Safeguarding Adults Review – Barry

safeguarding adults at risk
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1 Introduction

1.1 Barry died on 23rd May 2019. By taking an overdose of medication, he killed himself in his car which was parked in the car park outside Upper Eden Medical Practice in Kirkby Stephen, Cumbria. Boxes containing prescribed medication and empty blister packs were next to him. A suicide note was left in the car.

1.2 Barry moved to Cumbria at an unknown date in the late spring of 2018. His last address was in Kirkby Stephen. He had previously lived at Garrigill, near Alston, Wetwang in East Yorkshire, the Isle of Bute, Dumfries, Swaledale in North Yorkshire and Brierfield in Lancashire. It appears he left his address in Brierfield in February 2014 because this is when he let his house out to tenants. August 2014, Barry returned to his house in Brierfield to find it damaged having recently been used as a suspected cannabis farm. A close friend has suggested that this discovery was a trigger for Barry's mental health to deteriorate. Barry stated to professionals that the death of his mother in 2008 had a negative effect on his mental health. Barry never lived in Lancashire again and moved repeatedly after this event.

1.3 Barry was a lonely man with very few friends and family members. He suffered with depression. He sponsored a child in Ghana. Between November 2018 and May 2019, Barry accessed numerous different services in Cumbria on a regular basis.

1.4 Cumbria Safeguarding Adults Board (CSAB) undertook safeguarding adults review (SAR) because there were concerns about how effective the services were and how effectively agencies worked together for Barry.

1.5 Dan St Quintin, Detective Chief Inspector, Public Protection and Partnerships, Cumbria Constabulary chaired the panel established by CSAB. Membership of the panel is shown at Appendix A. Dan was also appointed as lead reviewer for the SAR. He has had no involvement with Barry and has acted independently and impartially.

1.6 An inquest into Barry's death has been opened and adjourned by the Coroner for Cumbria and this SAR report could be used by the Coroner to inform the inquest.

1.7 Cumbria Safeguarding Adults Board expresses sincere condolences to the family and friends of Barry.

2. Terms of Reference

2.1 The timeframe of the review is from early November 2018 up until his death in May 2019. Early November 2018 is when Barry's accessing of health and social care services in Cumbria increased significantly. Frequently, he moved around the country to live, so a small amount of information is included in this report from other places as either significant events in Barry's life or background information.

2.2 The key lines of enquiry for the review were:

Effectiveness:
i) How effective were services in identifying Barry's needs?
ii)Were Barry's needs effectively assessed and responded to?
iii) What interventions took place and were they effective?

Working Together:
iv) The level at which services worked together and were co-ordinated?
v) To what extent was the referral system effective in dealing with Barry's needs – especially the links between adult social care and mental health providers?

Person Centred:
vi) To what extent was Barry's voice heard, captured and acted upon?

Locality:
vii) The extent to which Barry's rural location affected the services he received.

3. Glossary

ALIS

The Access and Liaison Integration Service (ALIS) was previously known as the Crisis Team. At the time of Barry's death, ALIS services were provided by the Cumbria Partnership Foundation Trust (CPFT). Mental health services were transferred to Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) from October 1 2019. ALIS provides assessment and support for adults experiencing acute mental health distress and their carers. The team, made up of different health professionals, can support people at acute hospitals, in their own home, at GP surgeries and police stations. The assessments include Mental Health Assessments and Mental Health Act Assessments. ALIS provide the initial contact assessment details and will liaise with other professionals. They deal with urgent cases for short periods of time before referring cases to other teams or signposting people to third sector organisations like Age UK and Samaritans for support. The teams that ALIS refer people to are Community Psychiatric Nurses (CPNs), Community Mental Health assessment and Recovery Teams (CMHART), First Step, adult mental health social worker, Adult Social Care and Health and Wellbeing Coaches (HAWC). GPs can also make referrals to these teams. If a referral does not fit a team's criteria, then the GP will be notified of this. The Single Point of Access (SPA) service (see below) should capture all of these referrals.

After assessment, ALIS may then pass someone onto a Home Treatment Team. The ALIS service is at the front end of the process and looks at cases to be moved onto other teams within 24hrs. This team have weekly interface meetings with Community Mental Health Teams. ALIS contact social workers if they are aware that someone is open to a social worker.

‘Severe and Enduring’

This phrase is used to describe the criteria for continued ALIS and Community Mental Health Assessment and Recovery Team (CMHART) involvement. Severe and enduring mental health illnesses are those of both psychosis and non-psychosis that have a severe and enduring impact on the person. These are often described as “functional impairment which substantially interfered with one or more major life activities”. An example of these include schizophrenia, bi-polar, severe recurrent clinical depression and severe recurrent anxiety.

SBAR

Situation Background Assessment and Recommendations (SBAR) is a way of making structured notes usually used by Consultants or people who need to find and record specific information. Practitioners use this tool when conducting telephone triage calls to help formulate a plan.

Care Act Assessment

A Care Act Assessment is conducted under s.18 of the Care Act (2015) to assess the eligibility of a person for care needs. The needs assessment is the first step of the process. For this to happen the person involved has to consent to it. It can be done without the consent of the person if they are not able to give it or it is in their best interests. Usually the process starts with the local authority contacting the SPA line to activate a ‘start of’ assessment (see Single Point of Access section below). When appropriate this activates the Care Act process and a multi-disciplinary discussion (MDD) takes place. This is a professional discussion about a case.

The discussion will look at:

- The emotional and social side of the person’s life.
- Their skills and abilities.
- Their views, religious and cultural background and support network.
- Any physical difficulties the person may experience or any risks of harm they have.
- Their health or housing requirements.
- Their needs and wishes.
- It takes into account what the person would like to happen and
- Any information from carers or others.

An outcome could be that no further action is taken. Other outcomes could be that further actions are set or the team proceed to a full Care Act Assessment. If it is decided that a full Care Act Assessment is needed the needs of the person are identified and there is a support planning phase to ensure the needs of the person are met.

Circle of Support and Shared Agreement Tools

These are tools used by Health and Wellbeing Coaches (HAWC) to identify the support needs of the people they are working with. The HAWC adopt a ‘shared agreement tool’ that allows the person and their HAWC to consider what would improve their quality of life. The Circle of Support is a tool used to capture a summary of the person’s family, friends, community and professionals who are part of their life at present and what they would like it to be.

Community Psychiatric Nurse (CPN)

A CPN is a mental health nurse that works as part of the Community Mental Health Team.

Community Mental Health Assessment and Recovery Team (CMHART)

Community Mental Health Assessment and Recovery Teams (CMHART) support people in the community who have severe and enduring mental health conditions, which can include depression that is difficult to treat, personality disorders, people with dual diagnostics. For example people with mental health issues who also have a learning disability. The team is made up of mental health nurses, social workers, doctors, occupational therapists and psychologists.

First Step

At the time of Barry's death, First Step services were provided by the Cumbria Partnership Foundation Trust (CPFT). CPFT no longer exists following a restructure in October 2019. First Step (Improving Access to Psychological Services or IAPT) offer services for people experiencing anxiety and/or depression at a mild to moderate level of severity. This service offers evidence based talking therapies including Cognitive Behavioural Therapy (CBT). First Step will always offer telephone assessment initially to assess whether the person is appropriate for their services. Primary care services provide treatment for mild/moderate depression and anxiety in terms of sign posting to counselling services and self-help options. Prescriptions for antidepressant medication may be made by general practitioners, when this is deemed necessary.

First Step in North Cumbria provides free, talking therapies to adults. First Step can help with a range of common mental health problems including mild to moderate depression, anxiety disorders such as chronic worry, panic attacks, health anxiety and obsessions. First Step practitioners listen to experiences and work with patients to understand how they are feeling. With the patient, they will decide what sort of help might be the most effective.

Generalised Anxiety Disorder Tool (GAD)

The GAD tool is a seven-item process that is used to measure or assess the severity of generalised anxiety disorder. Each item asks the individual to rate the severity of his or her symptoms over the past two weeks. Response options include "not at all", "several days", "more than half the days" and "nearly every day". The GAD score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively, and then adding together the scores for the seven questions. GAD total score for the seven items ranges from 0 to 21. Scores of 5, 10, and 15 represent cut-points for mild, moderate, and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

GRIST and RIO

The Galatean Risk Screening Tool or GRIST provides a live evidence based, structured and systematic approach to risk assessment for assessing the risks of suicide, self harm, harm to others, self neglect and vulnerability. It is based on a consensual and holistic model of risk. Practitioners are also able to use their own knowledge and are able to look back at any previous risk assessments to enable a historical view. Structured clinical judgments are when clinicians formulate risk assessments using their own expertise and experiences. Actuarial approaches are risk assessments based on statistical analysis of population data. GRIST is the most widely used risk assessment within Community Mental Health Teams.
RIO is the system these assessments are recorded on and are used by the ALIS and First Step.

Health and Wellbeing Coach (HAWC)

HAWCs are a team of staff covering the county who are all trained to offer support and guidance through coaching. They work with anyone over the age of sixteen who wants to make positive change to their lives. Most people that HAWCs work with have faced a period of crisis or have multiple issues that they need to understand and work through. The overall purpose is to improve health and wellbeing through encouragement for the recipient to take their own action to become more independent and resilient.

Compass UK, Samaritans and Lighthouse

Compass and Age UK at the time were third sector agencies that provided ongoing support for individuals to access advice around benefits. They offered support to attend drop in groups and become more sociable. Barry often stated he was lonely and they would have supported him to access activities etc. Compass was set up in Cumbria but decommissioned after a short period.

