed until after his death.
The review deems YC1 in not sharing this information with relevant agencies or seeking verification with the family to ensure they were aware, as a missed opportunity in relation to safeguarding Jake.
Forming assumptions in relation to safeguarding adults at risk can create unsafe environments and the importance of remaining open minded cannot be overstated.

YC1 by forming the assumption that family and relevant agencies were aware of this information, resulted in it not being shared and no response undertaken to safeguard Jake.

Recommendation 12. The City of York SAB drawing upon the learning from this case should develop guidance to assist practitioners in avoiding the formulation of assumptions when working to safeguard "adults at risk".

At Jakes final counselling session with YC1 a decision had been made prior to the meeting to suspend these sessions. This owing to the high level of risk he posed to himself.

In response YC1 met with Jake and informed him of the decision.

YC1 confirmed with Jake that he had a pre-arranged appointment with his GP, was in contact with mental health services and continued to be supported by his family.

When Jake left the room at the end of the meeting YC1 noted Jake appeared despondent resulting in contact being made to his mother to inform her that the counselling had now ended, appropriately identifying her as Jakes main provider of support. The review identifies YC1 in contacting Jake's mother following him leaving as good practice.

b) Were services co-ordinated?

5.20 Whilst Jake was a child there is evidence of good practice involving CAMHS working with the school educational psychologist to develop a coordinated response to help build relationships with peers. This following an episode of an attempt by Jake to take his own life by strangulation as detailed at **3.2,** then subsequently again regarding behavioural issues at school as detailed at **3.6** and **3.8**.

5.21 Following the attempt by Jake to take his own life by jumping from a bridge as detailed at **3.16** there is evidence of good practice in relation to the coordinated response by NYP, the hospital emergency department and TEWV Crisis and IHTT when Jake was in crisis in relation to his mental health.

NICE guidance recommends that Health and social care providers should ensure that crisis resolution and home treatment teams are accessible 24-hours a day, 7 days a week.

The support provided to Jake by TEWV following this attempt to take his own life was consistent with this NICE quality marker.

https://www.nice.org.uk/guidance/cg136/chapter/1-guidance#assessment-and-referral-in-a-crisis

5.22 Following Jakes attendance at an appointment with GP1 and concerns in relation to Jake and his safety were identified, GP1 contacted TEWV to discuss his case as described at **3.27**.

During this discussion GP1 referred to their belief that Jake should be prescribed a course of anti-depressants and be closely supervised. Whilst the contact by GP1 to TEWV to discuss the identified concerns was good practice, the review has not identified as a result of this contact a coordinated plan being established involving Jake, his family TEWV and GP1, which may have helped address the concerns held by GP1 in relation to Jakes safety.

5.23 When the transfer of Jakes care to CMHT was being considered a meeting involving Jake, his mother and TEWV Crisis and IHTT was held as detailed at **3.37.**

The information recorded by TEWV refers to the requirement to hold a Multi-Disciplinary Team (MDT) meeting before discharge takes place.

NICE guidance references that some of the key factors for successful Multi-Disciplinary Team working is ensuring they utilise knowledge, skills and best practice from multiple disciplines to reach solutions based upon an improved collective understanding of complex patient need(s).

It identifies further that common features identified as present in MDTs that successfully work in the community are based around general practices working alongside specialists.

It is evident from the information provided to inform the review that GP1 and Jake had contact on a regular basis which indicated a positive relationship existed. However, the benefits of this relationship may have been further exploited by TEWV and GP 1 working more closely together formulating a joint plan in relation to Jakes care and through regular communication be better placed to respond to escalating risks.

The review has been unable to identify any MDT meeting being held prior to Jakes transfer to CMHT nor any meeting being held between TEWV and GP1 to discuss Jakes ongoing care. This should be addressed by the implementation of **Recommendation 4.**

This may have assisted for example ensuring Jake took the recommended anti-depressant medication and improve information sharing in relation to other relevant clinical issues.

When Jakes care was transferred from TEWV Crisis and IHTT to CMHT in circumstances as described at **3.48** and Jake met his new CMHT care coordinator, the previous crisis care coordinator was not present as the previous joint visit had caused Jake distress.
It is well documented that autistic people can find any type of change difficult.
Both Jake and his mother had expressed a desire that the newly appointed care coordinator be a practitioner with autism experience however despite these wishes and feelings the new appointee did not possess the required skill set.
A further change of a TEWV care coordinator with the requisite skill set being appointed as described at **3.53.** was achieved 7 days prior to Jakes death.

c) What evidence was there of communication and information sharing?

