# Safeguarding Adults Review

Riley

Final report

Tameside Adult Safeguarding Partnership Board

December 2023

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# 1. Executive Summary

## 1.1 Background and context for the review

The Tameside Adults Safeguarding Partnership Board (TASPB) commissioned this Safeguarding Adults Review (SAR) in Summer 2023, following a SAR referral in March 2023 related to the apparent death by suicide of a young adult man (hereafter referred to as Riley). The case was screened by partners in May 2023 and it was concluded that a formal SAR should be completed, due to concerns that organisations in Tameside could have worked better together to support Riley throughout his life, which could also have led to the prevention or reduction of the risks he experienced. The case is also the subject of a Coroner's Inquest.

This report provides an account of the best understanding of Riley's interaction with services using a timeframe up to and including around 19-20 months prior to his death in February 2023. Within that timeline, it seeks to understand Riley's contact with services in Tameside as well as his housing arrangements and the broader circumstances of his life.

However, the review has also considered relevant factors in his childhood and adolescence as these appear to be significant to his vulnerability and risks as a young adult and there is learning for both children's and adults services about how to support young people holistically. The report uses information supplied by Tameside safeguarding partners based on their case records, their own organisational learning processes, and conversations or reflective practice directly arising from Tameside colleagues' participation in the SAR process.

It is important to acknowledge that the scenario covered by this review is especially complex because so many services were involved in trying to work with Riley or responding to his evident need for support. Nine separate Tameside services providing mental and physical health care, social care, housing and employment support and substance dependency knew of him, regularly saw him or were actively engaged in trying to help Riley. However, Riley's relationship with and capacity to connect with services in a sustained way was also extremely variable, which is likely to be a direct result of his poor mental health and broader vulnerabilities, along with his young age and life skills/experience.

The review has also considered the extent to which the Covid-19 pandemic and the measures taken to reduce its transmission may have affected support to Riley. Although restrictions were in place at the start of 2021, between March – July 2021 there was a phased return to normal life. The review panel agreed that the effects of Covid-19 did not play a significant role in the support offered to Riley or the way in which he would have accessed help.

The findings of this SAR and recommendations are relevant to both children's and adults services and all organisations in Tameside who come into contact with or who

are working directly with adolescents and young adults who have complex and intersecting vulnerabilities.

### *a. Overview of* Riley*'s childhood and adolescent experiences*

Riley was nearly 20 years old when he very sadly lost his life to apparent suicide. He had been a resident of Tameside during his childhood and he and his family were known to children's social care. Social care records indicate that the first referral to children's social care made specifically in relation to Riley was in Summer 2015 at age 12, when he was reported missing from home by his family. His temporary disappearance was thought to be due to being bullied in school and the anxiety that this caused him. The implication was that the bullying was motivated by his sexuality, as he had self-disclosed that he was gay. A referral was made to the 'early help' service but it is not known what support was offered to Riley or the family at this point.

Riley's Child Health Record suggest signs of worsening mental health and wellbeing also emerging from c. 2015, which involved a referral to the Child and Adolescent Mental Health Service (CAMHS). At the time, the reasons for this referral was attributed to the trauma experienced by Riley following the loss of an infant sibling when he was around 6 years old. Following this, during two separate incidents in 2016 (at c. age 13) and in 2017, health records show attendances at the emergency department for treatment linked to Riley taking an overdose, in what were seen by professionals as non-fatal suicide attempts, although Riley denied suicidality at the time. In a review of the child health record for this review, one agency identified a clear history of self-harm, overdose and suicidal ideation evident in Riley's health record. During 2017, it would also seem that Riley's father expressed concerns about his son's behaviour, including issues with his weight/diet and use of drugs and alcohol, along with bullying linked to his sexuality.

A second referral was made into children's social care by Riley's school in February 2018, where it was noted in the referral that he was open about his sexuality in school. The referral was due to an assault by family members, which was said to be linked to his sexuality. A child and family assessment was completed, but he remained in the care of one of his parents and another referral was made to early help.

During 2018, two other referrals were made to children's social care and the case records indicate concerns for the mental health of both the children and adults in the family. The second of these referrals involved claims and counter claims of assault between parent and sibling family members, which included Riley both assaulting others (which he admitted) and being assaulted.

None of these referrals in relation to Riley resulted in child protection proceedings and Riley was not taken into care. The support offered to the family around Riley

took the form of early / family support, but it is not known exactly what intervention or help was offered or accepted. Following these allegations in 2018, it appears that during 2019, Riley relocated to another County with his mother.

The best understanding of this review is that Riley returned to Tameside at some point in early 2021, but in February 2021 his father approached children's social care as he felt unable to cope with Riley's behaviour. It was initially agreed that his father would continue to offer him a place to stay but this proved difficult for all parties to achieve in practice and as Riley was effectively homeless and not yet 18, this triggered direct support for him from children's social care. The aim of this support was to give him some structure and stability and to help meet his basic needs around housing, independent living, financial security and also his education.

Practitioners who worked with Riley following his return to Tameside in early 2021 were asked to describe their impressions of him, so that the review has some insight into who he was as a person. Several practitioners said that he presented as a friendly, bubbly, outgoing young man who could be flamboyant. He cross-dressed and was openly gay. When asked directly about his gender identity he said that his pronouns were he/him, but he also appeared to be comfortable with they/them pronouns used by one service.

However, practitioners also acknowledged that he was a very complex young adult and some, but not all practitioners, were aware of some aspects of his vulnerability. The people who worked directly with him felt that the most fundamental issue was his poor mental health and trauma history. However, all agencies agreed that there was no formal mental health diagnosis – although post-traumatic stress disorder (PTSD) along with anxiety, depression and emotional dysregulation were all recognised as important factors underlying Riley's mental health and wellbeing. Some practitioners believed that his poor mental health was the main factor driving his difficulty staying in contact with services and his decision-making.

Services that worked with Riley over a period of time observed that he could occasionally be aggressive and there was a perception that he was easily influenced by others, because he wanted to fit in and be accepted. Practitioners felt that this strong drive to be accepted may have contributed to him 'falling into' increasing use of substances and hard drugs such as cocaine, heroin and amphetamines during his time at the overnight temporary accommodation, as he got to know other young adults who also used the service and were involved in drug use.

Equally, practitioners said that he was self-aware and could speak with insight about his personal history. He had also reflected on some of his childhood experiences and had reached a new level of awareness and understanding with hindsight. The most significant of these was his recognition as a young adult, and subsequent self-disclosure to at least two services, that a 'relationship' with someone who was (thought to be) a neighbour, which started at the age of 8 years old, was in fact grooming/sexual abuse.