Samaritans are a telephone service that listen to people and offer basic advice/ reassurance. The Lighthouse project is a calm, safe and comfortable place for people in Carlisle and Eden to visit when they are experiencing crisis, feeling unsafe or finding it hard to cope. They are open 6pm to 11pm, every night of the year, when most other services are closed. They also provide telephone support.

Making Safeguarding Personal

This is a sector-led programme of change, which seeks to put the person being safeguarded at the centre of decision making. It involves having conversations with people about how agencies might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. It envisages a shift from a process supported by conversations to a series of conversations supported by a process.

Multi-Disciplinary Decision (MDD)

Cumbria County Council use this term to refer to the decision making process when a referral is received. It is a practice that takes place between the Single Point of Access (SPA) Officer and the duty team (Social Worker, HAWC, Re-enablement team and sometimes includes Team Managers). SPA teams (see below) are reliant on MDDs to provide guidance where cases are ineligible for services.

Multi-Disciplinary Team (MDT)

An MDT is the term used for a variety of different meetings where different teams from related services or multi-agency partners meet to discuss a case. An MDT might be a ward round, a general case discussion or a complex case discussion. An MDT can be used to discuss and deal with a general issue or a case relating to a specific person. Agencies cannot be compelled to attend MDTs. An MDT has multi-disciplinary rather than multi-agency representation.

Mental Health Assessment

The purpose of an assessment is to build up an accurate picture of a person's needs and an assessment may involve more than one professional. During Mental Health Assessment certain points are considered including mental health symptoms and experiences, the person's feelings, thoughts and actions, physical health, housing and financial circumstances, employment and training needs, social and family relationships and past experiences.

Section 42 Care Act 2014 Enquiry by local authority

Section 42 of the Care Act (2014) applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- Has needs for care and support (whether or not the authority is meeting any of those needs),
- Is experiencing, or is at risk of, abuse or neglect, and
- As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The local authority must make whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

Single Point of Access (SPA) service

There are two different SPA services in Cumbria. There is a limited SPA service for mental health services and this acts as a call handling and triage facility.
There is also a larger Adult Social Care SPA team which is a multi-disciplinary team that includes SPA Officers. It also has practitioners from the generic team and Learning Disability and Mental Health teams. HAWCs are also part of the SPA team. Information that comes in via SPA is inputted directly to the Adult Social Care system. For new cases it is expected that the SPA Officer dealing with the case would complete a 'Start Of' assessment, which is a triage process. The SPA Officer should collect robust information about the person and their needs, which supports decision making.

The SPA Officer would hold a Multi-Disciplinary Discussion (MDD) to triage the case and record the rationale for the decision. Once a person has an allocated worker, any further contacts received, would be recorded on a contact form and would be linked to the main referral. These additional contacts are notified to the worker. The exception to this would be when a further contact was for something non-related to the open case. This could be Occupational Therapy or if an allocated worker was absent. In these circumstances, the case should then be passed to the duty team to advise and respond.

Unless stated otherwise, the SPA service referred to in this report is the Adult Social Care SPA service.

The Silver Line

The Silver Line is a free, 24 hour confidential helpline for older people. It is an online befriending service.

4. Synopsis

4.1 When he died in 2019, Barry was 70 years old. His parents ran a Post Office in rural Lancashire, where Barry grew up. He had various jobs and had a passion for motorbikes and travelling. He had an older sister and two brothers. In the last five years of his life, Barry lived in Lancashire, different parts of North Yorkshire, Dumfries, the Isle of Bute, East Yorkshire, Cumbria, East Yorkshire and Cumbria again. He did not settle anywhere for more than a few months. A close friend described Barry as being set in his own ways, having 'wanderlust', having eccentric ideas that sometimes did not match the views of others and he tended to take over social situations. This is supported by police information showing that Barry started to organise a Facebook group that were going to carry out a protest at Prince Harry and Meghan Markle's wedding in May 2018. Before moving away from Lancashire, Barry lived in a house he owned in Brierfield for over ten years. It is believed that he sponsored a girl in Ghana, but no further details of her have been found.

4.2 In his later years, Barry told friends and professionals that he suffered from Chronic Obstructive Pulmonary Disorder (COPD). This was diagnosed in September 2018. He told others that he had arthritis. However, there is no mention of any diagnosis for this. In August 2018, Barry was diagnosed with peripheral neuropathy, which is a condition that causes chronic pain, especially in feet and sometimes in hands. In 2014, he informed Lancashire Constabulary that he only had one working lung. A close friend described Barry as having difficulty in walking and he had a mobility car at one stage. He had been diagnosed with mild sleep apnoea and had a breathing machine to help him sleep. In 2008, his medical records state he was treated for anxiety and depression for the first time. In 2006, his medical records state he took an overdose of pills and alcohol.

4.3 In July 2018, Barry was assessed by the Community Mental Assessment and Recovery Health Team (CMHART) as being low risk of suicide in a GRIST risk assessment and was deemed not to meet the criteria for CMHART. No rationale was provided for this decision. Even though there is no rationale for this decision, Barry did not have a severe and enduring mental health illness. He was informed of this decision the following day he was told that he did not have a severe and enduring mental illness, so he was referred to Compass.

4.4 In Autumn 2018, Barry was living at Garrigill near to Alston in Cumbria. On 06/11/18, he told his GP that he felt isolated where he lived. Two days later, Barry had a double length appointment at the GP surgery to discuss his mental health. He had been working with a psychotherapist. He denied feeling suicidal and said he was bored.

4.5 On 15/11/18, Barry self-referred to First Step. He stated he was depressed, anxious and having panic attacks that were affecting his motivation to socialise, get dressed, eat and clean his home. A telephone triage assessment was conducted using the GAD anxiety scale which gave a score of 12 which suggested moderate anxiety. It was decided by First Step that Barry did not meet their criteria. On 22/11/18, First Step deemed that Barry's needs were social issues especially around isolation. First Step referred Barry onwards to Age UK and he was encouraged to engage with a HAWC. He was working with a psychotherapist arranged by the GP and had an imminent HAWC appointment. When this decision by First Step was explained, it appears that Barry responded by stating he wanted someone to come and visit him every day. First Step explained that this is not a service they provided and that they provided structured and goal focussed therapy, which they were not offering to Barry. It was recorded that because Barry was already receiving therapy through his GP, he did not need First Step involvement as well. When Barry heard this decision, records state that he said he was 'better off dead' and hung up the phone. A GRIST Risk Assessment was conducted which deemed Barry to be at low risk of suicide and other answers to other areas like self harm, self neglect, harm to others, self harm and vulnerability were recorded as 'don't know'. The HAWC completed an assessment on the 23/11/18 and the GAD score was 13. This would suggest his anxiety was moderately severe. Barry's level of depression through the PHQ-9 depression scale and his was self-assessed at 24 - severe.

4.6 On 23/11/18, at a GP appointment, Barry reported that his anxiety had increased, he also felt frightened and a voice was telling him to kill himself. His anti-depression medication was increased. On 24/11/18, Barry contacted NWAS to report chest pain and he was referred to CHOC. He attended a CHOC base and during an extended appointment said he felt sad and lonely. CHOC advised him to contact his GP after he was assessed. A lower amount of antidepressant was prescribed aiming to reduce anxiety levels and a low dose of anti-anxiety medication was prescribed, but the details of dosage were not passed onto GP.

4.7 On 27/11/18, Barry attended A&E at CIC with headaches, anxiety and suicidal thoughts. This was via a SPA referral. Records state he said he had thought about killing himself in the past and had been a victim of anti-social behaviour. Lancashire Constabulary records support this showing police attended reports that youths were targeting him at home, where he lived on his own in April 2013 and February 2014. He also attended his GP the same day for a review of his depression and physical health.

4.8 On 29/11/18 he was brought into CIC by ambulance after reporting severe headaches. His GP arranged for the ambulance. He was discharged the same day. He did report he was suicidal to A&E staff and was referred to ALIS who spoke to him that day over the phone. No role for ALIS was identified. Barry stated he was feeling better and would speak to his GP.

4.9 On 30/11/18, Barry attended a GP appointment to discuss potential thyroid issues and was referred to Endocrine for specialist thyroid assessment.

4.10 The next day, 01/12/18, Barry contacted the SPA line reporting feeling anxious. SPA reassured him, which was received positively and he was referred back to his GP. No role for ALIS was identified. On 02/12/18, he contacted the SPA line in an 'extremely anxious' state. ALIS contacted the GP due to the increase in presentation and ALIS made a referral to CMHART. It was decided that an MDT would be convened to determine if a face to face assessment was required. Barry also contacted CHOC that day for advice on his anti-depressant medication. The dose was reduced.

4.11 On 03/12/18, the MDT discussion took place. The decision was that ALIS would contact Barry's GP requesting they refer him to the Community Mental Health Team. The GP told ALIS that Barry had been seen that day, he stated he felt isolated, suicidal and unable to cope. He told the GP that he had medication and red wine at home and he was thinking about killing himself. He was brought to the GP surgery that day by a member of the Alston Mental Health Facebook group. It was noted that he was functioning well. Based on previous information the GP stated to ALIS that they did believe he was high risk of suicide. GP records state that after a while Barry told them that he felt well supported by the GP practice. The GP encouraged Barry to get himself involved in social groups.