5.24 Whilst Jake was a child there is evidence of LYPFT CAMHS sharing information with his school in relation to parents concerns of escalating behaviour, which they believed to be impacting upon his education.
This resulted in the CAMHS therapist visiting the school and speaking to Jake so he may discuss any concerns he may have. Here Jake disclosed he was unhappy at home which he attributed to his parents being unreasonable and that he had no freedom or independency. He additionally spoke about having nothing to look forward to or having any friends.
The subsequent outcome resulted in a multi-agency meeting being held which involved Jake and his parents where an action plan was established. (as detailed at **3.8**)

5.25 When Jake was seen at the hospital by TEWV Liaison Psychiatry following his attempt to take his own life (as detailed at **3.16**) information in relation to the assessment was shared by letter with GP1.

5.26 When Jake attended and was assessed by the TEWV registrar at the “second look” clinic (as detailed at **3.23**), the outcome of the assessment was shared by letter with GP1. This proactive approach by GP1 resulted in an urgent Crisis assessment being undertaken that same day and a revised care plan being established.

5.27 There is evidence of communication and information being shared when GP1 contacted TEWV Crisis in relation to concerns that Jake was in crisis and he was evaluating whether he wishes to live or die (as detailed at **3.27**).

5.28 Prior to Jakes transfer to CMHT there is evidence recorded of liaison between the TEWV Crisis care coordinator and the newly appointed CMHT care coordinator.

5.29 When concerns were raised in relation to potential traces of dairy in the recommended anti-depressant medication there is evidence of TEWV liaising with the pharmacy who confirmed there was no contraindication in relation to Jake taking this medication to help manage his condition.

5.30 When GP1 saw Jake at the practice (as detailed at **3.15**) Jake disclosed to GP1 that he was having suicidal thoughts and shared details of the historic attempt to take his own life whilst at school.

GP1 secured Jakes consent to share this information with TEWV AMHS to identify services who may be able to help him.

The review identified that the records show that GP1 contacted TEWV following this disclosure who requested GP1 complete and submit a referral form so they may assess how best to help Jake. There is nothing recorded to indicate this referral was ever submitted.

The information provided to inform the review indicates Jake was generally content for his mother to be aware of his health information and she was present at many of his medical appointments. On this occasion his wish was for this specific information not to be disclosed to her was honoured. Adults hold a genuine right to independence, choice and self-determination including information about themselves and in the context of adult safeguarding usually only overridden in emergency or life-threatening situations or when an individual is assessed to lack mental capacity to make informed decisions.

https://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf

The review deems that whilst mother was recognised as “a protective factor” in relation to keeping Jake safe, there is no information identified to indicate that Jakes attempt to take his own life some 4 days later was predictable and for GP1 to have shared the information with his mother may have been inappropriate in the circumstances.

Information sharing is an important aspect of agencies and carers working together to safeguard “Adults at Risk” and a regular learning theme identified in Safeguarding Children’s and Adults Reviews.

The Joint Multi Agency Safeguarding Adults Policy and Procedures for West Yorkshire, North Yorkshire and York promote whenever possible, informed consent to the sharing of sensitive personal information should be obtained from “Adults at Risk”. The review deems it would have been good practice to have such informed consent clearly recorded by GP1 and other agencies who provided care and support for Jake. This would have provided clarity as to when, and with whom Jakes information could be shared with.

The City of York SAB should promote the circumstances of when information may be shared as detailed within The Joint Multi Agency Safeguarding Adults Policy and Procedures for West Yorkshire, North Yorkshire and York and the value of obtaining informed consent to safeguard “Adults at Risk “regarding the sharing of sensitive personal information.

https://www.safeguardingadultsyork.org.uk/media/1125/joint-ma-safeguarding-adults-policy-procedures-final-approved-april-2018.pdf

Recommendation 13. The City of York SAB should promote the circumstances when information may be shared as detailed within The Joint Multi Agency Safeguarding Adults Policy and Procedures for West Yorkshire, North Yorkshire and York and the value of obtaining informed consent to enable the sharing of sensitive personal information with partner agencies to safeguard Adults at Risk.

5.31 There is evidence of GP1 communicating and sharing information with TEWV Crisis following Jakes visit to GP1(as detailed at **3.27**) where it was reported by GP1 Jake was in crisis and evaluating whether he wants to live or die, identifying Jake was at serious risk of acting impulsively and carrying out these thoughts.

5.32 On the occasion when Jake disclosed to GP1 he had self-harmed by inflicting cuts to his forearm (as detailed at **3.50**) GP1 encouraged Jake to be open with his

mother and TEWV CMHT in relation to this occurrence. However, Jake never disclosed this information to mother or TEWV CMHT despite GP1's encouragement to do so.