He was also well-informed about local services and the colleagues that were supporting him said that he had a good understanding of what support was available. In fact, on a number of occasions he self-referred to services including Adult Social Care, the local substance dependency service and a talking therapy service.

### 1.2 The rapid review process

The review process followed for this SAR is adapted from the Social Care Institute for Excellence (SCIE) rapid review methodology, with a view to achieving a swifter turnaround of safeguarding learning, whilst still achieving depth and breadth. The review was completed during approximately a 4 month period between August – December 2023 and consisted of the following elements:

- Provision of a case chronology, from which the independent reviewer developed key lines of enquiry (KLOE) for discussion
- Individual agency meetings and record checks to discuss the KLOE, with additional information provided by several agencies as required
- A meeting to enable the independent reviewer to understand the approach to mental health commissioning and delivery in Tameside
- A practitioners meeting, where colleagues who had met and worked directly with Riley were supported to discuss the case, plus one individual follow-up meeting. This included four colleagues who had worked consistently with Riley over several months and had got to know him reasonably well
- Production of an initial analysis report, discussed at the first multi-professional Review Panel meeting
- Production of a final analysis report including recommendations for comment by the Review Panel

The findings and recommendations set out in this report draw on all these different forms of evidence, insight and collaborative discussion, to generate the best possible understanding of the circumstances leading up to the death of Riley.

### 1.3 An overview of contact with services in the time period of this review

Riley's initial contact with services on his return to Tameside began in February 2021, primarily with children's social care arising from contact made by his father. However, from the point of him turning 18 at the end of April 2021, he had ongoing but intermittent contact with multiple services, as a result of self-referral or referrals between agencies, which continued until his death in February 2023, almost 2 years later.

During this time there was a repeated pattern of Riley being open to multiple services who were trying to support him around different aspects of his health, wellbeing and care and support needs. However, this was often followed by case closure several months later due to his irregular engagement with services, which it seems was partly because he didn't have a phone or he had changed his phone number. However, a number of professionals and Riley himself are documented as saying that it was very overwhelming for Riley to have multiple repeated contacts from different support workers.

Between June 2021 and February 2023 hospital records suggest that Riley attended the emergency department at least 12 times. 10 of these attendances related to his mental health, whilst 2 concerned physical health complaints. One agency case record suggests that he attended the emergency department to manage overwhelming feelings associated with anxiety and depression.

Another significant feature of Riley's life during this 2 years is his extremely insecure housing situation. There is repeated evidence across the review that finding stable housing and somewhere he could have his own space and feel safe was very important to him. However, this was extremely difficult to achieve due to a range of factors, including the local availability of suitable supported living accommodation and Riley's 'non-priority' status for statutory homelessness support, along with his ability to be responsive to these opportunities when they were presented e.g. there are numerous instances where he didn't attend meetings or declined housing options that were well-positioned to support him.

The first record of his contact with wider services as an adult is at the end of April 2021 with a referral from a sexual health advisor into a local talking therapy service. This referral included historical information about his mental health and wellbeing, covering his contact with child and adolescent mental health services (CAMHS) and overdose/non-fatal suicide attempts as a younger teenager. At the time of this referral, Riley reported that suicidal thoughts 'come and go' but he had no specific plans to end his life. Riley is subsequently offered an assessment for talking therapy in May 2021, but he does not respond to this appointment.

After a domestic violence incident in mid-May 2021, it is mutually agreed that Riley should not stay at the family home any longer and on the same day the Police take him to a friend's house with an acknowledgement that a decision would need to be reached about his long-term living arrangements. What appears to follow from this point is that Riley stays overnight with different members of his extended family and family friends, interspersed with use of overnight non-statutory homelessness provision in Tameside.

Just over 2 months later at the start of August, Riley referred himself back into the talking therapy service. At this point he is said to be self-aware and states a desire to address his mental wellbeing because he didn't want to get into a position where he felt hopeless, which is when ending his own life could become an 'option' for him.

Two days later, Greater Manchester Police (GMP) responded to a welfare call and it is reported that Riley is no longer living with his sister following an altercation/domestic incident. It is recorded that he is very upset and behaving erratically.

Throughout August 2021 there is evidence that the talking therapy service liaises with other agencies, including the children's social worker, to assess and plan the best course of action. This includes an assessment with Riley, which he attends and describes his immediate issues as trying to cope with trauma and fluctuating moods. Following review by a senior mental health practitioner a decision was taken to refer Riley to the neighbourhood mental health team (NMHT). At this point, Riley was given advice about what he should do if he found himself in emotional crisis and he was asked if he felt that he could follow a safety plan. A safety plan was agreed with him and he was referred to the NMHT.

Between late Summer into Autumn/Winter 2021, a number of services appear to be working proactively with Riley, including the early help professional from children's social care, the NMHT and the provider of the temporary overnight homelessness accommodation. A joint meeting was arranged in mid-September between these three services to be held at Riley's temporary accommodation and it was hoped that Riley would be able to attend this.

In what seems to have been a parallel process, the multi-agency safeguarding hub (MASH) also called a meeting to discuss Riley just a few days later which included Adult Social Care (ASC). Riley had independently referred himself to ASC at the start of August 2021. As a result of this meeting, a decision was reached that ASC would withdraw from the case because other services were working with Riley around his use of substances and mental health.

Based on agency records and information sharing at this time, it would seem that whilst Riley was 'open to' and had participated in an initial assessment with the drug and alcohol service and there had been initial contact with a number of mental health services including MIND, the NMHT and the hospital mental health liaison team, in reality none of these teams had established an ongoing relationship with him. There is therefore no clear evidence that any agency was actively working and supporting Riley at the time of the decision made at the MASH meeting, other than the children's social care family support worker, who does not appear to have been invited to the MASH meeting or directly involved in any decision-making.

The case records made available to the review for the period September – December 2021 do not offer a clear picture of agency activity or contact with Riley. This may be because for part of this time, he appeared to be housed in a neighbouring borough. However, it has been possible to establish that a number of key events (in addition to the above) did take place:

- A Vulnerable Adult meeting was called and held over the telephone on 15 September 2021. It is not clear which agency initiated this discussion. One

agency's recollection of this meeting was that Riley's vulnerabilities were discussed, which included his history of non-fatal suicide attempts and there was a reference to him being a sex worker. However, the perception was that the action planning across agencies at the meeting was weak and unspecific, other than to agree the ongoing involvement of some agencies

- On 30 September 2021, a joint professional meeting is held involving Adults Social Care, NMHT professionals, housing options and the drug and alcohol support service and Riley is also in attendance. This meeting introduces him to support workers from the NMHT with a view to him being supported by them going forward, but records indicate that he engages with this service intermittently
- There is evidence from case notes that the out-of-borough housing support worker was concerned about Riley's deteriorating wellbeing and records of conversations with him suggest that he felt isolated in the out-of-borough accommodation and was struggling financially and to feed himself. There are indications of him self-harming and when the support worker discussed this with him, he speaks openly about his fear of hurting himself
- Near the end of November 2021, the children's services family support worker closed Riley's case. A goodbye visit is arranged with Riley and the NMHT and the drug and alcohol service are advised of the case closure. At the same time, the family support worker suggests that ongoing support should be co-ordinated because Riley found the multiple contacts from agencies overwhelming and it exacerbated his feelings of anxiety

Early in January 2022, Riley voluntarily attended the hospital emergency department with a friend. There are confused and contradictory reports between him and his friend about his circumstances but Riley self-reports drug use and poor mental health. His friend also implies potential abuse and exploitation by others.