4.12 On 04/12/18, Barry had a face-to-face meeting with ALIS to discuss the anxiety he had around his medication. Advice from the ALIS was given to him and by having the face-to-face meeting. This appeared to reduce his anxiety levels. Also, on the same day, a HAWC made their first home visit to Barry at Garrigill near Alston, where records stated he was feeling lonely this visit lasted two hours. He joined Alston library and was shown public notices about social events. A referral to The Silver Line was submitted. On 06/12/18, he attended his GP requesting more medication and this request was declined.

4.13 On 12/12/18, at his next HAWC appointment, Barry stated he often considered suicide and had methadone from a previous prescription. A close friend who had known Barry for over 50 years stated that he never touched heroin, but he did use cannabis regularly and took LSD occasionally when much younger. He was advised by the HAWC to hand the methadone into a pharmacy. He also made comments to his GP that whilst still feeling anxious, he was not suicidal and started talking about moving to Yorkshire or Kirkby Stephen. A few days later he said to his HAWC that he had found somewhere to rent in East Yorkshire. On New Years' Eve, he told his GP

that he was moving to East Yorkshire on 24/01/19. He was prescribed anti-psychotic medication to compliment a beta-blocker and an anti-depressant.

4.14 In a letter from ALIS to his GP, Barry told the ALIS team that when he is with friends, his headaches and anxiety cease, but they return when he goes home and is alone. ALIS saw him in A&E on New Year's Day reporting having headaches but no suicidal thoughts. Barry was reported to have been 'dismissive' of all the previous services he had received, but he did tell ALIS that he was being supported in the community. Earlier that day he requested an ambulance that took him to the CHOC base. He was referred to A&E by CHOC. Barry had reported to CHOC that he wanted to end it all, was feeling sad and had a tight chest. When told that he was being discharged and not staying overnight, Barry was very disappointed stating he hoped that he could stay overnight so that he would be looked after. He was given the number for Samaritans. Mental Health services conducted another GRIST Risk Assessment with Barry on 01/02/19. This assessed Barry as being at low risk of suicide. It also deemed him to be low risk of vulnerability, no self harm risk and no risk to others.

4.15 Later in January 2019, both the GP and HAWC recorded that they have seen Barry and he was feeling very positive about his move to East Yorkshire and presented as having a much brighter outlook.

4.16 At the end of January 2019, Barry moved to Wetwang , near Driffield in East Yorkshire. On 25/01/19, he saw the GP in Wetwang.

4.17 On 11/2/19 he contacted East Riding of Yorkshire Adult Social Care by phone. Barry stated he had made a mistake moving from Cumbria and felt very suicidal. His GP increased his medication but he still felt unhappy and was struggling to meet new people because of his anxiety. Barry also reported that he could not afford to live in his rented accommodation and could not cope with moving back to Cumbria. He stated he could not go out and do any shopping and did not feel like he can eat at all. He asked what services were available to him. Adult Social Care wrote to Barry and made repeated attempts to contact him by phone. They succeeded in speaking to him on 05/03/19 and Barry stated he did not require assistance with daily living activities and felt lonely and isolated. A referral was made to 'Health Trainers'.

4.18 In April 2019, Barry moved to Kirkby Stephen in Cumbria where he rented a flat. On 01/04/19, he attended his first appointment at Upper Eden Medical Practice in Kirkby Stephen. He was tearful, had pressure in his head and said he would be better off dead. He denied having any active plans to kill himself. Barry informed the GP that he tried to kill himself in 2008. It was clear to the GP that Barry wanted help. It was decided that he did not need a mental health input but would benefit from counselling. The GP made a referral to First Step. After an assessment on 04/04/19, this referral was declined by First Step who deemed Barry's issues to be social rather than mental health related and a referral was made to HAWC. Blood tests were taken to exclude any physiological issue.

4.19 Also on 01/04/19, First Step assessed the referral from the GP above. Barry's case was allocated to a High Intensity Worker for assessment due to Barry's 'complex history with other mental health services'. The outcome of this assessment was that Barry was offered a First Step assessment on 04/04/19 mentioned above.

4.20 On 03/04/19, the GP reviewed Barry. He had no more thoughts of ending his life, but stated he wished he was not alive because of worry and aggravation in his head. Barry was diagnosed with pre diabetes. Barry stated he did not feel like eating and would work on his diet. The GP thought working with a HAWC would be beneficial. Barry was open to First Step for an assessment so the practice psychotherapist could not see him.

4.21 On 04/04/19, HAWC services received a phone call from First Step, stating Barry wanted to re-engage with a HAWC. First Step had completed a telephone assessment. Barry said his problems started in 2008 when his mother died. He reported to First Step being lonely, depressed and lacking in motivation. First Step deemed that the appropriate way to deal with Barry's needs would be a referral to HAWC. They discussed the case with Adult Social Care who suggested the HAWC referral. A GRIST Risk Assessment was completed by First Step and it graded Barry as low risk of suicide and self harm.

4.22 On 09/04/19, Barry attended his GP and saw a different GP who did a brief mental health assessment and suicide risk assessment. These assessments happened most times Barry saw a GP. Barry's medication was reviewed and advice was given to him. Barry told the GP he had taken 'lots of party drugs back in the day', which was confirmed by his close friend who said he took cannabis regularly and sometimes had LSD when younger. The GP noted that Barry had had long-term involvement in services without very much improvement in his mental health. At this time, the GP noted chronic problems of low mood and severe anxiety, fleeting thoughts of suicide, even when out with friends. The GP referred him to psychiatry after First Step had declined him.

4.23 On 10/04/19, Barry had an assessment with First Step which identified his issues were around social isolation and housing. First Step referred him to Adult Social Care.

4.24 On 17/04/19, the GP had been reviewing Barry's medication with a consultant and saw him that day. The GP noted that First Step had declined Barry and referred him to a HAWC. Barry presented as frustrated because he believed that services were putting his issues down to loneliness and no one was listening to him. He told his GP he had been thinking about suicide again and wished he was not alive to stop the feelings in his head. He told the GP that he used cannabis, amphetamine and LSD from 1960-1972 and that he continued to use cannabis until 2010. The GP stated he was seeing his HAWC the following day and they were awaiting the psychiatry review. The GP believed Barry needed psychological therapies.

4.25 On 18/04/19, HAWC had a phone call with Barry. He was assessed as making good progress with getting involved in the community. No further referrals were deemed necessary. He saw his GP on 23/04/19 for a review of his medication and again on 29/04/19.

4.26 On 28/04/19, Barry contacted CHOC and then 111. He presented as being very anxious about whether the dosage of medication was appropriate. He spoke to ALIS who conducted a thorough assessment of his mental state. He did say that he regularly thought that life was not worth living but he would not kill himself because he had not thought about how he would do it. ALIS sent a letter to his GP to update them with this assessment and concluded there was no further role for ALIS to have.

4.27 On 01/05/19, Barry had a phone assessment with First Step screening team. It is unknown what triggered this assessment. No role for Community Mental Health Team was identified because Barry was deemed not to meet the criteria for their services although the rationale for this decision is not recorded. It was deemed that Barry's issues were social and First Step left a message with a HAWC. CMHART records state that Adult Social Care responded saying that HAWC involvement with Barry had now finished because he was able to meet his own needs and had used Samaritans and the SPA line to meet previous needs.

4.28 On 02/05/19, Barry attended his GP surgery feeling suicidal and wanting to be admitted to hospital. He stated he had thoughts of taking all his tablets but would do it at night time so no-one would find him. He stated he felt isolated and a burden on friends. The GP referred him to ALIS and gave him a prescription for anti-anxiety medication. ALIS spoke to Barry over the phone later that day. An SBAR assessment was carried out and Barry stated his chosen means of killing himself would be

overdose but he had no intention of carrying it out. Records show he stated to ALIS that he used the threat of killing himself as a way of expressing his emotions. Barry was clear to the practitioner that he did not want to die. He agreed to being contacted by phone by Lighthouse. In the evening of the same day, ALIS saw Barry to discuss other support services and arrangements. During this conversation, he told the practitioner that they were the reason 'people jumped off bridges' because he was begging to be admitted to a physical or mental health ward and this was being refused. A full triage assessment was conducted that day by ALIS, which did not identify the need for admission at that time. The ALIS practitioner recorded that they did not believe that Barry was in crisis and his needs were arising out of social isolation. Barry told him that he wanted to be 'cared for and looked after' but could not explain why. Each time the phone call drew to a close, Barry became tearful because he did not want to be alone. He stated he was going to see his GP in the morning.

4.29 On 03/05/19, Barry attended his GP surgery and is recorded as saying he felt that ALIS did not want to know and he was a burden on his friends. He was having thoughts of taking an overdose but understood the impact this would have on his friends. Support networks were discussed. GP records suggest Barry was a very regular walk-in patient who did not have an appointment and was seen by a GP when he attended. The GP had identified the frequency of the spontaneous presentations had increased recently. At this time the GP was still awaiting an Endocrine update regarding Barry's thyroid. GP records state that Barry was advised to contact the surgery if he formed any intentions to kill himself.

4.30 On 7/05/19 the GP had a 'frank chat' with Barry about his situation and signposted him to support services. The GP assessed that he was a continued risk for spontaneous suicide but he had no plans to carry this out. Records show Barry said he knew that things would improve. Barry said he was struggling day to day. The GP had not had the update from ALIS regarding their assessment on 03/05/19. The GP and Barry made a plan to improve his isolation.