Nice guidance identifies that people who self-harm have a higher likelihood of dying by suicide in the 12-month period after an episode than people who do not self-harm. https://www.nice.org.uk/guidance/QS34

GP1 was aware of Jakes previous low moods and suicidal thoughts and yet despite this new information in relation to self-harming did not contact TEWV AMHS or submit a referral to them to highlight the escalating risk factors.

The review has been unable to identify the reason why such a contact or referral was not made by GP1and can only attribute it to a lack of awareness on their behalf of the heightened risk of suicide associated with self-harming.

The City of York Suicide Safer Community Strategy was developed following analysis that indicated higher incidences of suicide in York than compared to neighbouring local authorities. It has been developed on the concept created by "The Living Works" Foundation in Canada and is an internationally recognised model used by many localities across the world to structure, focus and drive suicide prevention activity with delivery of the strategy led by the City of York Council Public Health department.

The review identifies the development of this strategy as good practice and it contains recommended actions with relevance to the learning identified from this case. Action 7 of this strategy refers to activity to be undertaken in relation to reducing events of self-harm. The City of York SAB drawing upon learning from this case should work in partnership with Public Health to raise awareness of the heightened risk of suicide associated with individuals who self-harm.

file:///C:/Users/user/Documents/York%20Sar/york-suicide-safer-community-strategy-2018-to-2023.pdf

Recommendation 14. The City of York SAB should work in partnership with Public Health to raise awareness amongst the safeguarding partnership of the heightened risk of suicide associated with individuals who self-harm.

As articulated previously, issues relating to information sharing are often identified as areas of learning in multi-agency safeguarding case reviews.

In this case there was nothing recorded to indicate Jake did not wish this information to be shared with TEWV although it is unclear from the information provided to inform this review whether Jake wished this information to be shared by GP1. If informed consent to share personal information had been obtained by GP1 this could have ensured this new identified concern be referred to TEWV so they may consider it and decide if an intervention was required. This reinforces the requirement for the City of York SAB to implement **Recommendation 13.** of this report.

5.33 When Jake attended his first contact counselling session with CYC, he made a disclosure to YC1 regarding his unsuccessful attempt to take his own life by jumping from a bridge.

YC1 did not share this information with other agencies as Jake had described involvement with TEWV crisis consequently.

YC1 assumed that as TEWV Crisis were mentioned to be involved that there was no requirement to share this information further. No further checks were undertaken by YC1 to confirm TEWV Crisis involvement. Whilst the review deems it reasonable for this assumption in the circumstances to have been made, it would have been good practice for YC1 to contact TEWV Crisis to confirm this was the case.

When attending his first counselling service with CYC (as detailed at **3.51**), Jake disclosed to YC1 that he had recently attempted to take his own life by hanging himself with a belt, but that his family had intervened and were now making sure that he was not left alone and removed his access to belts.

YC1 assumed Jakes mother and family were aware of this incident, when in fact this was not the case as it had been Jakes friends who had intervened unbeknown to YC1. This was an episode of attempted suicide neither mother nor agencies were aware of. It later transpired when speaking with Jakes mother as part of the review that Jake often referred to his friends as his family.

Despite YC1 obtaining Jakes permission when establishing the counselling contract to share information if it was identified he may be at risk of significant harm, YC1 did not share this information with TEWV or the family and consequently no response or support to Jake was provided following this latest episode.

The Counselling Service is currently delivered by York MIND a local mental health charity commissioned by the City of York Council to deliver counselling services for young people in the city since January 2019.
The review deems that the City of York SAB should review the current contract arrangements and assure itself that the service specification makes specific reference for all staff delivering counselling services to have appropriate safeguarding training as recommended by the board.

Recommendation 15. The City of York SAB should seek assurance from the City of York Council that staff delivering counselling services at the Young people's counselling service have appropriate safeguarding training as recommended by the board.

The Counselling Service operate within the B.A.C.P. Ethical Framework.
https://www.bacp.co.uk/events-and-resources/ethics-and-standards/ethical-framework-for-the-counselling-professions/
The Framework is underpinned by 6 core principles the first of which is "Being trustworthy- honouring the trust placed in the practitioner "
The framework addresses the issue of confidentially in clarifying to practitioners "that they should inform clients about any reasonably foreseeable limitations of privacy or confidentiality to protect a client or others from serious harm including safeguarding commitments".
YC1 established a counselling contract with Jake which he duly signed.
YC1 provided an explanation to Jake in relation to confidentiality and exceptions when information may be shared.YC1 then subsequently obtained Jakes permission to share information if it was identified he may be at risk of significant harm, indicating there was no real or perceived barrier to this information being shared with TEWV.