After attendance at the hospital both the NMHT and the drug and alcohol service begin to work with Riley, but this is characterised by only intermittent communication and engagement by Riley. As a result of this, these two services both close his case within a few days of each other at the beginning of March 2022 (3 and 9 March). There is evidence that the two case-workers knew of the other agency's involvement during February 2022 however, it's not clear if they consulted one another prior to their case closure.

On 25 Feb, Riley also self-refers to the GP for depression. There are several instances of Riley attending his GP for mental health reviews and the psychiatric clinic during 2022. From the middle of March 2022, the GP appears to be the only agency in contact with and supporting Riley. During 2022, the GP-based psychiatric professional appears to be one of the few services that Riley voluntarily engages with, although not consistently.

In May, Riley has contact with the Police due to an assault on his father and he is released on conditional caution and referred to the drug and alcohol service, but his case is closed at the end of July due to non-engagement, despite multiple attempts by the service. The service is then re-opened to Riley on a self-referral in October 2022 but subsequently closed for a third time in 2022.

On 5 August a family friend who Riley is living with calls the NMHT to provide an update and indicates that he needs help with his mental health. Riley is reopened to the service but there is mixed success in contacting and supporting him across the remainder of 2022.

There is a strong impression, alongside documented case records, of an ongoing stream of communication to Riley with appointment reminders and telephone messages primarily from the NMHT, the drug and alcohol support service and the GP across Summer and Autumn 2022.

Perhaps significantly, in mid-October following a period of apparent unresponsiveness to services, he self-refers into the GP in relation to his mental health and in the next 2 weeks also self-refers to the drug and alcohol support service and talking therapy service. It is possible that his proactive help-seeking behaviour at this point indicated his self-awareness of his worsening mental health and coping capacity. However, this is followed again by mixed levels of contact by Riley, but he did attend a mental health review at his GP surgery on 30 November.

On 28 December, it appears that Riley self-refers to the homelessness service and on 30 Dec he attended the GP for a mental health review, reporting high levels of anxiety and stress. He also attends the housing assessment appointment on 3 January following which he returns to the temporary overnight accommodation he had attended during part of 2021. In the few days after his return to the temporary accommodation there is a physical altercation in which he is seen to attack another resident, however, it is established by the Police that Riley's physical aggression had been prompted by the use of offensive and discriminatory language related to his sexual orientation. There is no evidence that this is recognised or recorded at the time as discriminatory abuse or a hate crime.

Riley then presented twice at the hospital emergency department in close succession on 15 and 17 January with self-harm and ongoing suicidal thoughts. The record made at the time stated that on the second occasion he wanted to be admitted to hospital on mental health grounds (under a formal Mental Health Act arrangement) to avoid further self-harm but this request also appears to have been motivated by him seeking a place of safety and to avoid sleeping on the streets, which is what he had suggested he had been doing. Riley says in this visit to hospital that becoming homeless (after a family friend had decided that Riley could no longer stay with them) had led to his deterioration and suicidal thoughts. However, the discussion with practitioners also highlighted that he had been using amphetamines

whilst staying at the overnight temporary accommodation specifically to stay awake, as he feared being sexually assaulted if he fell asleep there.

There are case records of further attempts to find alternative suitable accommodation for Riley but he did not attend appointments or could not engage due to his anxiety levels. For the remainder of January there is a pattern of Riley clearly finding it difficult to attend appointments or engage with services, but on 6 February 2023 he spontaneously calls into the drug and alcohol support service and self-refers to Adult Social Care (ASC) a few days later. He reports to ASC that he has been feeling suicidal for several weeks and feels unsafe whilst staying overnight at the temporary accommodation.

On 13 Feb Riley attends the emergency department via ambulance following what he described as an intentional overdose of prescription drugs alongside alcohol and an unknown amount of illicit substances. He is admitted overnight and discharged with transport the following day after a full assessment has been undertaken by a Mental Health Liaison Worker. When asked in the mental health assessment, he states that it was his intention to end his life. However, Riley was not willing to discuss safety planning and therefore advice was given to contact other services he was involved with and the temporary housing provider.

Following this hospital episode there appears to be a gap in contact with services for around a week, in which period agencies are communicating with each other, expressing concerns for his welfare, that he appeared to be uncontactable and it was possible that he was missing.

On the morning of his death Riley attended the drug and alcohol service needle exchange in Ashton with a friend. He received sexual health advice, condoms and was given advice about overdose and a naloxone kit (to counteract heroin overdose). He reported feeling positive about making changes to his life. Later this day, very sadly he died by apparent suicide.

### 1.4 The key issues under consideration

12 initial key lines of enquiry (KLOEs) were discussed with the safeguarding/agency leads most closely involved with and relevant to the case. A slightly adapted version of these questions was also explored at the multi-agency session with practitioners.

They were:

1. What was/is the escalation process in Tameside for a multi-agency discussion to be held around adults who have multiple vulnerabilities, needs and risks?
2. How was this process, or any other similar structured multi-agency discussion/MDT meetings, used by practitioners in the case of Riley?
3. When an adult is open to multiple agencies at the same time, how is support usually co-ordinated? Was this case typical of usual practice?
4. How do services manage non-engagement from vulnerable people who have been referred to them or who have self-referred? When services discharge service users/close the case due to non-engagement, what factors are considered?
5. To what extent was Riley's health and social care history pre-eighteen known by the agencies working with him as a adult?
6. Was Riley's mental capacity assessed – in particular his ability to keep himself safe, given his ongoing substance dependency and poor mental health?
7. How does homelessness / housing insecurity influence how agencies work with a young person?
8. Was the possibility of Riley's risk of exploitation by others actively considered?
9. Were Riley's sexuality, and potentially his gender identity, understood as factors in his vulnerability?
10. Are you satisfied that practitioners had a holistic view of Riley's vulnerabilities and were able to form a view on risk – particularly the risk he posed to himself?
11. Where adults are considered vulnerable and at risk of self-harm, or are experiencing suicidal thoughts, are agency policies and practices adequate to manage/address possible suicide risk, working with denial of suicidal thoughts/intentions despite evidence to the contrary, safety planning etc?
12. What is your assessment of what could have been improved or done differently in this case and do you think there were any key moments or missed opportunities in practice?