4.31 On 08/05/19, the GP was made aware that First Step & CMHART had declined referrals for Barry. First Step stated to the GP that Barry was lonely. Barry attended the GP surgery unannounced. He was in a state of panic, was sweating and stated he was going to cry when he left. He had been in a restaurant and felt he had to leave. Barry said his anxiety was stopping him from functioning. He was worried about his thyroid. He confirmed he was taking his medication and the GP contacted CMHART requesting they re-consider and see him.

4.32 On 09/05/19, Barry walked into the GP surgery again and was seen. He was in a low mood and was described by the GP as 'desperate'. He stated to the GP that he was thinking about taking an overdose and had pills laid out at home ready but cannot say what they are. He is deemed not to be actively suicidal just very lonely. It appeared to the GP that Barry was exaggerating his crying at one stage. The GP signposted Barry to Samaritans and a community group. They also gave advice to contact A&E and/or ALIS if he became suicidal.

4.33 On 10/05/19, Barry contacted the suicide prevention line stating he was going to end his life. They then contacted Cumbria Police who in turn contacted ALIS for more information. Police then contacted Barry by phone to check on his welfare. He confirmed to police that he did make the call and that he was okay.

4.34 On 13/05/19, Barry was seen again by his GP. Barry appeared very positive and upbeat. The GP was optimistic that the medication would stabilise him and the GP could then increase the medication for anxiety. Barry was keen to leave to volunteer in a shop. Usually he did not like to leave because he hated being on his own. He was given further medication and would be reviewed the following week.

4.35 On 14/05/19, Barry walked into the GP surgery and stopped a GP in a corridor. He requested to be placed in sheltered housing. The GP gave him the contact number for Adult Social Care and told him to make some enquiries. The same day, Barry contacted the SPA line requesting a Care Act Assessment. He stated he was unable to manage daily living tasks. A 'Start Of' Assessment was completed but this record appears to have been sent to the HAWC rather than an adult social worker to progress. Their record states that Barry told the adult social worker that he had a diagnosis of severe depression and anxiety and was awaiting a CPN to be allocated to him. Barry also said he had COPD and a lump on his thyroid. He is also recorded as saying he often felt suicidal and is unable to manage daily living tasks. This call was discussed with the duty worker in the Mental Health East team and it was accepted to be allocated to a practitioner. Barry was not contacted by the duty social worker. The case was allocated to the HAWC who had previously worked with Barry.

4.36 Also on 15/05/19, Barry walked into the GP surgery. He was crying and he was worried he might not get sheltered accommodation. The GP believed Barry had become fixated on this and also that his thyroid was possibly causing him problems with his mood. GP reassured Barry and pointed out that the thyroid issue might be a slight issue, it was his mental health that needed to be prioritised. The GP recorded that Barry always seemed to be reassured and calmed down a lot after seeing a GP, which is again what happened. He stopped crying and left talking about positive plans and talking about the future. As a result of Barry's positivity the GP assessed that the risk of suicide was low at that point.

4.37 Also on 15/05/19, the Adult Social Care referral regarding the Care Act Assessment was placed in the Mental Health East duty tray.

4.38 On 15/05/19 and on 16/05/19 the HAWC spoke to two different mental health social workers to update them with Barry's situation, his loneliness and social isolation. The Adult Social Care case was re-allocated to the HAWC, by the duty social worker stating the HAWC could request a Care Act Assessment and no further action was taken by Adult Social Care. On 16/05/19, the HAWC rang Barry. He spoke of hopelessness, not being able to manage his depression and he was crying a lot. He did say he had visited some sheltered housing in Appleby and had been advised that there was a bungalow available and care staff on duty 24 hours a day. The HAWC asked Barry to think about what he would like to achieve by working with the HAWC and advised him that they would ring him back the following week. The HAWC then left a voicemail for the duty social worker. It does not appear that the HAWC and social worker spoke, they exchanged voicemails. The requested Care Act Assessment did not happen.

4.39 On 16/05/19, GP practice staff took Barry to supervision following repeated treatments not working. It is common practice for GP practices to hold weekly team meetings where they can discuss issues including complex cases. GPs will also support each other as needed outside of meetings if necessary.

4.40 On 20/05/19, Barry walked into the GP surgery stating his friends are getting fed up with him and he feels like a burden to them. He was assessed as having suicidal thoughts, having stated that he 'may as well not be here'; he was at his wits end and that he will take his tablets and end it all. He also stated he was frightened of himself and did not want to kill himself. He was very emotional and took a long time to calm down. Barry stated he wanted to be in hospital and the GP discussed alternatives. He said that HAWC, First Step and ALIS had declined him. He did not want a referral to Adult Social Care. He turned down Lighthouse as he was unable to drive to Carlisle. He stated he felt like everyone just wants him to go away. In which case he may as well end it all. He agreed to do a face to face assessment with ALIS at Carleton Clinic who agreed to send a taxi to get him there. Barry was kept at the surgery until the taxi arrived. The GP who had had previous experience of conducting suicide risk assessments, recorded that on previous occasions he had seen Barry, they were not too concerned with Barry talking about suicide, because there was always mention of some future intentions and there were protective factors around

him. However, the GP stated that when they saw Barry on 15/05/19, there was no talk about future intentions, there were no protective factors and Barry now had a firm suicide plan. The GP's level of concern had risen significantly hence their referral to ALIS for the same day. After Barry was told of the ALIS appointment, he seemed very reassured and asked if he could go and pay his electric bill whilst he waited for the taxi so he did not get cut off if he was admitted. The GP still wanted ALIS to assess him because the GP felt Barry was very high risk when he first presented.

4.41 On 20/05/19, ALIS assessed Barry at the Carleton Clinic. He was offered the Home Treatment Pathway in light of his suicidal thoughts. Barry, who had capacity, declined this and stated he thought the option of Adult Social Care involvement was more appropriate because of the social isolation and loneliness he had. ALIS agreed with him. Barry was adamant he was not ill. ALIS agreed to assist with a referral to ASC to assist with the sheltered accommodation application. Barry came back to the GP surgery after the appointment and was seen. He stated to GP that he had been rejected by the ALIS again. The GP assessed him as seeming much happier and low risk of suicide.

4.42 Also on 20/05/19, ALIS recorded that they spoke to Barry and conducted another GRIST Risk Assessment. During this, Barry stated he had packed a bag with clothes and a bottle of wine and pills. Barry had a bag with him and was smartly dressed. He was described as incongruent in this assessment. He said he had the plan of parking his car near a friend's house and killing himself by taking the pills and gently falling asleep and would not wake up. ALIS recorded that Barry then came to the understanding that this approach may not be successful. It is not clear how he came to this understanding. Barry stated to ALIS that he has overwhelming thoughts of suicide in the morning that fade during the mornings. He said that he had thought about suicide since December 2018. Barry stated that he would undertake a suicide attempt to ALIS but went on to describe future plans and engagement like logging an application for sheltered housing and going on holiday with a friend. This GRIST Risk Assessment states that Barry was at no risk of self-harm and vulnerability was low risk. There is no mention of suicide in the concluding assessment and no risk assessment for suicide is recorded.

4.43 On 21/05/19, Barry returned to the GP surgery where he was seen. He stated to the GP that he felt like killing himself that evening with wine and pills. Barry also stated to the GP that he had a lot of anxiety, a headache, sore throat and a cough. He stated his head keeps telling him to kill himself. The HAWC rang him whilst he was there. The GP referred Barry to ALIS as he was deemed to be high risk and had plans to kill himself which was not what he usually said to the GP. The GP contacted ALIS, who after explanation of the situation by the GP, agreed to ring Barry. The GP updated Barry that ALIS would ring him. The ALIS team rang Barry who stated he was not going to commit suicide, that his GP was not listening to him and he was settled for the night. The allocated ALIS worker made contact with Barry on 21/5/19 and again on 22/5/19. Also on 21/05/19, the CMHART requested a Care Act Assessment. This was linked to the open referral with the HAWC and CMHART were advised that the HAWC were looking into this.

4.44 On 22/05/19, the CMHART team contacted the GP surgery to discuss the case. The GP explained their frustration with the situation. The practitioner stated that Barry was not serious enough for their mental health services to see him, but he was felt to be too unwell and too high risk for HAWC or First Step. This practitioner then contacted Adult Social Care to request a Care Act Assessment as they felt that Barry needed one. Adult Social Care acted on this concern by passing it to the HAWC. It appears that this was the second Care Act Assessment request made to Adult Social Care but the third in total. The first request was from Barry who spoke to the SPA line on 14/05/19 and this was passed to the HAWC. On 22/05/20, Barry walked into the surgery that day and was seen. The GP recorded that this was the best they had seen Barry. He said he was feeling a bit better and wanted to move to a bungalow in Appleby. He denied having thoughts of ending his life. He seemed to have hope and GP felt they had 'turned a corner'.

4.45 Also on 22/05/19, the ALIS team contacted Adult Social Care to request a Care Act Assessment because Barry was spending all day sitting in the GP surgery and then contacting the ALIS team at night stating he is going to kill himself. ALIS stated that Barry was not mentally ill. There is no record of Adult Social Care acting on this third request for a Care Act Assessment. Adult Social Care did link this third request to the existing Care Act Assessment referral. Also, the HAWC tried to contact Barry but was not successful and left a voicemail.