5.34 When following a management review by CYC a decision was made that Jake's counselling would be suspended a letter informing GP1 of this decision was shared by CYC on the 25th May 2018. This letter contained information detailing the suicide

attempt (as described at **5.34.)** and received by GP1 on the 30th May 2018, 3 days after Jakes death.

d) The timeliness of interventions for Jake and his family.

5.35 Following Jakes first attempt to take his own life in December 2012, there is evidence of CAMHS contacting mother on the day of the reported event.
There is then evidence of continuing support being provided to Jake by CAMHS for the following months until August 2013 at which point, he was discharged from their care and GP1 informed by letter accordingly.

5.36 When Jake attempted to take his own life by jumping from the bridge in February 2018, NYP made a timely intervention through responding to the report.
After securing Jakes safety they conveyed him to the local hospital where he was handed over to TEWV Liaison Psychiatry.

5.37 Following the attempt by Jake to take his own life by jumping from the bridge, mother informed Jakes college of this incident. It was decided that Jake could not return to college until a risk assessment meeting could take place.
The college were informed of the incident on the 3rd March 2018 and the risk assessment meeting held on the 12th March 2018.Here it was agreed that Jake could return to college on the 19th April 2018 albeit he returned on the 19th March 2018 following the establishment of a risk management and support plan.

5.38 In April 2018(as described at **3.44**) Jakes mother made a request to TEWV Crisis and IHTT to request that the newly appointed care coordinator be a practitioner who held experience of working with people who had autism. TEWV CMHT appointed a care coordinator with the relevant experience the following day.

The first meeting between Jake and the newly appointed CMHT Care coordinator with the relevant experience according to records took place 42 days after the request.
In the interim Jake continued to be supported by TEWV Crisis and IHTT and CMHT.
An internal review undertaken by TEWV following Jakes death highlighted a knowledge gap existed at that time in relation to autism across mental health services.
"A framework for improving the experience of autistic adults using TEWV services" was established in March 2018.
One of its three listed priorities is that all TEWV staff should be trained in autism awareness, and relevant clinical staff trained to a higher level of autism expertise.
Drawing upon learning from this case, The City of York SAB should seek assurance from TEWV as to the progress of this training delivery plan as detailed at **Recommendation 2.**
https://www.tewv.nhs.uk/content/uploads/2018/09/Autism-Framework-March-18-FINAL.pdf

e) Risk assessment and risk management.

5.39 Following Jakes attempt to take his own life in February 2018 there is no information provided to inform the review that any formal risk assessment was undertaken prior to discharge from hospital, though a comprehensive plan to manage his care and risk was produced.
During the subsequent period he was supported by TEWV up to the time of his death there is evidence of ongoing assessment of risk by TEWV. The effectiveness of any assessment of risk within a multi-agency safeguarding operating environment will often be dependent upon the dynamic sharing of information across agencies where perceived factors indicate a potential escalation of risk.
https://www.scie.org.uk/safeguarding/adults/practice/sharing-information

5.40 In March 2018 there is evidence of good practice where GP1 made direct contact with TEWV to raise concerns in relation to Jakes presentation and that he was contemplating whether he should "live or die".
There were other occasions the review deems where it would have been good practice for GP1 to share information with TEWV to assist in the assessment and risks posed

to Jake. These include where Jake disclosed, he was staying alone overnight at his newly acquired flat, when Jake reported not taking his anti-depressant medication as recommended and when he admitted to GP1 he had deliberately self-harmed by cutting his arm in April 2019.

NHS data indicates that more than half of people who die by suicide have a history of self-harm.

https://www.nhs.uk/conditions/self-harm/

The decision taken by GP1 not to share this information with TEWV, the review deems as a missed opportunity to safeguard Jake.

The issues of concern in relation to information sharing are dealt with under **Recommendation 4.**

5.41 In May 2018 when attending his first counselling session with YC1 Jake disclosed attempting to take his own life by hanging himself with a belt and that his family had intervened to rescue him.

YC1 from the account provided by Jake assumed that this information was known to TEWV Crisis and the family, when this was not the case. The information regarding this failed attempt remained unknown to TEWV and the family until after Jakes death.

The issues of concern in relation to the formulation of assumptions when working to safeguard "Adults at Risk" are addressed at **Recommendation 12.**

f) The extent to which Jake's Mental Capacity was considered.

5.42 Principle 1. of the Mental Capacity Act 2005 states that every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.