Based on these initial KLOEs and following discussion with the agency leads in the first stage of the review, 3 themes of interest around both routine care and safeguarding practice were generated by the independent reviewer. They are:

- Multi-agency co-ordination of care and support

- Working with adults with multiple vulnerabilities
- Multi-agency collaborative risk management

The findings from the SAR process were then analysed under these 3 themes in detail, using a number of sub-themes designed to highlight issues of particular significance and practice improvement that have emerged from the review. (See below.)

### 1.5 Good practice learning

There are inevitably aspects of the support to Riley and its co-ordination that could have been significantly improved, which will be discussed in further detail, but there are also examples of good practice and practitioners showing concern and compassion for a young man they recognised to be vulnerable and who they wanted to help.

These good practice issues from across agencies are collated here:

- The Early Help professional in children's social care kept Riley's case open until late November 2021 (almost 7 months after his 18th Birthday) in order to support him to reach a more stable situation in terms of his housing, education/work opportunities and financial circumstances, alongside referrals into specialist services that could support him with his mental health and wellbeing, sexual health and alcohol use
- Although Adult Social Care did not directly support Riley following 2 self-referrals, his case file was left open for a period of 11 months on the first occasion due to concerns about his wellbeing and to assist the other agencies that were working with him
- There is evidence that housing with support options that may have been more suitable were considered for Riley, such as housing that specialised in LGBTQ+ client groups and residential-based rehabilitation, but he either refused some of these options or did not attend the appointments that had been arranged to discuss them. It should be acknowledged that one of the reasons he is said to have refused some accommodation was due to cost and affordability
- A number of practitioners were recognised by colleagues from other services for going beyond what would have been usual practice e.g. the early help professional and the key worker at the overnight temporary accommodation
- There are a number of reports from different agencies of a multi-agency MDT meeting being held in September 2021 by the MASH, at which it was determined that Riley would no longer be held as a case by Adult Social Care as other agencies were already involved in supporting him with his alcohol/drug use and mental health. Children's social care records indicate that representations were made by children's social care in relation to this decision, specifically to flag

Riley's risk of vulnerability to exploitation, which were concerns also documented by the Neighbourhood Mental Health Team (NMHT)

- There are good practice examples across the chronology of services openly and directly checking whether Riley was experiencing any suicidal thoughts, and undertaking a level of safety planning with him if there were any concerns, but this does not always appear to have been consistent across services. In some cases, this may have been because practitioners did not know he had a history of suicidal thoughts and behaviours.

### 1.6 Summarising commentary

This SAR has explored the complex history and circumstances of a vulnerable young man with a view to understanding if services could have supported him more effectively, particularly from the point that he returned to Tameside in early 2021.

In particular, it has highlighted the largely disjointed practices of the 9 agencies that had often repeated and overlapping contact with Riley over the 2-year period prior to his death and it poses legitimate questions about the sufficiency, safety and age-appropriate support available to vulnerable young adults with care and support needs living in Tameside.

One of the most poignant observations made by professionals in the course of this review is that whilst Riley's vulnerabilities were broad and deep, his circumstances meant that he had only low or no eligibility for statutory support, yet he relied almost entirely on public services for guidance and care across all aspects of his life – emotionally, financially, educationally, to meet his housing and physical health needs, and also for wider issues that he was trying to manage around substance use and his sexual health and safety. In this sense, public services in Tameside were a de facto corporate parent for this young man, but this does not seem to have been recognised at the time.

An important observation is that the behaviour of agencies unwittingly mirrored Riley's inconsistent engagement with services, instead of an appropriate lead professional taking a more direct co-ordinating role, whilst also committing to forming a relational rapport and mutual trust with Riley.

Although there is evidence that some practitioners did work well with Riley, their efforts were typically isolated from wider multi-agency practice and relevant information or insight was not shared with all agencies. However, when one statutory agency expressed concerns about the risk of possible sexual exploitation, this appeared not to be heard or acknowledged by other statutory agencies, potentially because this information contradicted an adult safeguarding decision that had just been made.

Some of the most important learning to emerge from this review relates to the identification of sexuality as a fixed interpersonal risk, which may commonly emerge in adolescence, but which can continue to be a source of relational and emotional challenge, alongside possible discriminatory harassment and abuse in young adulthood. Unfortunately, the impact of Riley's sexuality and the tension that this created in his family was overlooked when he was in contact with services a child, as was the discriminatory harassment he experienced as a young adult in his wider environment.

The review also asks questions about how unconscious bias and stereotyping may have shaped practitioners' interpretation of the behaviour of a young adult, and which may have also obscured and skewed professionals' perceptions of Riley being the victim of sexual exploitation. These safeguarding judgements also failed to take account of Riley's context i.e. his overall vulnerability and history, his age and his isolation from family support networks and other stable social support.

Lastly, there have been numerous references across the review to the availability of suitable accommodation in Tameside, which provides a safe and secure environment for homeless young adults with 'low priority' for statutory housing support and which crucially does not expose them to ongoing or increased risks. Having a safe place of his own was clearly important to Riley, as case notes document, and he said repeatedly that he did not feel safe at the non-statutory temporary overnight homeless accommodation. Despite the fact that the key worker at this setting formed a strong rapport with Riley, the central question is whether this accommodation was an appropriate option for a vulnerable young adult and whether the risks to him were appropriately managed by professionals.

## 1.7 Recommendations

The recommendations follow the evidence from the review process and aim to address the primary learning points relating to the experiences of Riley. The recommendations are organised under the 3 primary themes of interest identified for this safeguarding adult review.

### i. Multi-agency co-ordination of care and support

**a)** The Tameside Safeguarding Children Partnership (TSCP) and the Tameside Adult Safeguarding Partnership Board (TASPB) should jointly consider whether the multi-agency approach in Tameside to supporting adolescents and young adults, especially young people who have limited or unstable family or social support networks, adequately and safely meets need in the 14-25 population. This includes:

- the support pathway for this age-group
- co-ordination of support, and
- the availability, suitability and age-appropriateness of support to meet needs

Any deficiencies in the approach should be jointly addressed by both Partnerships.

**b)** The TASPB should seek assurance from the relevant agencies that the joint protocol covering case-handover between children's and adults social care is reviewed in light of the learning from this SAR. The focus of this review should be to ensure that 18+ young people who have ongoing care and support needs into adulthood (but who may not have a EHCP and/or are not care-experienced) are appropriately supported and also involved in conversations about their needs.