4.46 On 23/05/19, the GP reception staff saw Barry's car had been parked outside the surgery for several hours in a disabled parking space. At lunchtime staff checked on Barry who was asleep in his car. He said he was OK and just sleeping. They noted he had boxes of what appeared to be his prescribed medication on the passenger seat. Barry denied taking any of the medication and declined an invitation to come inside the surgery. He said he was okay and just tired. Barry was encouraged to move his car to a different parking space. He agreed to do this but did not move his car at that time. Later in the afternoon one of the GPs noticed Barry's car had been moved to the opposite side of the car park. His head was against the steering wheel. Blister packs of medication were on the passenger seat. Barry was pronounced dead at scene. A suicide note was left in the centre console of the car that was seized by police. As part of their enquiries police searched Barry's address after he had died and found four further suicide notes, saying very similar things to the one found in the car. It appears they were all written around the same time.

5. View's of Barry's Family

5.1 Barry's brothers have not been contacted regarding this review. Barry was distant from his family. His sister has been approached and has declined to contribute to this review. There is no obligation to do so.

5.2 On 12/11/19, Cumbria Safeguarding Adults Board wrote to Barry's sister to inform her that this review was being conducted into the death of her brother. She was also informed that a review group of multi-agency partners had been established and DCI Dan St Quintin would provide the report identifying key learning that will be shared with agencies. Barry's sister is aware of how to get involved. Barry's sister will be kept updated and will be invited to meet DCI Dan St Quintin to review the report and comment upon it.

6. Analysis

6.1 In this section of the report, the key lines of enquiry for the review will be considered.

How effective were services in identifying Barry's needs?

6.2 On various occasions, Barry presented with issues to service providers that were serious to him. However, after initial discussions with professionals the severity of Barry's issues regularly decreased to less concerning levels. Barry often used professionals and service providers to ease his loneliness. It was encouraged by GP surgeries to do this when he felt lonely. Often, Barry would report his conditions inaccurately. Often, what Barry felt was the issue was not the case when a professional assessed him. It was also the regular case that Barry's anxiety levels reduced just by being contacted by a professional and/or having a conversation with him. He found these conversations very reassuring. The effectiveness of the services that Barry received were affected by inconsistencies in information that was provided by Barry and the swift decrease in risk that was presented after an intervention had happened.

6.3 Barry needed constant reassurance that he was OK. This is because he suffered from anxiety about his health. It also appears that Barry felt that he needed regular 'fresh starts' in new places which, he deemed would be better than where he was at the time. Moving regularly around the country has had an effect on professionals being able to take a long term view of Barry's needs. The regular moves caused increased contact with professionals in the new area as they developed an understanding of Barry as a person and his needs.

6.4 From his records and from accounts given by professionals and a close friend, Barry used cannabis for over thirty years. Sustained cannabis use is associated with adverse outcomes in later life and has been found to increase levels of welfare dependence, decrease levels of relationship satisfaction and decrease levels of life satisfaction (Fergusson & Boden, 2008).

6.5 Points, 6.2, 6.3 and 6.4 have to be taken into account because they have made effective service provision more challenging.

6.6 It is clear that GP surgeries, ALIS and HAWC provided Barry with a very high level of service throughout. In Barry's GP records it states that he attempted suicide in 2008. It is not clear from GP records made in the last six months of Barry's life whether this previous suicide attempt was taken into account, when recent assessments of risk around suicide were made. It is unclear if mental health teams knew about the suicide attempt in 2008 and whether this affected their decision making. It appears they did not know this.

6.7 In the six months before Barry's death, it is estimated that Barry was seen, discussed or had a telephone consultation with professionals 239 times. Over 100 referrals were made between different services and teams in health, social care and HAWC. From this high volume of contact with services, it is clear that current structures are not effective in responding to issues where serial cases like Barry do not reach the criteria for individual services. A formal process needs to be created or existing multi-agency procedures developed, to enable multi-agency partners to take ownership, intervene early, meet, share information, allocate actions and resolve serial situations.

6.8 Barry attended the GP surgeries in Alston and Kirkby Stephen on a nearly daily basis. Sometimes he would attend more than once a day. He was often seen by a GP when he did not have a booked appointment. The visits that involved seeing a GP or other medical practitioner at the surgeries were recorded. It was often the case that Barry would attend the surgery and sit in the waiting room. On these occasions staff recalled that he would remain there for different periods of time before he left. He was often offered a drink and he was never turned away. The collective view of the GPs was one of frustration. It is clear that Barry received a very high standard of service from both surgeries. Medical needs were identified effectively. Both surgeries tried to help Barry. The GP surgeries did identify what Barry's needs were but needed to refer to other services to resolve them. Repeated referrals were made to other services and the surgeries demonstrated a great degree of care. However, even after over 40 appointments with GPs in the six month period, Barry's issues worsened. This is not through a lack of effort on behalf of the surgeries. Where possible Barry's needs were being identified by the surgeries. Importantly, once the GP had identified what an issue was, the referral system did not enable effective resolution of those identified needs. Other services had to be involved to provide more specialist assessments to determine whether Barry's needs were health related or social care related or both. The referral system relies on quality information being shared. In this case, there needed to be more conversations between services and teams to discuss the case. On 20/05/19, the GP and ALIS saw Barry. In the ALIS meeting he did describe how he would kill himself but did not identify any timescales and whether he was actually going to do it. There were no records provided to show that this information was shared with the GP. The GP was told by Barry about his preferred way to kill himself on 03/12/18. There are no records provided to show that this information was passed to ALIS. Barry told ALIS the same information on 02/05/19.

If this information was shared it would have affected assessments of the situation. If this happened, it would have enabled a richer picture of Barry's needs to be identified and what his risk levels were. Levels of concern may have increased. However, even if levels of concern had increased, there appears to be no mechanism for these concerns to have been discussed formally on a multi-agency basis. An effective co-ordination process needs to be introduced to reduce and manage the amount of repeat referrals, identify where a case is most appropriately dealt with and provide direction to professionals.

6.9 Psychiatry assessment (mental health services) is different to a psychiatrist assessment. Given Barry was on numerous medications and had seen many professionals, a psychiatrist assessment may have assisted in gaining a new perspective, confirming existing decisions and reviewing medication. GPs did request a psychiatrist assessment and mental health services declined to progress this. It is not clear whether outcomes for Barry would have changed if a psychiatry assessment had gone ahead.

Were Barry's needs assessed effectively and responded to?

6.10 The information Barry gave repeatedly to ALIS was that he was lonely and socially isolated. Many offers of support to address this are documented. Services from HAWC and others record that steps were taken to address these issues. Records also show that Barry had mental health issues like anxiety and depression. Some of these issues are health related and some are social care related. In order to deal with Barry's case a more joined up approach between health and social care was needed. Barry's issues needed to be resolved or managed. A joined up, early intervention approach would have been more effective than relying on the referral system which is not effective when the service user's needs do not fit the front door criteria of service providers.

6.11 There was a conversation with the consultant in Eden because the GP had asked for advice around medication. A referral to CMHART at this stage may have assisted the GP's treatment of Barry's mental health issues.

6.12 On 14/05/19, a SPA officer instigated the 'Start Of' assessment. It was then passed to a HAWC to complete. There was a perception by SPA that Barry was an open case for the HAWC. This was not the case. He had been a closed case since January 2019. An MDD needed to be activated and the 'Start Of' assessment needed to be passed to a social worker. This referral needed to be placed in the duty tray. It is unclear whether the HAWC was aware that this assessment had been passed to them. No actual conversations took place. Updates were made using voicemail. The 'Start Of' assessment was completed by a SPA officer. It was triaged by the duty mental health social worker and passed to the duty team. After initial information was gathered, an MDD was convened and a decision was made to send the case to a social worker for assessment or a HAWC. On 17/05/19 the case was transferred from mental health to the HAWC because it was felt that the HAWC knew Barry and had built up a rapport with him. This was recorded on the Adult Social Care system (IAS). Voicemails were left for the HAWC.

6.13 The Care Act Assessment request was made three times, by Barry, CMHART and ALIS. There was a self-request from Barry on 14/05/19, a request from a CMHART practitioner on 21/05/19 and the ALIS request on 22/05/19. These requests were not progressed by the duty social worker. The Care Act Assessment referrals were passed to the HAWC inappropriately. The social worker and the HAWC did not have a conversation about Barry although the voice mails were left. No-one from Adult Social Care contacted Barry by phone to discuss this assessment. Contact was made via SPA and the HAWC. The procedure to formally discuss and identify Barry's potential social care and support needs was not activated. A review of Care Act Assessment processes needs to take place to ensure there are no other similar cases in the system and to minimise the risk of what happened in Barry's case from happening again. Barry's case for the Care Act Assessment remained open from 17/05/19 to 03/06/19.

6.14 At present there is no nationally agreed definition of an Adult at Risk. Within the Care Act (2014) an adult at risk is defined as 'any person who is aged 18 or over who has care and support needs and is experiencing or at risk of abuse and is unable to protect themselves from either the risk or the experience of abuse or neglect'. Barry did not fit within this definition and was not at risk of abuse or neglect by others. A s.42 assessment around safeguarding would not have been appropriate. However, he was deemed at different times during the last six months of his life to be at risk of suicide. Due to the Care Act definition, those adults who are at risk of suicide are not systematically discussed in any safeguarding forum in Cumbria. People are only referred regularly to third sector organisations for support around suicidal thoughts. However, by not falling within the criteria for multi-agency safeguarding responses, options to respond to Barry's needs effectively were limited. As a result, Barry's needs were not responded to effectively and this appears to have increased his frustrations that his perceived needs were not being met. Along with other factors, his frustrations do appear to have contributed to his decision to kill himself. Any forum that is created to deal with people with similar cases needs to take into account the risks of harm that individuals may pose to themselves and others.