No formal assessment of Jakes Mental Capacity was ever undertaken during the timeline of this review and it was confirmed during the learning event that practitioners were of the view Jake had mental capacity with regards to his ability to make informed decisions.

Jake was known to have Asperger's an autism spectrum disorder which is a complex neurological and developmental disorder. Owing to his condition there is the potential

he may have had an impairment of, or disturbance in the functioning of his mind or brain.

The Act identifies a two-stage test of capacity that may be applied.

Stage 1. Is there an impairment of, or disturbance in the functioning of a person's mind or brain? This could be due to long-term conditions such as mental illness, dementia, or learning disability, or more temporary states such as confusion, unconsciousness, or the effects of drugs or alcohol. If so,

Stage 2. Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?

The Act goes on further to say a person is unable to make their own decision if they cannot do one or more of the following four things:

a) Understand the information given to them.

b) Retain that information long enough to be able to make the decision.

c) Weigh up the information available to make the decision.

d) Communicate their decision.

Whilst the review deems it reasonable owing to Jakes high functioning presentation for practitioners to form the assumption of capacity, it would have been good practice to assess and formally record the assessment of capacity where he was making significant decisions, for example his decision not to take his anti-depressant medication, despite a recommendation to the contrary in helping him managing his mental health. Evidence that he fully understood the potential consequences of this decision and the potential impact upon his well-being do not appear to have been explained or recorded.

The Social Care Institute for Excellence (SCIE) recommend generally, there is no need to record assessments of capacity in relation to day to day decisions.

It advises though professionals are subject to higher standards in terms of record keeping and a formal record will be required to be kept, for example in the patient's clinical notes if a doctor or a healthcare professional is proposing treatment for someone who lacks capacity.

Recommendation 16.

The City of York SAB should assure itself as to the extent which the Mental Capacity Act 2005 is being applied across the safeguarding partnership in York.

Recommendations.

1. TEWV drawing upon the learning from this case should ensure carers providing support to patients are informed of their eligibility to access a "Carers Assessments" as per the Care Act 2014.

2. The City of York SAB should closely monitor the progress of the TEWV delivery training plan and seek evidence how it is improving outcomes for autistic adults experiencing mental health problems.

3. The City of York SAB should seek assurance from TEWV as to how referrals made to the Young Peoples Counselling Service are quality assured, to ensure high risk cases that require support by Adult Mental Health Services are not inappropriately referred for counselling.

4. The City of York SAB should communicate to the safeguarding partnership the value of multi-agency working and the sharing of information to safeguard "Adults at Risk" as described in The Joint Multi Agency Safeguarding Adults Policy and Procedures for West Yorkshire, North Yorkshire and York.

5. The City of York SAB should work in collaboration with public health to communicate the potential heightened risk to people with autism in relation to suicide, to the safeguarding partnership.

6. The City of York SAB should share the learning from this case with the All Age Autism Strategic Board to seek to influence the direction and implementation of the strategy, and commissioning arrangements for adults living with autism in the City of York.

7. The City of York SAB should assure itself that in similar cases to these that agencies can deliver a coordinated response in addressing the needs of bereaved families and promote awareness of the Major Incident Response Team and the process of accessing its support.

8. The City of York SAB drawing upon learning from this case should seek assurance from commissioners that GPs in York, are reminded of the requirement that when adults present with depression, they are offered a stepped approach in line with NICE guidance.

9. The City of York Safeguarding Adults Board should seek assurance from TEWV of the effectiveness of the Autism Strategy for young people with Autism, when transitioning into adulthood.

10. The City of York SAB drawing upon the learning from this case should develop a programme of Autism awareness training which may be accessed by practitioners from across the safeguarding partnership in York.

11. The City of York SAB should seek assurance as to the progress of the recommendations as detailed in the TEWV Serious Incident Review report.

12. The City of York SAB drawing upon the learning from this case should develop guidance to assist practitioners in avoiding the formulation of assumptions when working to safeguard "adults at risk".

13. The City of York SAB should promote the circumstances when information may be shared as detailed within The Joint Multi Agency Safeguarding Adults Policy and Procedures for West Yorkshire, North Yorkshire and York and the

value of obtaining informed consent to enable the sharing of sensitive personal information with partner agencies to safeguard "Adults at Risk.

14. The City of York SAB should work in partnership with Public Health to raise awareness amongst the safeguarding partnership of the heightened risk of suicide associated with individuals who self-harm.

15. The City of York SAB should seek assurance from the City of York Council, that staff delivering counselling services at the Young people's counselling service have appropriate safeguarding training as recommended by the board.

16. The City of York SAB should assure itself as to the extent which the Mental Capacity Act 2005 is being applied across the safeguarding partnership in York.