**c)** The TASPB and the TSCP should jointly consider reinforcing guidance for practitioners around record-making and proportionate information-sharing practices, where historical and/or current information about an adult is relevant to immediate professional judgements around risk and safeguarding. This should include guidance around:

- sharing of relevant information from child social care and health records
- appropriate recording of self-disclosures
- seeking consent to share information or refer to relevant services
- existing legal provisions which allow for assessment or information-sharing without the explicit consent of the adult

**d)** The Tameside Mental Health Commissioning Team should continue to review with local mental health service providers, the mutual arrangements around information-sharing, communication and joint working across all providers of mental health support, to ensure that practice is effective, safe and also avoids duplication of support to the same individual.

### ii. Working with adults with multiple vulnerabilities

a) The Tameside Suicide Prevention Strategy Group should be made aware of this SAR and its findings by the TASPB. The Suicide Prevention Strategy group, alongside local Mental Health Commissioners, should then take steps to clarify:

- what is the local specialist offer around self-harm and suicide prevention in Tameside - both clinical and non-clinical provision

- best practice that should be followed by individuals, services and families in Tameside where there is a concern about potential risk of suicide
- how professionals and services who work with vulnerable adults in Tameside access local training around self-harm and suicide prevention

b. The TASPB should promote practitioner awareness of sexuality and gender identity as a fixed interpersonal risk for some young people and adults and develop/incorporate training which improves understanding of this, conceptually and in practice situations. This should include explicit recognition that abuse, bullying, harassment or discrimination based around someone's (perceived or actual) sexuality or gender identity should be regarded as a safeguarding concern

c. Building on partners' existing work and the TASPB's leadership role in this area, the TASPB should seek assurance from all agencies that an awareness and appreciation of unconscious bias and unintentional stereotyping in professional decision-making around safeguarding, is incorporated into agency training and supervision practices, specifically:

   - How gender or sexuality-based biases surrounding perceptions of sexual behaviour may lead to sexual exploitation being overlooked
   - The stigma and stereotyping of people who use drugs/alcohol as engaging in other risky behaviours purely as a way of acquiring substances, without due consideration of other motivations, such as the need to meet basic human needs for food, shelter or safety

   And that the relevance of training on this topic is clearly communicated to and made accessible to wider agencies and partnerships e.g. housing providers, the Community Safety Partnership

d. The TASPB should seek assurance and evidence from safeguarding partners that services that regularly work with vulnerable young adults:

   - are aware of the need to adapt policies and practices to be age-appropriate and make reasonable adjustments in line with the life skills, capacities and wellbeing of young adults
   - are using person-centred practices that emphasise the development of trust and rapport with the young person
   - apply non-engagement policies and practices in a flexible and age-appropriate way
   - have appropriate management oversight in place to ensure that case closures do not place young adults at increased risk

- advise other agencies in advance of planned case closure so that support to a young adult can be better co-ordinated

e. The TASPB should investigate and review:

- Whole system-level awareness and knowledge of adult sexual exploitation, its presentation, and the appropriate contextual interpretation of sexual behaviour, especially amongst young adults
- the extent to which a clear pathway exists in Tameside to prevent, identify, respond to and support victim recovery from adult sexual exploitation

Following these enquiries, the TASPB should take steps to address any weaknesses identified.

### iii. Multi-agency collaborative risk management

a) As an immediate measure, to address concerns relating to the multi-agency co-ordination of support to vulnerable young adults in Tameside, the TASPB should ask agencies to audit their arrangements for supporting young adults already known to services. This should be with a view to ensuring that an appropriately experienced lead professional has or is given responsibility for coordinating services to the young person and is supporting their engagement.

b) The TASPB should seek assurance that the new 'TRAM' multi-agency risk assessment approach provides a clear and easy-to-access pathway for the co-ordinated risk management/escalation for 18+ young people who are experiencing multiple, intersecting risks, including:

- How it applies in the context of transition between children's and adults services
- How it guides the resolution and escalation of professional disagreement about risk

c) The TSCP and the TASPB should jointly consider how to address the apparent gap in local transitional safeguarding capacity and expertise, to ensure that vulnerable young people and young adults whose safeguarding risks persist or emerge in early adulthood are supported and kept safe as far as possible

d) To address the housing-related issues identified in this review, the TASPB should:

- seek clarity from statutory housing partners about the statutory and non-statutory housing offer for homeless vulnerable young adults in Tameside, the current operational challenges in this area of homelessness/housing provision and its implications
- arrange for information about current available housing options for vulnerable homeless young adults, and relevant qualification criteria, to be shared amongst practitioners
- emphasise robust and effective risk management practices around homeless young adults, to mitigate exposure to new risks or the exacerbation of existing risks linked to their use of temporary accommodation

e) The TASPB should consider taking advantage of the emerging learning from the national 'Changing Futures' programme around support for adults experiencing multiple disadvantage and also the Greater Manchester programme, in order to enhance the operational and strategic approach to adults with multiple, intersecting and often complex needs in Tameside

## Detailed report

## 2. Analysis by the key issues explored in the review

### 2.1 Multi-agency co-ordination of care and support

a. *Use of multi-disciplinary team approaches*

During the period covered by this SAR it has been challenging to identify evidence that the ongoing dialogue between the agencies supporting Riley was formalised in the context of ongoing multi-disciplinary team discussion(s) e.g. an opportunity for professionals to come together to discuss Riley's presenting needs (ideally with him also in attendance), his personal history, to discuss how to co-ordinate the support he needed and recognise any safeguarding or other risks to his wellbeing or safety.

There are numerous examples of professionals informally sharing updates (via phone or e-mail) about Riley e.g. Summer 2021, Spring 2022 and early in 2023, but these typically appear to be motivated by the need to get in touch with him and get hold of his most recent address or contact number.

Where there were co-ordinated multi-agency attempts to discuss or support Riley they appear to be disjointed, happening in parallel but separate processes, called by and involving different professionals. There are three such meetings that happen within a few weeks of each other:

- 15 September 2021 – a Vulnerable Adult meeting
- 17 September 2021 – a multi-professional meeting between the family support worker, the employment support worker from the NMHT and the housing key worker from the temporary overnight accommodation. It is understood that the primary purpose of this meeting had been to engage Riley meaningfully and it was held at his accommodation to encourage this, but unfortunately, he did not attend
- 22 September 2021 – a Multi-agency Safeguarding Hub (MASH) meeting

It is not clear why these meetings were held in isolation from each other and the outcomes simply appear to reinforce the status quo e.g. the drug and alcohol support service and the employment support worker from the NMHT would continue to work independently with Riley.