6.15 Some records within mental health services record the decisions that were made but do not record the rationale for why decisions were made. For example, on 22/05/19, ALIS records state they did not believe Barry to be mentally ill. However, no rationale for this decision has been provided. The North Cumbria Integrated Care NHS Foundation Trust (NCIC) needs to review this and assure itself that the decision making records are of an appropriate standard.

What interventions took place and were they effective?

6.16 There were numerous interventions that took place and it has been identified that numerous professionals tried very hard to provide a high level of service. On many occasions, interventions provided by professionals were effective in reducing Barry's levels of anxiety in the short term. In the short term, Barry's needs were met frequently just by the professional speaking to Barry and providing reassurance. However, in the longer term these conversations did not resolve Barry's needs. They seem to have enabled a cycle where Barry's needs were met and issues managed through daily reassurance and personal effort on behalf of the practitioner, rather than effective long term solutions being identified and employed.

6.17 On 06/11/18, a double appointment was made by the GP so there would be more time to assess Barry's mental health. The GP provided a psychotherapist to assess the situation further and help to resolve these issues. This situation continued for a period of time and some progress was made. However, as time went on, more specialist services were identified as being needed and referrals were made by the GP to activate these.

6.18 On 15/11/18, Barry self-referred to First Step. A triage assessment was conducted over the phone. Barry's needs were deemed to be social issues. By this stage, Barry had been diagnosed with depression and anxiety that GPs could not manage in isolation. It is unknown if First Step had access to this information and whether it formed part of their assessment. What First Step did know was that Barry was receiving therapy through his GP surgery. This was a factor in deciding not to offer Barry any First Step services. On 04/04/19, First Step deemed that Barry's needs were social issues and referred him to Adult Social Care It appears that there was an over reliance from First Step that Barry was lonely. However, First Step can arrange talking treatments like cognitive behavioural therapy (CBT), which is designed to change a person's way of thinking, feeling and acting. Barry did have diagnosed mental health issues and providing CBT in November 2018, may have resolved some issues. Barry had diagnosed mental health issues, which affected his outlook and his motivation around social issues. Being isolated and lacking motivation to socialise and carry out daily functions then affected his mental health. His mental health and social issues were interconnected and affected each other. Barry stated to First

Step that the death of his mother in 2008 significantly affected his mental health. CBT or another therapy may have addressed this issue and reduced his anxiety and depression. This would have needed a discussion to take place between First Step and the GP to determine which therapy would have been most effective for Barry at that time. Records provided suggest that this discussion did not take place. It would have needed to have been instigated by First Step after Barry informed them of the GP provided therapy. It is unknown which therapy approach would have been the most appropriate. The determination by First Step that Barry only had social issues was inappropriate. Barry had mental health issues that can be seen to fit the criteria for First Step services. He self-scored in his conversation with First Step as having moderate mental health issues on 15/11/18. Had a First Step intervention taken place in November 2018, rather than the continued GP therapy, this may have dealt with Barry's mental health issues more effectively than what the GP therapist was providing. By providing a form of talking therapy at this stage, First Step would have provided an earlier intervention that may have addressed Barry's needs. Onward referrals by First Step to Age UK and a HAWC were not effective or appropriate to deal with Barry's mental health issues effectively. Barry was an appropriate client for First Step.

6.19 Barry and his GP discussed a potential problem with his thyroid. This can be a physiological cause of some mental health issues. The GP arranged tests of Barry's thyroid. The results showed that the thyroid was at the high end of the acceptable parameters for concern. However, to ensure a hyperthyroid issue could be ruled out as a cause for his mental health issues, the GP referred Barry to Endocrine for specialist thyroid assessment. Endocrine are hormone specialists in hypothyroidism. Barry was very worried about his Thyroid and the headaches he was getting. He appeared to have significant health anxiety, which is something that First Step can assist people with. It is not known whether First Step were made aware of this.

6.20 In the first few days of December 2018, Barry had four contacts with the SPA line and ALIS. An MDT meeting was convened and ALIS saw Barry in person and provided reassurance. The MDT involved three professionals from mental health services. A record of the outcome of this MDT has not been provided. There was an opportunity to widen this group to include professionals from social care and the GP surgery. On an ad-hoc basis, this would have enabled a wider understanding of Barry's situation and enabled a joined up approach between mental health and social care teams. Barry's mental health needs and social needs were dealt with in isolation, which led to ineffective outcomes for Barry and repeated inefficiencies in service provision.

6.21 When Barry moved to East Yorkshire in February 2019, he contacted Adult Social Care by phone. An onward referral was made to 'Health Trainers'. It is unclear if Barry responded to this referral but he did report he was lonely and isolated. Barry was not in East Yorkshire long enough for local services to understand his situation and to respond effectively.

6.22 In April 2019, the GP made a referral to First Step because they deemed Barry's mental health needs to require more specialist intervention. First Step referred Barry onwards to a HAWC because First Step deemed Barry to have social needs around loneliness rather than mental health needs. The constant referral and signposting from single agency to single agency rather than adopting a working together approach perpetuated ineffective responses for Barry. A different approach was needed but this was never activated. This is because the level of personal service and care the professionals gave Barry enabled his day-to-day anxiety to be managed through reassurance, medication and all the single agency responses. It is not known whether a multi-agency response would have been more effective because it was not tried. What is clear is that the single agency responses were not able to resolve Barry's needs in the longer term.

6.23 There was significant HAWC involvement in the last six months of Barry's life. Circles of Support and Shared Agreement tools were used. The HAWC facilitated Barry joining social groups and improving his life skills. The HAWC enabled Barry to get involved in the community. This activity aimed to deal with Barry's loneliness and isolation and when Barry did involve himself in community activities, his loneliness and isolation decreased. The effectiveness of any HAWC service relies on the individual to want to make changes.

6.24 On 28/04/19, ALIS spoke to Barry and conducted a thorough assessment of his mental health state. ALIS referred Barry back to his GP and concluded they had no further role. According to Cumbria Partnership Foundation Trust records provided, First Step conducted a phone assessment with Barry on 01/05/19. It is not known what activated this assessment. It was deemed that Barry did not meet the criteria for First Step services. It was deemed that Barry's needs were social and referred to HAWC. However, the HAWC involvement had finished because Barry was able to meet his own needs. On 02/05/19, a full triage assessment took place which concluded there was no need to admit Barry. The ALIS practitioner recorded that Barry's issues were as a result of social isolation.

6.25 There was no multi-agency conversation or meeting to discuss the case. Single teams or agencies made individual decisions to stop their services or not activate them without any consultation with professionals from different services. Single agency interventions, working in isolation were not effective because Barry had both mental health and social issues. A consequence of services ceasing for Barry or not getting involved, resulted in increased visits to the GP surgery, where Barry reported increasing suicidal thoughts and feeling isolated.

6.26 On 14/05/19, Barry requested a Care Act Assessment. Two other requests for this were made by professionals. However, this assessment request was missed and not acted upon. The duty Adult Social Worker did not make contact with Barry and the case was allocated back to a HAWC, which was inappropriate and the social worker and HAWC did not discuss the situation.

6.27 On 20/05/19, the GP saw Barry and was concerned about his mental state. The GP contacted ALIS who arranged for a taxi to collect Barry from the surgery and take him to the Carleton Clinic for assessment. This journey was around 45 miles each way. Barry declined ALIS services and ALIS agreed to assist Barry with the referral for sheltered accommodation. Barry was then taken back to the GP surgery by taxi where Barry told the GP that ALIS had declined him, which was not accurate. Barry declined the services offered by ALIS. This is an example of where Barry provided mixed messages to different services.

6.28 On 21/05/19, Barry returned to the GP surgery and told the GP that his head was telling him to commit suicide. The GP contacted ALIS who rang Barry. Barry stated to them that he was not going to kill himself and his GP was not listening to him.

6.29 Barry was offered services that he regularly declined. Sometimes, he told mental health services that his issues were social related, which meant he did not get offered services. This made it more challenging for professionals to identify his needs and put measures in place. Barry's actions contributed to the high amount of interventions, contacts, appointments and referrals that took place. However, there were 239 times when Barry came into contact with services and 100 referrals made. This is a clear indicator that even though Barry seemed unwilling to help himself at times, the system used by professionals was not effective in responding to his needs.

The level at which services worked together and were co-ordinated?

6.30 There were some good elements of agencies working together. There were good levels of communication between the GP surgeries and the mental health services. The GP surgery and ALIS responded effectively at times to ensure a joined up approach to individual events. This joined up working was led by the GP in response to their levels of concern rising about Barry. This enabled risks to be mitigated by specialist services that were activated swiftly. In some instances, it is clear that great care was taken to facilitate joint working like ambulances being arranged or taxis being booked to transport Barry to where he could receive treatment or assessment.

6.31 Cumbria Health on Call (CHOC) worked well with other teams and agencies to ensure Barry's calls to them were responded to.

6.32 On one occasion, an MDT did take place in an attempt for mental health services to discuss the case and identify appropriate next steps.