This does however seem to culminate in a joint professionals meeting on 30 September 2021 involving Adult Social Care, NMHT professionals, housing options and the drug and alcohol support service and Riley is also in attendance. This meeting introduces him to support workers from the NMHT with a view to him being supported by them going forward.

However, there is evidence of disagreement between professionals about the right course of action following the MASH meeting, where it was determined that ASC would withdraw from the case. The family support worker, who was not in attendance at the meeting, later voiced concern about Riley's vulnerability to exploitation, in particular sexual exploitation. This followed the conversation held on 17 September where the 3 professionals involved in that meeting had discussed concerns about Riley's lack of money leading to exploitation by male residents at the temporary accommodation, as it was thought that he was performing sexual acts for payment.

No evidence has been presented to the review of any meaningful risk management or planning discussion at this time e.g. clarity about which agency was leading on or should assume responsibility for co-ordinating support to Riley or managing the risks associated with Riley's multiple vulnerabilities, including the risk he posed to himself. Although several practitioners and agencies were clearly trying to help Riley and were aware of aspects of his vulnerability, those individual efforts were isolated, fragmented and un-coordinated.

It would also seem that the practitioners / agencies that were at the front-line of meeting Riley's support needs, following the meeting on 30 September, were not aware of his history of childhood trauma, his previous non-fatal suicide attempts as a young teenager, and later his multiple attendances at the emergency department during 2021-2023 linked to poor mental wellbeing and self-harm.

b. *Developing a shared understanding of individual context, history and risk*

Although many practitioners said that they recognised that Riley was a vulnerable young man with a range of complex needs, some said that they did not have a full picture of his background or history – particularly in reference to his self-harm and suicide risk. For those practitioners who had got to know Riley and had been able to develop a relationship of trust with him e.g. the staff at the overnight temporary accommodation, he did self-disclose some features of his past and more recent personal history and was able to analyse and reflect on these experiences. Understandably, it would seem that Riley was more likely to spontaneously self-disclose his mental health history when speaking to a mental health professional e.g. the GP psychiatric clinic, the talking therapy service, the senior mental health professional in the NMHT, on visiting the hospital emergency department with the mental health liaison team etc

It is not clear the extent to which agencies asked for Riley's consent to share relevant information with other services, or make referrals, particularly where the purpose of sharing such information was with the explicit aim of keeping him safe and enabling information about risk to be shared across all agencies.

It does seem that some health partners, such as the hospital and the GP, would have had access to a fuller history as they would have been able to see Riley's child health record, which included references to his mental health and self-harm as a younger teenager. However, there are no indications that the GP or the mental health professional at the practice was ever approached or involved in any multi-agency conversations.

## 2.2 Working with adults with multiple vulnerabilities

a. *Supporting young adults*

There was a broad consensus when discussing Riley's case with both practitioners and wider professionals that there is a gap in provision in Tameside for vulnerable young people and 18+ young adults who have multiple support needs. Although there is an independent review underway to understand and address these currently unmet adolescent needs, led by children's social care, it has not yet reported its conclusions. However, the findings from this review suggest a need to consider five areas, which go beyond children's services:

- Suitable age-appropriate accommodation for young homeless people in which they can feel safe, and which does not expose them to ongoing or increased risk of physical or emotional harm or exploitation
- A shared approach between children's and adults social care that enables a careful and considered hand-over of support for 18+ young people who have ongoing care and support needs into adulthood, which directly involves the young person
- Local expertise and approaches to transitional safeguarding that recognise and provide support to young people beyond age 18 e.g. typically up to age 25, especially when those risks arise outside of the home, such as exploitation. There is a useful body of national evidence and good practice around transitional safeguarding and support for young adults.[1]
- A fuller consideration and understanding of how Care Act eligibility and assessment applies to vulnerable young adults, particularly around wellbeing, feelings of safety and ability to meet basic needs, such as housing and food for instance
- A system-wide approach that both recognises vulnerable young people and commits to co-ordinating support for them, *especially* when they have no or low-priority entitlement to statutory support

[1] https://www.researchinpractice.org.uk/all/topics/transitions/

Attention to these issues will create a more effective safety net for vulnerable young people in Tameside, especially for young people who do not have access to parental or family support networks and therefore rely entirely on public services to support and guide them.

The other important piece of learning from this review process relates to the way in which professionals interacted with Riley as a vulnerable young man. There are numerous case notes that refer to the fact that Riley felt overwhelmed when multiple agencies were trying to contact him, which increased his anxiety, and his frequent 'opting out' from arranged appointments was also linked to his feelings of anxiety. The family support worker flagged this on several occasions and when he closed Riley to children's social care, he suggested that one agency take a co-ordinating role to avoid this. One of the practitioners involved in the case also felt that the multi-professional meeting held on 30 September, which Riley attended, was not conducted in an age-appropriate way.

There is a sense across the case that professionals were largely expecting Riley to engage with services on their terms, without recognising the very real effect that his age, his vulnerabilities and his feelings of anxiety, would have on his capacity to engage and then continue to do so in a sustained way.

One agency observed that professionals who regularly work with adults with multiple vulnerabilities may eventually see 'chaotic' patterns of behaviour as normal and fail to use professional curiosity in their interactions with clients and service users, especially when their caseload is very demanding.

b. *The implications of insecure housing*

One of the most striking aspects of Riley's experience in the final 18 months of his life is the impact of becoming homeless. Based on the evidence from the review, it would be fair to conclude that becoming homeless increased the negative trajectory of his wellbeing, vulnerability and exposure to risk, in the following ways:

- He frequently reports that he does not feel safe at the temporary accommodation
- He is exposed to discriminatory language and attitudes relating to his sexual orientation at the temporary accommodation
- Practitioners said that he got into the habit of using harder drugs whilst living in the temporary accommodation, through his association with other residents
- It is likely that he became a target for sexual exploitation whilst staying at the temporary accommodation
- He also reported that he feared sexual assault in his sleep and had been using illicit drugs to stay awake

Although Riley also spent significant periods of time staying overnight in the homes of extended family members and family friends, these arrangements often proved extremely unstable, lasting only a few days in some instances. There is also a suggestion of altercations and arguments with the people who were supporting him, which inevitably meant that their support was eventually withdrawn. There is no judgement of any party intended in this commentary, but it is important to recognise that even when Riley was not staying at the temporary homeless accommodation, his housing situation was rarely secure or guaranteed, as he was homed on a goodwill basis. The effect on a young person of having no permanent or safe base to live and sleep for over 18 months must have been incredibly destabilising, demoralising and frightening.

However, it must be recognised that multiple attempts were made on numerous occasions to find Riley a more appropriate housing option, but sadly either these options only worked on a short-term basis, he declined some suggestions, or he missed the appointments offering alternatives.

There is a sense that his final period of homelessness, shortly after Christmas 2022, where his only remaining option was to return to the temporary homelessness accommodation, or sleep on the streets, may have been a precipitating factor in his death. Three visits to the emergency department followed in January and February 2023 linked to self-harm, and on one of these occasions he asked to be formally detained in hospital under the Mental Health Act.

c. *Recognising sexuality as a fixed risk*

The practitioners meeting highlighted the fact that Riley's sexuality became a fixed interpersonal safeguarding risk from an early age, following the bullying incident at school and as his family struggled to accept his sexuality. His sexual identity, and the discrimination and harassment that he experienced because of it, appears to have been a source of emotional instability from his early teens, which continued into his late teens and early adulthood. There are numerous reports of homophobic physical aggression and verbal bullying at the temporary accommodation, to which Riley sometimes responded with aggression and violence himself. A practitioner who had seen Riley in the month leading up to his death also reported a 'hearsay' homophobic incident reported by another adult who knew Riley from the temporary accommodation, which is said to have taken place shortly before his death, but it has not been possible to substantiate this during the review process.

Children's social care colleagues also offered some reflection on previous practice when Riley was a child. There was a useful observation that the approach to family support at the time focused largely on ensuring that one parent was in a position to safely look after Riley, but overlooked the fact that Riley's relational difficulties and vulnerabilities could also be linked to his emerging sexual orientation.

The Practitioners meeting agreed that recognising sexuality as an inherent risk for some young people and adults, is a crucial piece of learning from this review.

d. *Trauma, self-harm and suicide risk*

As this report documents in detail, Riley had a history of childhood trauma and ongoing self-harm and suicidality into his adulthood, but this does not appear to have been fully known or understood by many of the services working with him. Although practitioners felt that progress has been made in Tameside towards more trauma-informed thinking, this is still considered to be inconsistent across services and there is further work needed to embed practice.

Mental health commissioners felt that the 'Storm' self-harm and suicide prevention approach was well embedded in Tameside and were clear that the consistent message given to practitioners over several years was that the hospital emergency department should not be the first port of call for someone experiencing suicidal thoughts. However, it was not evident in discussions with agencies or practitioners that the Storm training was widely known about or that a crisis response plan / safety plan was acknowledged as the primary approach to managing suicide risk. There would appear to be scope to reinforce best practice in self-harm and suicide prevention across relevant services in the borough.

Another apparently important factor in the support made available to Riley was the fact that whilst his poor mental health was widely acknowledged, it was agreed that he did not have a formal diagnosis of a mental health condition. This does seem to be the case on his initial return to Tameside but as he self-refers to his GP and has more contact with the surgery, there are later references made in his GP records to post-traumatic stress disorder (PTSD) and a mental health assessment relating to mixed anxiety and depression. It is not clear whether either of these would have been regarded as a *formal* mental health diagnosis in a homelessness assessment, or whether these views were shared, but it is possible that it could have positively affected Riley's eligibility for services, including housing and Adult Social Care.

It has been observed in the course of the SAR that diagnoses of conditions such as PTSD or anxiety and depression *should* be formally considered as part of the consideration of need in assessments, in the same way that a severe and enduring mental health condition would be for example.

The chronology for this case shows that Riley had contact with 4 different mental health services – the talking therapy service, the senior mental health practitioner(s) in the NMHT, the psychiatric professional at the GP and the mental health liaison worker(s). There is no indication that there was any direct consultation between these services/professionals, or indeed that they necessarily knew that other mental health professionals were or had been involved in Riley's case. This poses questions around how mental health support services in Tameside relate to one

another, what case records they share and how mental health support can be better co-ordinated to avoid duplication of effort and a more stream-lined offer for residents.

Although this is an accurate assessment of the position at the time of this review, services reported that a number of steps have since been taken to improve the co-ordination of low-level mental health provision in Tameside. This has included the use of regular multi-agency 'huddle' meetings in the NMHT to reduce duplication, enhance co-ordination of support to adults and tighten practices around information sharing. The drug and alcohol support service is also recruiting to new 'mental health navigator' posts to support clients to access mental health provision, in recognition that many individuals who require their support also need help to maintain and manage their mental health and wellbeing.

e. *Managing non-engagement*

One of the distinctive features of this SAR is the unusual pattern of self-referral and proactive help-seeking behaviour by Riley, coupled with repeated periods in which he wasn't able to engage with services. It has already been discussed that there were some legitimate reasons for Riley's lack of response, including changes of address or phone number and his feelings of anxiety sometimes being overwhelming. Equally, there is no doubt that this prevented services from supporting Riley to the best of their ability.

There are no easy solutions to working with adults who are not able to engage with the support on offer for reasons linked to their underlying emotional health and wellbeing, but non-engagement can also be linked to issues of trust/rapport with practitioners and services offering a traditional '9 to 5' model of support to adults who aren't used to managing fixed appointments. For example, the mental health practitioner at the GP practice said that it was Riley's habit to go to the surgery without an appointment and wherever possible this was responded to flexibly.

The reality for most services with long waiting lists and heavy case-loads is that non-engagement by the individual results in case closure and all services reported that they had a policy to govern decisions around this. One of the agencies that was at the front-line of working with Riley closed his case 3 times, based on their non-engagement criteria, presumably without being aware that this put Riley at risk of having no other agency support or involvement.

A number of services reported that they have/will review their approach to non-engagement and introduce more managerial oversight of case closures. However, what this case specifically highlights is that case closure decisions taken in isolation, which involve an adult with multiple vulnerabilities - especially when that person is a vulnerable young adult - may unwittingly leave the individual without any form of support and could lead to an escalation in their difficulties and increased marginalisation.

There is scope to consider a more nuanced approach to both non-engagement and case closure and how case closure is co-ordinated between agencies.

## 2.3 Multi-agency collaborative risk management

a. *Managing suspected sexual exploitation*

The case of this young man has emphasised the difficulty of judging the difference between:

- sex work as an adult's choice
- 'survival sex' which is defined as regular/irregular sex work 'traded' to meet basic human needs such as food or a bed for the night - but it may also include sex in exchange for money or drugs
- sexual exploitation of a vulnerable person by others

The practice meeting highlighted differences in views amongst professionals, with some practitioners feeling that although Riley experienced shame associated with previous sex work, it was a choice on his part and not exploitative, whilst other agencies saw his overall vulnerability and age, combined with his overnight stays in the shared temporary accommodation with much older adults, as legitimate reasons to see the situation through the lens of sexual exploitation or abuse.

Riley is documented as saying on numerous occasions that he felt sexually vulnerable at the temporary accommodation and the children's social care family support worker voiced concerns about sexual exploitation at case closure by ASC in September 2021. This concern is voiced again by a family friend who had been informally supporting him, who reported exploitation by older adults at the temporary accommodation in January 2022.