6.33 Towards the end of May 2019, some professionals were realising the need for a Care Act Assessment to be started. A degree of multi-agency working is evident from the referrals for this assessment being submitted. It was requested three times but it never happened. Joint working could have been done with mental health Adult Social Care staff and HAWC. The HAWC was aware of the numerous visits to the GP surgery. It is unclear why Adult Social Care did not respond to the Care Act Assessment requests. In short, Barry was not deemed by CMHART to have severe or enduring mental health issues. Apart from SPA services, Adult Social Care did not have involvement with Barry's social care issues. Barry had both mental health and social issues. The mental health issues did fit the threshold for First Step services to be provided but they declined him. It appears that First Step viewed Barry's issues as being social ones rather than due to mental illness. This may have been based on the information presented to them by Barry. It is unknown what other information was shared with First Step by other agencies. As a result of First Step not being involved, this meant that the GPs and HAWC provided most services to Barry. Professional mental health involvement from First Step may have been beneficial for Barry and may have complimented services provided by the GP and HAWC. Barry remained in the system because he did not meet the threshold for some services and a multi-agency forum in Cumbria did not exist at the time to discuss and resolve serial cases like Barry.

6.34 Even after 239 contacts, appointments, assessments or interventions with agencies during the last six months of Barry's life, no professional or practitioner took charge of co-ordinating a multi-agency approach to identifying exactly what Barry's needs were and creating a multi-agency plan to address his needs. Barry was a serial user of agencies on a frequent basis. Repeatedly, he gave conflicting accounts to different professionals which made responding to him difficult. Through information Barry supplied in appointments and assessments, he was not deemed to reach the criteria to be suitable for specialist mental health or social care support. He had mental health issues and social care needs, but these were never discussed at the same time by relevant professionals to identify an appropriate joint approach to both types of issues. As a consequence of not working together, Barry was moved around many front doors into agencies but was never taken on. It appears that the underlying causes in Barry's case were only ever going to be identified and responded to more effectively if agencies worked together rather than individually. A GP was aware that the situation was not being resolved but was unclear who they could escalate the case to, to activate alternative responses. As Barry's primary care provider, his GP was the lead agency and they worked very hard and showed a high degree of care repeatedly in trying to treat Barry. When faced with this complex situation, the GP was not aware of the process to escalate concerns.

6.35 There has been a lack of leadership and supervisory oversight with Barry's case in arranging and co-ordinating a multi-agency response. No meaningful multi-agency meetings took place to take Barry's case forward. His issues were a combination of anxiety, depression, loneliness and isolation. These issues were connected and a perpetual pattern can be seen: Barry was an anxious person who worried a lot about his health. He was also lonely and did not have any family and very few friends to talk to and socialise with. Barry used professionals to talk to and he felt reassured when he had contact from them. This reduced his loneliness and reassured him about his health. As a result, his levels of anxiety and depression reduced significantly in a very short space of time and therefore reduced the risk of harm he posed to himself. When one agency or team could not offer anything, or their services were declined, Barry would contact another team or agency which would enable him to feel reassured and less lonely. The invitation from the GP surgeries for Barry to sit in waiting rooms certainly eased his feelings of loneliness. The opportunity to see a GP as a walk-in patient without an appointment provided Barry with reassurance about his health, which left him feeling much better. On a day-to-day basis, this was an effective way of managing Barry's needs but this situation did not provide a resolution or more effective approach. It was apparent that as this situation continued, levels of frustration grew amongst professionals that the case was not getting resolved. Even though there were frustrations, the level of effort and care demonstrated by many professionals, especially the GPs was commendable. However, without the leadership to co-ordinate a multi-agency response, Barry's situation was going to remain unresolved. It is important to note that there is no guarantee that a multi-agency approach to Barry's case would have resolved it, but it would have enabled professionals to share information, identify conflicting accounts, identify appropriate courses of action and hold each other to account. This may have broken this cycle described above and provided better outcomes for Barry. Without any leadership through formal co-ordination and an appropriate multi-agency forum to discuss this case formally, it is probable that Barry would still be in the same situation now, if he were alive.

To what extent was the referral system effective in dealing with Barry's needs – especially the links between adult social care and mental health providers?

6.36 Over 100 referrals were made between agencies and teams regarding Barry in the last six months of his life. This referral system has not been effective in resolving Barry's needs. In some instances it took long periods of time for referrals to get to the desired recipient. Whilst there has been an evident and sincere desire by many professionals and practitioners to help Barry and provide the appropriate support, the referral system appears to have created a degree of ineffectiveness for Barry. There was an over reliance on the referral system, with Barry's case being repeatedly communicated to another team or department rather than a team or department co-ordinating a more effective response.

6.37 Some referrals were inappropriate for the role. For example, the HAWC could not deal with mental health issues that were referred to them.

6.38 Very little leadership was shown in pulling together a multi-agency response. It appears that on many occasions a referral to another agency or team was viewed as an outcome that concluded involvement for the referring agency or team. In reality, a referral is not an outcome for the person involved. It appears to have been a method for moving the case elsewhere for another practitioner to attempt to resolve Barry's issues and deliver support. Sometimes this was necessary, especially for primary health care like GPs to activate services beyond their remit. However, in this case there appears to have been an over reliance on the referral system to eventually find a solution for Barry's needs. It did not. The solution was never found for Barry because his needs did not match the necessary criteria for most services. It does appear that First Step would have been able to provide some appropriate services, especially in late 2018.

6.39 Individually, practitioners tried extremely hard to serve Barry but the current system lets down those with repeated needs that cannot be dealt with solely by a GP. Currently, they appear to get lost in the system and there does not appear to be a system in place to deal with cases like Barry to ensure they get the services they need. If a case reaches a certain amount of referrals without the case being resolved by individual agencies or teams, then this needs to trigger a multi-agency supervisory review of the case. Not only would this provide a better service, it would also reduce inefficiencies in the system. It is not clear whether the number of referrals across different agencies can be counted by a system that would trigger a case review. Automating this process would ensure greater reliability and consistency of service. It would highlight relevant cases automatically and ensure reviews take place.

6.40 From a legal perspective, the Care Act (S.6) puts forward the 'Duty to Co-operate', which sets out that Local Authorities must co-operate generally with relevant partners - and vice versa – with respect to carrying out care and support functions. If any multi-agency responses are triggered then all relevant agencies must adopt a co-operative approach.

To what extent was Barry's voice heard, captured and acted upon?

6.41 Barry's access to GP services was excellent and the escalation of Barry's physical health needs was efficient and effective. A great degree of care was taken by the GP surgeries with Barry. There was also good information sharing between the GP and ALIS team and vice versa. This did enable Barry's voice to be acted upon quickly when required. The support Barry received from the HAWC was of a high standard and there were numerous face to face meetings and telephone conversations with Barry by ALIS and Community Mental Health. Barry was escalated around his thyroid and may have benefitted from being escalated to a psychiatrist.

6.42 On an individual basis, agencies and teams did establish Barry's needs, based on the information available at the time. This information was gathered from assessments, referrals and information that Barry provided. It is clear that Barry was listened to and his decision making was respected. There were discrepancies in the information from referrals and the information that Barry provided. His needs often changed from the time the referral was sent to the time the contact took place. Barry refused some treatments that were appropriate to meeting his needs, like the Home Treatment Pathways offered by ALIS. Professionals did rely on the information that Barry provided and took his wishes into account. Barry was able to influence the services he received. His voice was acted upon by professionals.

6.43 Barry moved frequently. He was a lonely male who did not have any family or many friends in the areas he lived. He lived alone and did not join many groups. As a result, it was difficult for professionals and agencies to know Barry. His history was held on many different systems across the country. Little was known about his younger life, his friends and family and his previous history. There were gaps in knowledge about Barry when he briefly moved to East Yorkshire. A picture of his previous history and relationships, would have assisted in identifying whether Barry had any traumatic events in his life and what may have caused his mental health to decline.

6.44 As stated above, a clearer picture about Barry's needs and any conflicting information would have been gathered and acted upon, if a multi-agency meeting took place. This would have enabled a more co-ordinated approach to the information that was available. It would have enabled more robust communication links between mental health teams and Adult Social Care. A multi-agency approach would have reduced delays in information being received between services and enabled earlier interventions to be made. A richer picture of what was happening would have been obtained, instead of relying on referrals that sometimes were only one or two lines long between ALIS and Adult Social Care. By having a forum to take the lead and co-ordinate the care of Barry, this would have increased the efficiency and effectiveness of the responses he received. His voice would have been heard more, captured more and acted upon more effectively and efficiently.

6.45 In relation to Barry's needs being met around his medical needs, the GPs tried very hard to resolve these. In relation to the social issues, the GP attempted to get Barry to join community groups. However, Adult Social Care did not receive any referrals from the GPs and there appears to be a lack of some knowledge within general practice about the social care options that GPs can explore.

6.46 There was an unacceptable delay in instigating and providing a Care Act Assessment for Barry. Three requests were made including one from Barry. There was also the issue in the referral system where the requests for the Care Act Assessment were passed to the HAWC rather than the duty adult social worker by the SPA team. There did not appear to be a discussion about who the Care Act Assessment request should go to. A Care Act Assessment should have been started earlier. This statutory process would have enabled Barry's social care and support needs to have been assessed and his voice would have been heard. However, it cannot be determined whether Barry would have been eligible for statutory support and it is not known whether this intervention would have been effective had he been eligible. As a result of the situation around the Care Act Assessment not being implemented, it left the HAWC carrying an unacceptable level of risk.

6.47 Analysis of information shows that Barry's age was not an issue. There is a risk that professionals can view it to be more acceptable for older people to be lonely, because they are more likely to be lonely. This situation did not arise for Barry. Professionals tried very hard to address Barry's needs around loneliness, especially the HAWC.

The extent to which Barry's rural location affected the services he received.

6.48 Analysis of the information provided shows that there was very little effect of Barry's rural location on the services he received. The only minor issue was that Barry felt he could not attend evening drop in sessions at The Lighthouse in Carlisle.