Taking this into consideration, the overall evidence from the review would suggest a strong likelihood that Riley was most likely a victim of sexual exploitation whilst staying at the temporary accommodation. Perhaps the most telling indication is that Riley reports using amphetamines to stay awake at night in the temporary accommodation, which practitioners confirmed was driven by a need to stay awake overnight to avoid the risk of unwanted sexual contact/abuse whilst he was asleep.

Although this is undoubtedly an issue which calls on professional judgement and careful weighing of the context, most agencies agreed that there was not adequate or active consideration that Riley could have been the victim of sexual exploitation. Given his overall vulnerability, it isn't clear why practitioners - even those who recognised it as a concern - didn't go on to raise the matter formally as a safeguarding concern or escalate the issue.

b. *Safeguarding practice*

Continuing from the previous point, it would seem that throughout the time period under investigation in this review, no safeguarding concerns were raised for investigation. This is despite possible sexual exploitation and discriminatory harassment being part of the records seen in the review process, both of which are formally part of the safeguarding framework.

Although poor information-sharing and lack of multi-agency co-ordination may have obscured practitioners knowledge and awareness of some of these incidents, they were clearly known to individual agencies at the time they were reported or disclosed by Riley.

There is some important learning here about the robustness of local practice around what agencies regard and report as a safeguarding concern. Although, some agencies have reported taking steps to tighten and reinforce internal safeguarding training, standards and audit processes to address some of the concerns arising from this review, the messages around discriminatory harassment/abuse and sexual exploitation would benefit from further reinforcement across all agencies.

It would also be useful to explore in all future agency safeguarding training the extent to which unconscious bias may affect professional judgement in relation to certain types of abuse. In the case of this young man, the review panel felt that there was a likelihood of unconscious gender or sexuality bias in relation to perceptions of his sexual behaviour and therefore his risk of sexual exploitation, alongside the stigma commonly associated with drug/alcohol dependency and the stereotyping of people who use drugs/alcohol as engaging in other risky behaviours in order to acquire substances.

One agency has already made progress towards embedding an understanding of unconscious bias in its safeguarding training and upskilling employees to recognise how it can affect professional judgement and practice. This insight should be extended to other agencies.

c. *Risk escalation*

As mentioned above, it has not been possible to find evidence of any concrete multi-agency discussions or planning around safeguarding or proactive risk management, despite most agencies recognising Riley's level of vulnerability at the time. This is a significant gap in practice, which indicates failings in risk management awareness and approaches at both individual agency and at a multi-agency level.

The review has found only limited evidence of internal organisational escalation being used to discuss Riley's case, and no explicit evidence of formal escalation between agencies. In fact, the personal reflection and learning of one of the practitioners who worked with Riley was that the case should have been escalated to

one of the statutory agencies, with an explicit request for them to co-ordinate the support to Riley.

In effect, this meant that three agencies – and 3 practitioners - were carrying the responsibility for and risks associated with supporting Riley, mostly in isolation from each other, for the majority of the time period covered by this review. These were the employment support worker in the NMHT, the key worker at the drug and alcohol service and the psychiatric practitioner at the GP surgery. It is notable that only one of these workers is a qualified mental health professional, but it seems likely that at the time, no other practitioners were actually aware of the mental health support being provided to Riley via his GP surgery.

One of the additional questions this narrative poses, for both individual agency and multi-agency practice, is the appropriateness of practitioners with no formal mental health training being placed at the forefront of working with adults with a previous and current history of trauma, anxiety and depression, self-harm and suicidality.

Unfortunately, the absence of any managed co-ordination of support across agencies, particularly during 2022 and the early part of 2023, led to duplication of effort and weak or a complete absence of highly relevant information-sharing about risk.

At the time of Riley's case, there was a local multi-agency risk protocol in place, but when asked about whether this should have been invoked to manage Riley's support, a number of agencies said that it hadn't been considered and the policy threshold was probably set too high. The weakness in this protocol have since been recognised and are now in the process of being addressed - the new approach will recognise tiered levels of risk and proportionate multi-agency intervention.

d. *The role of statutory agencies*

There are three significant observations around the role of statutory agencies involved in this case and the decision-making / recording underpinning their involvement.

- It is acknowledged that at the outset of this case, Riley's need for housing (as a young adult) would have been regarded as low-priority from a statutory homelessness point of view. However, his poor mental health appears to exacerbate significantly over the ensuing months and there are subsequent notes relating to PTSD and a diagnosis of mixed anxiety/depression on his health record. It is not clear if this information was known or considered in later contacts with the homelessness service.

  Although the service manager highlighted that the service was under significant pressure at the time and homelessness officers were carrying heavy caseloads, it is a learning point for the future that repeat homelessness assessment takes full

account of deterioration in health and wellbeing, new physical or mental health diagnoses and the individual's presenting risks.

- Riley self-referred to Adult Social Care (ASC) twice, but it would seem that on both occasions he was informally screened (via a contact assessment) but not assessed under the Care Act. The second occasion was only two weeks prior to his death and agency enquiries were made.

  The more significant referral is on the first occasion, where agency case notes report that it was the view of ASC that Riley was unlikely to meet Care Act criteria for support because he could meet all his physical needs. Along with the findings from ASC's own learning review, it is clear that there was an assumption that Riley did not have eligible needs, based on what appears to be a narrow and very traditional view of what constitutes care and support needs. There are also indications of a service-led mindset rather than a person-centred approach which considers the personal history, wellbeing and lived experiences of the individual adult, in line with the expectations of the Care Act.

  A number of managers and practitioners also observed that as a young adult Riley is not a typical user of ASC and this, along with his self-referral and presentation as an articulate, self-aware young man may unfortunately have led to pre-judgement of his need for support and a lack of professional curiosity.

- The local mental health trust was involved in working with Riley both in the context of the mental health liaison team (MHLT) and it's mental health practitioners are also part of the NMHT. Clear case records were supplied to the review in relation to significant events where the MHLT saw Riley in the emergency department for instance.

  However, it is unclear from the mental health trust's own records, what the role of the mental health practitioner was when working with the Riley in the context of the NMHT e.g. there appear to be no independent records of their clinical assessment of Riley or a risk assessment held on their case recording system. The limited notes seem to link to the work of other teams or basic information about sharing crisis information and a helpline number with Riley.

  It would seem that the NMHT policy/approach to case recording should be revisited to ensure that all professionals involved in working with an individual record key information about their separate contacts with adults. It is acknowledged that the different agencies involved in the NMHT keep their case records on separate systems, so there is no electronic single case record, but there should be an understanding that all practitioners and agencies share equal responsibility for keeping adequate records about their contact with adults.