Good practice

There are many examples of good practice in the case including:

- On an individual agency basis Barry's needs were established based on the information given at the time. There was a very high level of professionalism maintained by the GPs that saw Barry. Barry was always listened to, he was not turned away and decisions around what referrals should be made were taken after listening to his wishes.
- The GPs at Alston and Upper Eden Medical Practice did excellent work and provided Barry with a very high level of service for his physical needs. They promptly raised mental health concerns appropriately. The GP records have been very detailed, especially from Upper Eden Medical Practice that were towards the end of Barry's life. These records have been extremely useful to this review to enable an understanding of Barry's situation and the wider contexts. It is important to note the high level of care that was shown by the GPs and other surgery staff to Barry. The responses by GPs at Upper Eden Medical Practice were key in instigating swift specialist mental health services for Barry. It appears that the GPs found the situation they were dealing with frustrating but the level of patience and tenacity shown by GPs and others to help Barry and try to find solutions to his needs has been very evident.
- There was swift escalation of Barry's physical health needs. The GP pursued Barry's thyroid issues despite no clinical presentation. The referrals to Endocrine were progressed promptly.
- GP information sharing with other agencies was prompt, professional and regular contact with other agencies was maintained.
- There were numerous face-to-face meetings with Barry by professionals and practitioners even though he lived in very rural areas. Although many professionals and practitioners had repeated contact with Barry, no-one appeared to become de-sensitised to Barry's needs and many professionals and practitioners tried their hardest to help and support him.

- Barry was very well supported by HAWC. The initial HAWC response was prompt and Barry was seen regularly and his goals were identified and worked towards.
- ALIS responded quickly to concerns from the GP and provided an excellent service to get Barry to urgent face to face meetings. ALIS were respectful of Barry's decisions.
- Legitimate requests were made to Adult Social Care to conduct a Care Act Assessment.

7. Findings and Recommendations

7.1 This Safeguarding Adults Review focusses on how partner agencies worked together to prevent harm to Barry and meet his needs. It is not clear whether any single agency or multi-agency interventions would have prevented Barry from killing himself. Although the many single agency contacts and responses were well meaning and addressed short-term needs and physical medical needs, this repeated approach was not effective in meeting Barry's needs in a lasting way. It is unknown what effect a multi-agency response would have had for Barry because it was not considered or instigated. A multi-agency approach needed to be tried so Barry's needs could have been assessed in their entirety, information shared and actions allocated to address his multiple presentations.

7.2 There was a lack of co-ordination between agencies and a lack of understanding about who needed to take a leadership role. In reality, any one agency or professional could have taken responsibility for this. This was compounded by a lack of knowledge about what options were available outside the area of individual practitioner's expertise.

7.3 Within community care agencies and organisations there is an over reliance on the referral process to provide solutions. It appears that some professionals assume the referral system will 'own' the case and provide the necessary co-ordination. In Barry's case these assumptions and over reliance were present and whilst referrals were made, most did not meet the criteria for access to that service. This lack of a collective view of the frequent attendances, repeated referrals, referrals not accepted and referrals not acted upon by specific services led to a failure to gain an overall picture of Barry's needs and a plan to support him was not created.

7.4 The approach of single agency supervision on the case and the absence of any agreed approach to multi agency supervision also led to service driven responses rather than needs led ones.

7.5 The current system for community care does not have any formal multi-agency processes in place to respond to serial users of services who have needs that do not meet the criteria for one specialist team or agency to deal with. Unless this changes, there is a strong risk that other people will experience the same situation as Barry did before he died.

7.6 Over 100 referrals were made about Barry. It is probable that Barry would still be in the same situation now if he were alive. This amount of referrals should have led to a multi–agency meeting, robust supervisory oversight and co-ordination of Barry's case.

Recommendation 1:
Cumbria Safeguarding Adults Board should seek assurance from partners about how agencies work together to protect adults with multiple needs, taking into consideration cases where adults do not meet thresholds for some services.

7.7 Analysis suggests that there is little supervisory oversight of the referral system and there are few measures in place to ensure that decisions made by professionals are appropriate and consistent. Analysis here also suggests that the quality of the information passed between professionals can vary significantly. Poor quality information affects the level of service a person receives negatively. Where the information passed between agencies is of a high standard, this enables much more effective decisions to be made and more effective services to be provided.

7.8 Without effective supervisory oversight of the referral system between agencies, decisions by professionals to move cases inappropriately can happen. This happened on a number of occasions in Barry's case. It was inappropriate for First Step to determine that Barry did not have mental health issues and that his issues were social. His mental health issues were appropriate for First Step to provide services. The assessment was not completed to determine whether Barry did have social issues and it was inappropriate for Adult Social Care to assume that Barry's needs could be met by a HAWC. It is concerning that inappropriate referrals are not captured at a supervisory level and challenged. This enables individual cases to be passed around the system without being co-ordinated. This is sometimes due to inappropriate decision making. This results in poor levels of service, delays and inefficiencies in the system.

Recommendation 2:
Cumbria Safeguarding Adults Board seek assurance on how agencies work together to identify care co-ordination requirements. Also, that effective oversight of decision making, care provision and information sharing is present and it is consistent to ensure appropriate and timely interventions.

Recommendation 3:
Cumbria Safeguarding Adults Board seeks assurances from Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust, North Cumbria Integrated Care NHS Foundation Trust, North Cumbria Clinical Commissioning Group and Adult Social Care that there are systems in place to identify individuals who frequently access services like Barry and they are responded to effectively.

Recommendation 4:
Cumbria Safeguarding Adults Board seek assurances that where adults with care and support needs that do not meet thresholds for mental health service provision, appropriate signposting is available for alternatives which meet the person's needs.

7.9 Analysis of Barry's case has shown that three requests for a Care Act Assessment were not followed up even though there is statutory obligation to do so. The referrals were sent to the HAWC which was inappropriate. The process to request that a Care Act Assessment takes place can be complex. The first request was from Barry. No one contacted him to update him or discuss his request. Also, professionals identified the need for a Care Act Assessment in May 2019. As a result, two further requests were made by practitioners for a Care Act Assessment. These were not followed up by Adult Social Care. One of the key areas of concern was that Barry's risk of harm was increasing and so far all the services provided had not had a lasting effect. One of these further requests was from CMHART. CMHART identified the need for the Care Act Assessment following a conversation with the GP - Barry appeared to require care and support. A Care Act Assessment would have focussed on Barry's needs and determined how his needs affected his wellbeing. This assessment would have considered both his mental health and social care needs in a formal way.

Recommendation 5:
That the Cumbria Safeguarding Adults Board seeks assurance from Adult Social Care that the process for requesting Care Act Assessments is robust and requests for them are dealt with appropriately and consistently.

7.10 The GP surgeries tried their best to meet Barry's needs. They saw Barry on many occasions and attempted different approaches. It has been highlighted that the GPs were unaware of all the social care options that were available to them, including Care Act Assessments. This lack of knowledge did restrict the opportunities that GPs had to pursue social care services.

Recommendation 6:
Cumbria Safeguarding Adults Board request Adult Social Care work in partnership to develop methods and strategies to strengthen the knowledge of GPs and other professional groups. This is in respect of the range of support available from Adult Social Care and how to request their involvement.

7.11 Whilst the open-door approach the GPs employed with Barry is recognised as good practice, it does appear that he went to the GP surgery virtually every weekday for six months. Barry was often seen by a GP when he had no appointment. This built a rapport with Barry who used the GP surgeries and the professionals within them to ease his loneliness. It would have been appropriate for the GPs to set boundaries with Barry to reduce the amount of visits he made. This would have been easier to do if GPs were more aware of the social care options that were open to them in serving Barry. It appears that the GPs felt they had sole responsibility to deal with Barry's needs and resolve them as a single agency using specialist services when deemed appropriate. GPs needed to share the responsibility with other agencies and needed to know how to activate multi-agency responses to assist them and provide co-ordination.

Recommendation 7:
CSAB seek assurance from Clinical Commissioning Groups that GPs are supported when dealing with complex cases or frequent attenders and understand when and how to activate multi-agency involvement or responses.

7.12 Barry was a lonely man who had no contact with family and little contact with friends. He used professionals as friends who he eased his loneliness with. The HAWC worked hard to address this issue. Loneliness occurs when people's ability to have meaningful conversations and interactions is inhibited. With an aging population in Cumbria, loneliness is an increasing social issue. Being lonely has a significant impact on wellbeing and quality of life (Age UK, 2018). Age UK research suggests that people are more likely to be lonely if they have no-one to open up to, are widowed, in poor health, feel as though they do not belong in their neighbourhood, unable to do what they want and live alone. Barry experienced most of these factors and his loneliness did affect his mental health and outlook on life.

Recommendation 8:
CSAB consider the impact of loneliness in light of national strategy; "A connected society; a strategy for tackling loneliness 2018" and how agencies can work to improve outcomes for adults with care and support needs.

8. References

1. Multi-Agency Chronology
2. CSAB Letter to Barry's sister
3. Phone Call with Barry's close friend on 27/12/19
4. 'Cannabis and Later Life Outcomes' Fergusson, D. M. & Boden, J.M. (28.06.2008) in 'Addiction' Vol 103, Issue 6. Wiley. London.
5. Signs of Safety Reflections from Learning Review held on 19/12/19.
6. 'All the Lonely People: Loneliness in later life' Age UK, September 2018.

9. Appendices

9.1 Panel Membership: