Safeguarding Adult Review

Under Section 44 of the Care Act 2014

In respect of Shannon

Self-portrait with her mother by Shannon
Reproduced with permission of Shannon's sister

Report produced for Sandwell Safeguarding Adults Board by
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Acronyms

ADASS: Association of Directors of Adult Social Services
BCC: Birmingham City Council
BSMHFT: Birmingham and Solihull Mental Health Trust
CCG: Clinical Commissioning Group
CGL: Change Grow Live
CMHT: Community Mental Health Team
CQC: Care Quality Commission
CPN: Community Psychiatric Nurse
DBT: Dialectical Behavioural Therapy
DoH: Department of Health
DOLS: Deprivation of Liberty Safeguards
ED: Emergency Department (NHS)
GP: General Practitioner
IMR: Individual Management Review
IRIS: Identification and Referral to Improve Safety
LPA: Lasting Power of Attorney
MCA: Mental Capacity Act
NHS: National Health Service
NIHR: National Institute for Health Research
SAB: Safeguarding Adults Board
SAR: Safeguarding Adult Review
SUI: Serious Untoward Incident (NHS)

Glossary

Best interests: Any decisions made, or anything done for a person who lacks capacity to make specific decisions must be in the person's best interests.
Care Programme Approach is a package of care for people with mental health problems that includes a care co-ordinator and a regularly reviewed care plan.
Dialectical Behavioural Therapy is an intensive psychological treatment that focuses on enhancing a person's skills in regulating their emotions and behaviour. It aims to address and alter patterns of behaviour by finding a balance or resolving differences. The therapy can help a person gain control of behaviour such as self-harm and substance misuse.
Mental Health Act 1983 (amended 2007) A law mainly about the compulsory care and treatment of people with mental health problems.

- Section 2 - Admission for assessment (or for assessment followed by treatment)
- Section 3 - Admission for treatment
- Section 117 - places an enforceable duty on health and social care to provide aftercare services to a patient on discharge from hospital with the aim of preventing a deterioration in their mental disorder.

Acknowledgements

Members of the review panel offer their sincere condolences to Shannon’s family and thank them for their contributions and patience whilst the review reached its conclusions.

The panel wishes also to thank all those who have assisted with this review including the authors of the Individual Management Reviews and the professional support from the Board.

A Statement from Shannon's Sister

"On the 9th of January 2019 my little sister Shannon took her last breath at Oak House and she was ripped away from a family that miss her every single day. Her death was avoidable, and the neglect that she suffered was a direct contributory factor to her death. She didn't want to die: she wanted to be supported, she wanted to be safe.

My little sister was 24 when she died. She looked forward to a bright future despite the challenges she faced. She was a sensitive and gentle young woman; she loved animals; she read books with enthusiasm and passion; she was extremely talented and enjoyed art; she oozed creativity and she often advocated for justice, fairness and equality. She deserved her own justice and fairness and unfairly wasn't given that chance.

The impact this has had on our family has been profound. I myself was training to be a mental health nurse when my sister died, as the difficulties she faced from a young age inspired me to want to work to support people who struggled during crisis. Unfortunately, due to the traumatic nature of her death I'll never be able to revisit this aspiration as it would be too difficult.

My sister's niece has lost the opportunity to grow to know her aunty more, and her aunts, cousins & uncle have all been hugely impacted by her loss of, and the nature of her death.

Shannon's friends would describe her as talented, loyal and caring and, of course, a true friend. She was a real loss to so many people.

Our mom sadly passed away at the beginning of 2023, but I would like to include some of her words-:

> *"On the day Shannon died my world crashed, exploded never to be the same again. My beautiful daughter was gone forever leaving me with a void so wide my world would never ever be the same again."*

Unfortunately, Shannon's story is one of many similar experiences. There are many families that have lost their loved ones whilst they were meant to be protected and safe. Something has to change, because there have been many documented deaths that could have been avoided. This is a national crisis that truly needs to be taken seriously and neglect from services that are in place to help should never be the reason of any further avoidable deaths.

It is my hope that people who are neurodiverse and experiencing mental health crisis are supported properly and consistently throughout all services, and that therapeutic intervention is available and adhered to for all of the most vulnerable people in our society. It is also my hope that, moving forward, avoidable deaths will be prevented. A holistic approach must always be sought as multi agency approaches will be crucial in identifying support so vulnerable people's needs are met. I also want parent carers as well as vulnerable people at the centre of all planning and assessment - it is crucial that families' voices are heard, as parent carers can and do offer an invaluable insight into their loved ones' needs, into deteriorating mental health and play a key role in identifying the need for rapid intervention. It is crucial that placements sourced in and outside of statutory services are suitable and robust planning goes into ensuring that placements are and remain suitable."

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1. Introduction

1.1 Summary of the circumstances leading to the review

1.1.1 This review was commissioned by Sandwell Safeguarding Adults Board. It concerns the circumstances leading to the death of Shannon who was aged 24 when she was found dead in the mental health rehabilitation unit in which she was living. The coroner concluded there had been a gross failing of care by a staff member at the unit and that neglect had been a direct contributory factor in her death.

1.2 Legal framework

1.2.1 Section 44 of the Care Act 2014 places a statutory duty on Local Safeguarding Adults Boards to undertake a safeguarding adult review if an adult with care and support needs in its area has died and there is reasonable cause for concern about how agencies worked together to safeguard the adult, and the Board knows or suspects that the death resulted from abuse or neglect.

1.3 Purpose, Process and Methodology

1.3.1 The purpose of safeguarding adult reviews is not to apportion blame, but to learn lessons to improve practice in the future (s44.ss5). The key lines of enquiry are included in Appendix 1 and focussed on agency involvement from March 2018, prior to Shannon being referred to Oak House, and whilst she was an inpatient receiving treatment, until her death in January 2019.

1.3.2 An independent lead reviewer was appointed, and a multi-agency panel established consisting of senior managers who were independent of the case.

1.3.3 The review applied an investigative, systems approach, underpinned by agencies undertaking Individual Management Reviews. The review also incorporated learning from parallel reviews as featured below.

1.3.4 The panel considered it to be imperative that the views of the family and details of their involvement would be included in this review. In doing so, it sought to ensure that the review enshrined the principles and practice of Making Safeguarding Personal, a core value signed up to by all agencies working as part of the Sandwell Safeguarding Adults Board.

1.3.5 It should be noted that the review was subject to considerable delays as a result of the lack of meaningful participation of Camino Healthcare Limited in the review. The Safeguarding Board was forced to issue two Section 45

notices[1], under the Care Act 2014, in order to require their participation in the review and the reports eventually received were insubstantial and insufficient in the detail that would be required for effective analysis. The review therefore sought permission from the coroner to use the information provided for that purpose to reach the conclusions within this report. The matter of the involvement of private care providers within reviews of this nature is addressed further in the report.

1.4 Parallel Reviews

1.4.1 An inquest in August 2019 found there had been a gross failing of care by a staff member at Oak House and that neglect had been a direct contributory factor in Shannon's death. A coroner has a duty to identify circumstances which create a risk of future deaths and report where action should be taken to prevent those circumstances happening again or to reduce the risk of death created by them[2]. In this case, the coroner issued 'Reports on Action to Prevent Future Deaths' to Camino Healthcare Limited and Birmingham and Solihull Mental Health NHS Foundation Trust.

1.4.2 A serious incident review[3] was undertaken by Birmingham and Solihull Mental Health Trust and the learning from this activity has been included with this review.

1.4.3 Although an earlier Care Quality Commission (CQC) Inspection of Oak House in September 2017 found the provision to be good in all features, following notification of Shannon's death in January 2019, and upon receipt of information from the coroner in April 2019, CQC undertook a comprehensive inspection of Oak House in May 2019. As a result of the information obtained about Shannon's death, one of the areas of focus for this inspection was how Oak House staff supported people who self-harmed or expressed suicidal ideation. Following this inspection, the CQC issued two urgent notices of decision relating to ligature risks at the service. It then revisited Oak House to ensure that the necessary action had been taken. At a follow up inspection in January 2020, improvements were found at the service and the rating for the location changed from Inadequate to Requires Improvement.

1.4.4 Subsequent inspections in July and November 2020, found further areas of concern and the CQC took steps to remove Oak House from Camino Healthcare Limited's registration via a notice of proposal. This action was

[1] Section 45 of Care Act 2014 covers the responsibility of others to comply with any request for information from the safeguarding adults board for the purposes of progressing an enquiry.
[2] under paragraph 7, Schedule 5, of the 2009 Act and Regulations 28 and 29 of the Coroners' (Investigations) Regulations 2013
[3] For more information, see: https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incidnt-framwrk-upd2.pdf

terminated when Camino Healthcare Limited de-registered the service voluntarily.

1.4.5 As part of the CQC's criminal investigation, it obtained and reviewed documents from Camino Healthcare Limited, Black Country Coroner and West Midlands Police. Amongst these documents were Shannon's care plans and daily records, Camino Healthcare Limited's policies and procedures and staff training records, the police log, sudden death report, the coroner's inquest bundle and witness statements from staff on duty at the time of Shannon's death.

1.4.6 Following its review, the CQC concluded in January 2022 that there was insufficient evidence to bring criminal enforcement against Camino Healthcare Limited.

2. Summary of Circumstances

2.1 Background

2.1.1 Shannon grew up in Solihull with her mother and older sister. She was a gifted artist and had ambitions to be an art therapist.

2.1.2 She first came into contact with mental health services when aged 14 when she took an overdose, after which she was in a coma for 4 months. Thereafter, she was diagnosed with Asperger's Syndrome and dyslexia, developed anorexia and began to self-harm, refusing to attend school. Eventually she attended a Special Educational Needs school where she was considered to be gifted and talented and went on to study fine art at university. She found the university experience difficult and started to misuse alcohol and left university after completing her second year.

2.1.3 Shannon received secondary mental health services, either as an inpatient or in the community, throughout most of this time. She was latterly diagnosed with anxiety and Emotionally Unstable Personality Disorder, which manifested itself in a range of behaviours, including difficulty in regulating emotions, fear of rejection and a pattern of significant and repeated self-harm.

2.1.4 When under the influence of alcohol, Shannon became more impulsive and her self-harm was exacerbated. She was referred to Solihull Addictions Service in 2016 but they were unable to engage with her.

2.2 Period in acute hospital

2.2.1 In August 2017, Shannon was admitted to a female acute admission ward of Mary Seacole House, which is an inpatient mental health unit within Birmingham and Solihull Mental Health Trust. Following a period of assessment, she was detained at the facility under Section 3 of the Mental Health Act 1983 (MHA) for care and treatment and was accepted for the Solihull Enhanced Personality Disorder Pathway.

2.2.2 Whilst an inpatient, Shannon's self-injurious behaviours reduced in nature and frequency, and she was allowed accompanied leave with her family for up to three days per week.

2.2.3 Thereafter, her discharge from hospital was first discussed at a discharge planning meeting at the beginning of December 2017 **(01.12.17)** under Section 117 Mental Health 1983 aftercare arrangements, hereinafter referred to as Section 117 aftercare plans, and she was considered to be suitable for discharge from inpatient care from January 2018 onwards. It was agreed that Shannon would not return to the family home due to her mother's own physical health needs and because it was agreed that it would be better to support her towards independent living. Therefore, suitable accommodation was to be found.

2.2.4 The assessment that was undertaken at the time by mental health services considered her ongoing self-harm, mainly in the form of ligatures and cutting. The assessment considered that Shannon had limited insight into her self-harm behaviour and appeared to struggle significantly with tolerating distress or other emotional experiences. As a result, she would become frustrated if she was unable to harm herself but had been trying to use a traffic card system to communicate her emotional experiences with varying degrees of success. It was concluded that her level of risk was high according to the criteria:

> "'*Challenging' behaviour that poses a predictable risk to self, others or property. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions"*

2.2.5 In January 2018, Shannon's consultant wrote to the Mental Health Joint Commissioning Team sharing concerns that the delays and uncertainty in finding suitable accommodation was creating added tensions for Shannon. The consultant described this as creating a vicious circle whereby the worse her tensions around this became, the more challenging her behaviour became and the harder it was becoming to find suitable accommodation. Indeed, between January and March 2018, Shannon was taken to the Emergency Department of Birmingham Heartlands Hospital on three occasions as a result of her self-harming and overdosing on medication whilst visiting family. Her mother accompanied her to hospital on each occasion.

2.2.6 Meanwhile, the Joint Commissioning Team had been trying for a number of months to identify a suitable placement. One local provider was rejected by the panel because it was unable to indicate how it would mitigate and manage the risks that Shannon faced. A further four providers were considered and not recommended to panel for a variety of reasons, not all known to the review.

2.2.7 In March 2018, Shannon was taken to the Emergency Department as a result of self-harm which required sutures. This was repeated a couple of months later. On both occasions, she was accompanied by staff from Mary Seacole House. On a further two occasions over those months, she was reported missing to the police as she had not returned from her agreed daytime leave period, but presented herself back to the ward each time, albeit late.

2.2.8 During March, Shannon's case was allocated to a social worker (SW1) who commenced discussions with a supported living provider advising them of Shannon's patterns of regular self-harming: overdosing on tablets and tying ligatures whilst on the ward. In terms of location, it was identified that she needed to remain within range of her existing community mental health team and to live close to her mother who lived in East Birmingham. In terms of needs, it was identified that she would need 1:1 support and staff to support her when she transitioned from hospital to the community.

2.2.9 Shannon went on to visit this accommodation in East Birmingham which she liked and was hopeful of having 24-hour care with waking night staff. However, at the joint mental health functional funding panel **(18.05.18),** the application for funding was declined on the basis that more robust risk management was necessary in order to keep her safe. In the meantime, Shannon explained that her current self-harm was due to her frustration at her prolonged stay in hospital.

2.3 Planning for Discharge

2.3.1 By June 2018, Oak House in Tipton was considered to be the most suitable placement. Oak House was one of the units within Camino Healthcare Limited's estate and provided residential accommodation and support for up to 16 adults with mental health needs. It specialised in supporting individuals who have a primary diagnosis of mental disorder or mild learning disability and was registered to provide residential care with nursing. The social worker had visited Oak House **(26.06.18)** and been reassured by the unit manager, that staff were well experienced in meeting the needs of an individual who self-harmed. The social worker observed that Oak House "had a good strategy in place to monitor the needs of residents promptly and efficiently". Moreover, given Shannon's needs, the unit manager stated that a five-minute observation strategy could be implemented to monitor and support Shannon during critical

periods. This level of intensive care did not appear to be questioned by the social worker directly, or with partner agencies.

2.3.2 Shannon and her mother were initially opposed to Oak House as it was out of the area: some 15 miles from her mother and away from everything that was familiar to her. She was also concerned that she would need to move to a new mental health team. However, they visited the establishment and liked the way it operated. Shannon voiced her remaining concerns on her return to hospital and was assured that travelling facilities would be arranged for Shannon and her mother to visit each other. Her approval was offered, subject to this being arranged. Shannon later went on to say that she felt that she had not been listened to throughout the accommodation finding process.

2.3.3 At the end of June 2018, (**28/06/2018)** the joint mental health functional funding panel agreed the funding in principle for Camino Healthcare Limited. The provider had assessed her and were able to offer a placement at the cost of £2198 per week. The clinical team felt that, as Shannon was receiving the Enhanced Personality Disorder Pathway, psychological and occupational therapy interventions were not required and requested that the provider remove them from the support plan which reduced the cost to £2049 per week. The funding panel requested clarity on how the support plan would be reflected without the occupational therapy interventions, and what this meant for Shannon and her recovery plan. The panel agreed, subject to the details of the occupational therapy interventions being clarified to the panel members.

2.3.4 Funding was agreed for 6 months under Section 117 of the Mental Health Act 1983, hereinafter referred to as the Section 117 aftercare plan, with a funding spilt agreed 70% NHS and 30% Social Care. Camino Healthcare Limited were asked to provide monthly progress reports to the Joint Commissioning Team and the care co-ordinator was to carry out a 3-monthly Care Programme Approach (CPA) review which was to be submitted to the Joint Commissioning Team members.

2.3.5 A CPA pre-discharge meeting was held at the hospital in July 2018 shortly before Shannon was discharged from hospital and was attended by a representative from Oak House. Shannon’s consultant explained her diagnosis of Emotionally Unstable Personality Disorder and Asperger’s in detail and advised that she had been settled on the ward in recent months. It was confirmed that Shannon was to continue to be under the care of her community mental health team who would liaise with local mental health services. Her current medication and psychotherapy would also continue.

2.4 Placement at Oak House

2.4.1 After a series of visits and an overnight stay whilst under Section 3 (MHA), Shannon moved into Oak House in July 2018 **(24.07.18)** on a voluntary basis and she was adjudged to have full capacity to be making these decisions. Her clinical psychologist from the Solihull Enhanced Personality Disorder service, who had been working with Shannon whilst she was in hospital, visited her. Shannon described how she "tested staff" to see how they would respond to her needs, giving examples of times when she felt supported and times when she did not feel understood. With the help of Shannon, the psychologist provided detailed written information to staff at Oak House about how she would like them to respond to particular scenarios, her condition and any associated risks.

2.4.2 Shannon also discussed her alcohol misuse and agreed to self-refer to alcohol treatment and the contact details for the local alcohol treatment service, Cranstoun Sandwell, were provided.

2.4.3 Shannon began self-harming with a razor from the beginning of her placement and her wounds were mostly treated by nursing staff on-site without recourse to hospital. However, within 2 weeks, **(06.08.18)** Shannon had taken an overdose of mixed medications and gin after breaking into the family home and was assessed by Psychiatric Liaison at Birmingham Heartlands Hospital Emergency Department where she denied any further suicidal intent. She attended the hospital with her mother who alerted practitioners to her daughter's alcoholism although Shannon denied that she was an alcoholic currently and was reluctant to discuss that episode of self-harm further. Mental health practitioners were fully aware of Shannon's conditions and care plan but considered this presentation to be a relatively minor one and a discharge letter was sent to her GP by the hospital.

2.4.4 Solihull Enhanced Personality Disorder Pathway contacted Oak House to provide support after this incident and continued to support Shannon throughout her placement. A few days later, the GP Out of Hours service were called by Oak House as Shannon had drunk a small amount of window cleaner.

2.4.5 Later that month, **(21/08/2018)** Shannon attended her GP appointment, for a medication review, accompanied by a member of Oak House staff who was present throughout the consultation. This appointment was to follow up her recent overdose and to review pain relief medication as she was experiencing pain most days from inverted ankles and wrists and her chart showed that she was taking twice her prescribed dosage.[4] The GP advised that Shannon was at risk of becoming dependent on codeine and advised to reduce whilst finding

[4] Prescribed one tablet per day but taking one tablet twice daily

other strategies to help rather than resorting to analgesia. There was no active enquiry made with Shannon about her placement and general wellbeing, but Shannon was reported to be well kempt, articulate and engaging in her consultation. It did not appear that the GP updated the mental health team about the concerns over Shannon's risk of becoming dependent upon codeine. Three days later (**24/08/2018),** Shannon attended the Emergency Department again with self-harm lacerations to her arm.

2.4.6 The placement at Oak House was reviewed by the contract manager from the Joint Commissioning Team after Shannon had been resident for four weeks and a further contractual review scheduled for six months later. However, shortly afterwards, **(04/09/2018)** the Business Development Manager from Oak House contacted the duty social worker to discuss Shannon's needs for occupational therapy support as this was not being provided by the community mental health team as planned. The Business Development Manager sought a resolution as Oak House were providing free occupational therapy sessions to prevent Shannon having a mental health relapse. Moreover, the Business Development Manager advised that Shannon's mother and the social worker (SW1), who was not currently at work, had had a "private agreement" to assist her with financial costs for transport to visit her daughter which was not being honoured by the authority.

2.4.7 In the absence of the social worker (SW1), the case was allocated on the following day to a new social worker (SW2) who updated the support plan identifying that:

> *"Shannon has expressed a wish to move into supported accommodation with 1:1 support, attend courses for their personal development, continue with their artwork and maintain contact with her mother on a regular basis. Shannon would eventually like to move towards an independent life in the community and the ability to make choices and have control over their life. Shannon to have 24-hour support and supervision for their mental health needs. Shannon has a supportive mother and has a sister that understands [her] mental health needs. Shannon is currently seeing their mother twice a week. Shannon relies on [her mother] for support when attending appointments and discussing [her] mental health issues with other professionals. Shannon would struggle without the support."*

2.4.8 In the same week, Shannon was offered a place on the Dialectical Behavioural Therapy (DBT) Programme, which she had attended previously, and a meeting was held between Shannon, the psychologist and two members of Oak House staff to prepare for this. **(06.09.18)**

2.5 Escalating self-harm

2.5.1 On the following day, (**07/09/2018 – 08/09/2018),** Shannon attended Russell's Hall Hospital with her mother, following an attempt at deliberate self-harm through swallowing a razor blade. A full history was taken, and Shannon disclosed that she was not feeling suicidal. However, she declined to be seen by Psychiatric Liaison Team whilst in the Emergency Department, saying that she was already under mental health services and documentation provided no indication that she lacked capacity to make that decision. She was admitted to the surgical ward for removal of the razor blade and afterwards went on to self-discharge against medical advice. Her mother told staff she would accompany her home and a ward nurse telephoned Oak House to notify them of the self-discharge.

2.5.2 Although the GP was not alerted to the self-discharge, they were notified through their Out of Hours service about the incident stating:

> "*There is no safeguarding concern. Patient is currently in mental health rehabilitation centre and has access to razor blades. This has been risk assessed as being safe to have these."*

2.5.3 A few days later **(11/09/2018 – 14/09/2018),** Shannon was taken to Russell's Hall Hospital by ambulance again, after she had disclosed that she had swallowed a 3-inch screw. Oak House staff reported that Shannon had pulled her bedside table off the wall in order to access the screws and swallowed one intentionally. After being admitted, she tried to abscond from the ward, but nursing staff were able to persuade her to stay. Shannon's mother raised concerns that her behaviour was becoming a pattern and requested that her daughter be reviewed by the Psychiatric Liaison Team whilst an inpatient. A referral to Psychiatric Liaison Team was part of the medical plan but there was no record to suggest that she was seen by them. Shannon was discharged after an x-ray confirmed that the nail had progressed safely through her system and the GP was notified.

2.5.4 Four days later (**18/09/2018)** Shannon attended the Emergency Department of Solihull Hospital, accompanied by her mother, after swallowing a screw. She was given laxatives and discharged with a plan for her to return two days later for further x-rays. A discharge letter was sent to her GP.

2.5.5 Over the following week, the social worker (SW2) was able to establish from the care co-ordinator that the psychology sessions continued to be provided by Birmingham and Solihull Mental Health Trust even though Shannon was out of their area, in order to provide continuity, as it was felt that the placement would not be long term.

2.5.6 The social worker went on to discuss with Oak House the need for occupational therapy intervention. The manager (DM1) advised that most of their rehabilitation activities relied upon integrated occupational therapy, but

they had been told by the community mental health team that Shannon did not have a community occupational therapist nor would be provided with one. Significantly, the Oak House manager stated that Shannon needed the occupational therapy activities in order to be occupied and to prevent her from a high risk of self-harm and relapse. As result, the care co-ordinator was advised to present the rationale for funding occupational therapy to the funding panel.

2.5.7 Later in September (**26/09/2018)**, Birmingham City Council Adult Social Care received a Deprivation of Liberty Safeguards (DoLS) application from Oak House stating:

> *"Personality Disorder, high risk of self-harming, on 5 mins observation. Very restrictive regime in place".*

2.5.8 The following day, a Best Interests Assessor contacted the staff nurse from Oak House as there was no mention of Shannon's mental capacity in the DoLS application. The Best Interest Assessor determined that Shannon was not deprived of her liberty as she had capacity to make an informed decision about her care and accommodation. The staff nurse explained that there was a brief period of mental health decline, where it was felt that Shannon lacked capacity in this respect, but there were no current or ongoing concerns.

2.5.9 A review undertaken by the contract manager from the Joint Commissioning Team on the same day found deficits in the care plans in so far as they were not signed by staff and not evidencing client involvement in care plans or risk assessments. The contract manager found nothing recorded around observation levels in the care plan. These points were taken up with the manager and the contract manager also went on to argue for funding for the occupational input, at least in the short term, to support the development of Shannon's daily living skills.

2.5.10 In October, Shannon commenced her Dialectical Behavioural Therapy programme **(02.10.18)** where her self-harm was discussed but there were no acute concerns at this time. Shannon continued to attend weekly sessions over the coming months, taking the opportunity to disclose and explore her self-harming behaviours.

2.5.11 However, Shannon's significant self-harm continued, and she was taken by ambulance to the Minor Injuries Unit of Russell's Hall Hospital, with a member of staff from Oak House, after deliberately cutting her right forearm with a razor blade **(06/10/2018).** Shannon told staff that she had self-harmed when she felt low but did not wish to kill herself. The wounds required sutures and a follow-up Emergency Department clinic appointment was booked for three days' time, and she was discharged with the Oak House worker's support. She did not attend the Emergency Department for her wound review as planned and no action was taken to make contact with her or Oak House to understand why or

rearrange the appointment and the GP was not advised to take over her wound care.

2.6 3-month review of placement

2.6.1 Later that week, **(10/10/2018)** a review of Shannon's placement was completed at Oak House as planned, as Shannon had been resident for three months. It was arranged by the social worker and attended by Shannon and the staff nurse (SN2) and activity worker (AW1) from Oak House. Other partner agencies who were involved with Shannon's care, such as the care co-ordinator (CPN) and psychologist, did not appear to have invited as would have been expected. Neither did the follow up that had been undertaken by the Best Interest Assessor in relation to the recent DoLS review, appear to have been considered at this review.

2.6.2 During the review, Shannon reported that she was continuing to experience mood fluctuations and that her self-harm appeared to be triggered by small things and was related to her poor self-esteem, self-worth and lack of confidence. She gave examples of these triggers and the extent of her self-harm including those that required recent visits to hospital. The social worker advised Oak House staff that this provided evidence of Shannon's need for close supervision and monitoring; for sharp objects to be kept out of reach and for the on-site nurses to provide any immediate emergency medical assistance required. Staff reported that Shannon was on observations every 5 minutes and the social worker advised them to seek alternative professional support where necessary.

2.6.3 Shannon also took the opportunity to discuss how alcohol was a problem for her and can often trigger her to self-harm. She described wanting to give it up and wanted to explore the opportunity of having an alcohol service work with her. In other aspects Shannon recognised that her social anxiety was improving and that she was benefiting from participating in more activities. She hoped to do some voluntary work in a charity shop when her mental health stabilised. The social worker concluded that the current support plan was working well; recommended that Oak House were to access a local alcohol service; recommended a further review for a few months' time and advised that their ongoing social work involvement was likely to end.

2.6.4 **(12/10/2018)** When making enquiries about the funding for the mother's transport, the social worker (SW2) was advised by their supervisor that it would be expected that disability benefits would pay for this.

2.6.5 At the end of the month, Shannon's care co-ordinator visited her at Oak House and discussed her future plans with her. Shannon described how she was very

positive with Oak House and happy with the placement, despite becoming upset with other residents. However, the care co-ordinator was concerned that Shannon's care was becoming fragmented with her living out of area and planned to meet again one month later after talking with the social worker about plans for accommodation after the 6-month placement has ended. The care co-ordinator tried to contact the social worker, leaving a voice message but no communication was held.

2.6.6 During October, the GP received notifications and an update report from the community mental health team advising that Shannon had attended thirteen out of fifteen Dialectical Behaviour Therapy sessions.

2.6.7 At the beginning of November **(01-03/11/2018),** Shannon attended the walk-in clinic at Sandwell General Hospital accompanied by her support worker from Oak House. She reported having swallowed three razor blades but X-rays did not identify any immediate concerns. She was discharged and a follow-up arranged for two days later which she attended, and the GP was notified.

2.6.8 In mid-November **(16/11/2018),** Shannon was taken by ambulance to the Emergency Department of the same hospital following deliberate self-harm to her right leg which was sutured on admission. She was seen by Black Country Partnership's Mental Health Liaison Team and whilst she was initially reticent to engage, as she would normally speak with her Dialectical Behavioural Therapist, the nurse was able to engage with her.

2.6.9 Shannon described her history and her services and stated that she self-harmed on a daily basis. She explained that her self-harm that day was prompted by her anxiety due to a noisy Children In Need party at Oak House and that she was irritated with herself as she had not planned to cut herself so deeply. She went on to describe how she enjoyed being at Oak House, undertaking structured activities and being supported with shopping and food preparation, and that she found it helpful. She denied any suicidal intent and was future focussed, making plans with staff from Oak House to undertake some volunteer work. Staff at Oak House were contacted for the context to Shannon's self-harm and medication compliance to be checked. Shannon wanted to stay with her mother that evening and the Emergency Department contacted both Oak House and her mother to check that they were both happy with the plan. The nurse was aware that Shannon was under the care of the community mental health team and the GP was notified.

2.6.10 In the following week **(22.11.18)**, Shannon met with a locum GP accompanied by a support worker from Oak House in relation to the laceration from self-harm to her right lower leg, two days prior, and a review of medication was undertaken at the same time. There is no documentation about her wellbeing and mental state at that time.

2.6.11 Following attempts earlier in the month to contact the social worker about concerns over the fragmentation of Shannon's care, the care-coordinator

contacted Shannon to arrange to see her away from Oak House, but she was told by staff that Shannon would not come to the phone **(29.11.18).** Following this up, the care co-ordinator thereafter contacted Oak House for an update **(11.12.2018)** but no-one was available to come to the phone. The care co-ordinator understood that Oak House had agreed to send a log of Shannon's self-harms to them, but this was not received.

2.6.12 At the end of the month, Shannon attended the GP practice with a (named) support worker from Oak House following further self-harm and lacerations to her leg. She was treated by a locum GP with antibiotics and her overall medication reviewed. This was the last time that the GP Practice had contact with Shannon, although they were later called upon by Oak House to increase her medication for anxiety[5] as she was becoming more agitated.

2.7 Increasing anxiety and self-harm

2.7.1 As December progressed, Shannon stopped her regular attendance at her weekly Dialectical Behaviour Therapy sessions and was taken to Birmingham Heartlands Hospital (**12/12/2018)** having taken an overdose of her mother's medication. A mental health assessment was completed by the mental health liaison team where she denied wanting to end her life. Although she would not engage with the mental health liaison team, she was considered to have mental capacity to make informed decisions and was discharged back to the care of Oak House and the GP was notified. After this incident, Shannon's care co-ordinator contacted Oak House staff and advised that she wanted to see Shannon and make arrangements for more regular contact. Thereafter Shannon's attendance in therapy improved.

2.7.2 On New Year's Eve 2018, the Ambulance Service responded to a 999 call from Oak House as staff were unsure of how to handle Shannon's behaviour. She had been out drinking alcohol, returned to the unit drunk and started to act erratically. She had made herself sick and then lay on the floor and was poorly responsive. Shannon refused any observations and became aggressive to the attending clinicians, reportedly threatening one with a razor blade, and had to be restrained by Oak House staff. The ambulance clinicians concluded that there was no medical need for their service and felt that she was in a place of safety with staff that knew her. They provided advice on sobering Shannon, removing sharp objects, letting her calm down and contacting the mental health crisis team or GP if required. Oak House staff

[5] Lorezapam increased from 1mg to 2mg in split doses

were dissatisfied with this response and refused to sign the Ambulance Service paperwork and sent Shannon to her mother's home in a taxi.

2.7.3 After this incident, Shannon's mother tried to contact the social worker to find that they had left the post and there was no replacement. She then contacted the care co-ordinator expressing concerns about the increase in her daughter's self-harm and with worries that Oak House were not managing the risk very well, recounting the experiences of New Year's Eve. A review of the placement was to be arranged.

2.7.4 One week later **(07/01/2019)**, a third social worker was charged with undertaking a review of the placement. This social worker contacted Shannon's mother and discussed her concerns over the difficulties over transport in terms of both cost and her own disability. Shannon's mother thought that her daughter would like to move back to Birmingham and the social worker agreed to undertake a review in liaison with Shannon and her care co-ordinator.

2.7.5 In the meantime, because Shannon had complained that she was distressed by the noise levels in her room, she was moved to a room on the first floor and was reportedly pleased with the move.

2.7.6 The following day **(08/01/2019)**, Shannon met with the Dialectical Behaviour Therapy Nurse who did not perceive any concerns regarding Shannon's mental health and Shannon denied any suicidal intent. The care co-ordinator also met with Shannon that day along with her mother and discussed moving accommodation nearer to the family home. Shannon reported that there were inconsistences with staff approaches and standard procedures at Oak House. She recounted feeling alarmed that she wasn't searched on her return to the unit as she had managed to bring large quantities of alcohol back into the unit. She also recounted that some staff escalate her behaviour when they make comments such as "not again [Shannon]" when she self-harms.

2.7.7 The care co-ordinator committed to contact Oak House concerning the feedback, which was done on the following afternoon. Oak House staff explained that they searched Shannon's bag on her return to the unit, but that Shannon was hiding alcohol in places that they could not access, such as down her trousers. The care co-ordinator contacted Adult Social Care to seek accommodation options nearer to the family home and Oak House staff made an appointment for Shannon to attend alcohol treatment services at the end of the month.

2.8 The day of her death

2.8.1 On the following day (**09/01/2019**), which was the day of her death, Shannon had been on a supervised shopping trip to Poundland and by 17:00hrs was colouring in the communal area and presented as bright in mood.

2.8.2 At 17:55hrs, a support worker undertook a routine observation under the 5-minute observation regime that had been implemented.

2.8.3 A change of shift of support workers took place at 18:00hrs and no observation was undertaken of Shannon at 18:00hrs as planned. The support worker stated that they had come onto the shift and undertaken observations on the ground floor before arriving at Shannon's bedroom at 18:05 to see her with a ligature around her neck. This was in full view of the bedroom window and the support worker raised the alarm. The review noted that the observation log appeared to have been corrected to state that observations had been undertaken by staff at both 18:00 and 18:05 and discrepancies over the exact timings of the sequence of events at Oak House at this time, have not been resolved.

2.8.4 Staff reportedly panicked and summoned the qualified nurse in charge who removed the ligature using the ligature cutters attached to her belt. The nurse commenced CPR and advised staff to call for an ambulance.

2.8.5 At 18.09, the support worker entered observation notes but did not refer to the incident.

2.8.6 At 18:17, a 999 call was received by Ambulance Services, and paramedics arrived at the scene at 18:26. Cardiopulmonary resuscitation (CPR) was administered, and a second ambulance crew arrived one minute later.

2.8.7 When asked by the paramedic, the nurse was unsure of what time Shannon had last been seen alive, at first stating that she had not been seen for half an hour but would check with colleagues.

2.8.8 Despite attempts at advanced life support, Shannon was pronounced deceased at 18:54.

2.8.9 The health and fitness tracker which Shannon was wearing at the time of her death, together with her electronic tablet which linked to the tracker, and which would have been able to corroborate the time of death, later went missing and have not been found since. The room in which Shannon had died, was not kept locked as requested and the police investigation considered that it was during this time that said items, along with her bank card, went missing. The police were unable to identify the source of the apparent theft.

3 Analysis

3.1 Each of the organisations involved with Shannon reflected upon the services that they provided and, with the exception of Camino Healthcare Limited, discussed their analysis with the review panel. The major organisations are represented below.

3.2 Birmingham and Solihull Mental Health NHS Foundation Trust

3.2.1 Shannon had been under the care of the community mental health team almost continuously since her transition from youth services in 2012. During this time, she had been discharged only for a brief period of three months when she went to university.

3.2.2 Her care was managed under the Care Programme Approach (CPA). As such, she was allocated a care co-ordinator, with whom she met on a monthly basis and her case was periodically reviewed by a consultant psychiatrist. Shannon was involved in choosing the type, duration and intensity of her therapy. Her care package after discharge from inpatient services went on to include Dialectical Behavioural Therapy, for individual and group work, as well as the support of the Solihull Enhanced Personality Disorder service. Shannon had a person-centred risk assessment in place that was produced with her involvement and which reflected identified risks and a clear formulation that was reflected in her care plan.

3.2.3 After a placement was found for her out of area, the decision by the Trust to maintain the continuity of her care and support within their community mental health team was seen as a compassionate decision which recognised Shannon's anxiety about forming relationships with a new team and the consequential loss of her Dialectical Behavioural Treatment which she valued. It was also made within the context of the Trust's understanding that the placement of the supported accommodation was only to be relatively short-term as preparation her for the long-term plan of her living independently and close in distance to her mother. It was not the understanding of the Trust that Oak House would be providing care and treatment for her mental health issues and there was no shared care agreement with them in this regard.

3.2.4 Nonetheless, in order to prepare Oak House staff for the placement, they invited the clinical lead to make an assessment on the ward and the key worker to attend the pre-discharge meeting where the consultant discussed Shannon's condition and associated risks. Thereafter, the Enhanced Personality Disorder service provided Oak House staff with support and liaison as well as an introductory report on her condition and associated risks

and provided a training session to enable staff to provide daily living support. In this way, they considered that they had provided good pre-discharge and risk information and support.

3.2.5 Although the matter of sharing case and medical records was raised by the coroner,[6] the Trust felt that there was no question about sharing Shannon's records beyond what had been shared: there had been no request to do so and there was no shared care arrangement which would have indicated that this was necessary. However, in the future the Trust will ensure that in all complex cases, as well as providing a detailed handover, that they will respond to any requests from the placement concerning sharing certain records, with the service user's consent, in order to ensure that they have any necessary, proportionate information.

3.2.6 Consideration was given to the Trust's response to the out-of-area nature of the placement and considered that the Solihull Enhanced Personality Disorder pathway was established to provide support to carers and service users for out-of-area placements. The IMR author saw no gaps or deficits in their response recognising it be a short-term placement in an adjacent area.

3.2.7 The Trust considered that they had maintained good engagement with Shannon and applied a risk enablement approach: empowering, supporting and encouraging her to take responsibility for her self-harming actions and incorporating this into her care planning. Recognising that she may have fluctuating capacity and impulsivity when under the influence of alcohol, mental health practitioners encouraged her to engage with alcohol treatment services and supported Oak House to provide support and advice in developing boundaries and a consistent approach around her alcohol misuse.

3.2.8 The Trust considered that Shannon's mother was involved and engaged in key decisions about her daughter's care, and confident to raise concerns with them. This was evident when, in the final days, Shannon's mother contacted the care co-ordinator about her concerns around Oak House and was responded to promptly with a joint visit with her daughter.

3.2.9 However, whilst there was record of her mother being referred to the local carer's group, they were unable to find record of her being offered a carer's assessment in order that her voice, concerns and own needs could be formally expressed. Since this time, the Trust has developed a new Family and Carer Strategy (2019-2022) which requires that a family and carer pathway be embedded alongside training and support to clinical teams and the introduction of a Carer's Engagement Tool. Each of these aspects of the strategy will embed the need for effective, positive engagement with families

[6] The coroner provided Birmingham and Solihull Mental Health Trust with a Regulation 48 Report on Action to Prevent Future Deaths

and carers, ensure the carer's own needs can be articulated, met and reviewed and highlight if a statutory carers assessment should be offered.

3.3 Birmingham City Council Adult Social Care

3.3.1 Adult Social Care's role was initially to support Shannon's discharge from hospital and thereafter to support and co-ordinate her aftercare in the community. Shannon was entitled to aftercare services under Section 117. How effectively agencies worked together to meet their responsibilities under the Act will be considered in the thematic section which follows. However, this section will consider the specific role of the social work service.

3.3.2 After the social worker (SW1) supported Shannon in her move to Oak House, there was a ten-week absence of intervention by social work services between June and September 2018 as a result of that social worker's absence. This was not addressed until prompted by Oak House enquiring about funding agreements over occupational therapy services and represented a lack of continuity in her support. It was recognised by the local authority that in these circumstances, that the same social worker would normally retain the case until the first review and where there is long term sickness, that the case should have been re-allocated by a senior practitioner. We shall see how the revised multi-agency memorandum of understanding has introduced prescribed processes covering discharge from hospital and the local authority in turn has strengthened its internal processes.

3.3.3 Despite making references to it, social workers did not appear to have a copy of the Section 117 aftercare plan, and it was not evident that they had an understanding of the broad application of what constituted aftercare, as indicated by the Care Act 2014. For example, being accommodated out of the area meant that the significant cost of travel for Shannon's disabled mother to be able to visit her regularly was difficult for her. Staff incorrectly advised Shannon that Adult Social Care was not able to pay for travel costs despite this having been indicated previously.

3.3.4 Whilst social workers contacted Shannon's family and mental health services at times to ensure a joined-up approach to her care, it would have been expected that more parties would have been involved in her reviews. For example, the social worker (SW2) undertook a review of Shannon's placement in October 2018 but did not appear to have invited other partners, including the care co-ordinator and psychologist who were intrinsically involved in Shannon's care, or the GP, and despite the Joint Commissioning Team tasking the care co-ordinator to undertake 3-monthly CPA reviews. As a result, Adult Social Care has committed to increase staff understanding of

Section 117 aftercare responsibilities and the processes and recording requirements which need to underpin it. The multi-agency recommendations around Section 117 aftercare plans which follow, will also apply to this service.

3.3.5 After the first 3-monthly review, the social worker recommended that the case be re-allocated for a review which was due in a few months' time. Although this transfer of a case was seen to be relatively common practice when a review was due relatively soon, it was considered that in view of the complexity of Shannon's needs, coupled with her difficulties with social interaction, that Shannon would have benefited from a continuity of professional support. This decision appeared to have been the result of an inadequate review and a lack of understanding of the appropriateness of the placement for the staff involved. Indeed, at this 3-month review the social worker was advised that Shannon was subject to 5-minute observations, having been advised that this was a possibility at the outset. This should have prompted the social worker to question whether this setting was suitable for this level of supervision and highlights the need to undertake joint assessments, a factor which is now included in the S117 memorandum of understanding between the local authority and health services.

Learning Point: Section 117 assessments and reviews should be multi-agency and benefit from shared expertise and co-ordination.

Learning Point: No worker should complete an assessment that they do not feel qualified for.

3.3.6 The suitability of the placement from a multi-agency perspective is considered further in the thematic section which follows.

3.4 Black Country Partnership NHS Foundation Trust

3.4.1 Through the Mental Health Liaison Service, the Trust provided a nurse-led, mental health assessment and signposting service attached to Sandwell General Hospital. Whilst staff undertake joint working with colleagues in the hospital, they are also required to undertake autonomous assessments.

3.4.2 Shannon was only referred to the Mental Health Liaison Service on one occasion, in November 2018, and she was seen by a registered mental health nurse. There were no issues identified during the psycho-social assessment by the mental health nurse which was recovery focussed. The nurse also acted in accordance with NICE guidelines by involving Shannon in the decision being made regarding her management plan. Risk management

was undertaken in relation to taking a mental health history and in liaison with Oak House and Shannon's mother and the community mental health team were notified of the incident and assessment.

3.4.3 However, consideration did not appear to have been given to seeing Shannon on her own without the support worker present and in the intervening period, the Trust has undertaken a widespread developmental programme order to promote professional curiosity amongst practitioners.

3.4.4 Also since this time, the service has become 24 hour which ensures continuity in the assessment and management of individuals referred from the acute hospital.

3.5 Dudley Group NHS Foundation Trust

3.5.1 Shannon attended the Russell's Hall Hospital Emergency Department as a result of deliberate self-harm on 3 occasions over the course of a month in Autumn 2018. She was accompanied each time by a carer from Oak House and her mother. Two of these attendances also required inpatient treatment and observation under the surgical team and she did not attend the follow-up appointment for wound care at the end of this period. The Trust has recognised that on each occasion, there were missed opportunities to recognise, act upon and document any potential safeguarding concerns and to effectively hear Shannon's voice.

3.5.2 In respect of safeguarding, there were missed opportunities to exercise professional curiosity as to how Shannon could self-harm three times within a month, whilst staying at Oak House, and have access to the items that could cause harm such as screws and razor blades. Professional curiosity could have been exercised to contact Oak House to ascertain the exact support Shannon was receiving and if this was sufficient as well as raise concerns with her GP, her allocated mental health practitioner and Adult Social Care, as needed.

3.5.3 Although there was clearly rigour in obtaining a history from Shannon and evidence that she was asked about her self-harm and her suicidal intent, the Trust recognised that Shannon provided only superficial explanations. Thereafter there was no apparent professional curiosity to probe further despite Shannon's mother raising her concerns about the pattern of self-harm that was emerging.

3.5.4 The Trust could not account for why Shannon was not referred to the Psychiatric Liaison Team on her second attendance, as agreed, or why the medical plan was not followed prior to discharge and concluded that this was an oversight by the medical and nursing team on the following day. Although Shannon was not referred again to psychiatric liaison on the third occasion,

the Trust did not consider that this lack of referral was a recurring theme in the Emergency Department but likely to be because practitioners believed Shannon was in receipt of specialist mental health support at Oak House which was variously described in notes as residential and rehabilitation care interchangeably.

3.5.5 Once on the surgical ward there was no documentation to suggest that any further action, consideration or support were offered to Shannon in relation to her mental health needs prior to her self-discharge against medical advice. It was unclear if the decision to self-discharge was discussed with a medical professional; whether any follow-up was required; why Shannon wished to leave or if there were any doubts about her capacity to make the decision, although her lack of capacity was not indicated. There were also no details about whether red-flags or safety net advice were provided; whether the GP was notified of her self-discharge and no incident report was completed in line with their self-discharge policy.

3.5.6 When Shannon did not attend her appointment at the Emergency Department for a review of her sutures, the Trust recognised that more should have been done to understand the reason for her non-attendance, offer an alternative appointment or notify the GP to follow-up with Shannon in the community.

3.5.7 As a result, the Trust has made recommendations:

- to raise awareness of potential signs of neglect of adults who self-harm in a care and residential setting and
- to raise awareness of Making Safeguarding Personal and professional curiosity.

3.5.8 The Trust's 'Discharge Against Medical Advice Policy' is currently being updated and therefore the Trust is asked:

- To provide assurance to Sandwell Safeguarding Adults Board on the effectiveness of the updated 'Discharge Against Medical Advice Policy' in respect of responsibilities to assess mental capacity, to complete an incident report and/or take action to safeguard an individual where required.

3.5.9 The Trust's 'Patient Access Policy' has since been updated and the Trust is asked:

- To provide assurance to Sandwell Safeguarding Adults Board on the effectiveness of the updated Patient Access Policy in enabling staff to consider safeguarding of adult who do not attend particularly if they have care and support needs including mental health issues or for those living in a care or nursing home.

3.6 General Practice

3.6.1 The GP Practice received several discharge letters from the hospitals and Ambulance Service concerning Shannon's self-harm. They also received updates from mental health services regarding her care. However, during the period within scope, GPs only met with her twice and she was accompanied by a support worker from Oak House each time. It was not clear to the review whether it was appropriate to have the support worker present throughout the consultation, particularly on her second visit which was both a medication review and a follow-up to her self-harm. It was not known whether she was asked whether she wanted the support worker present or whether the role and the position of the support worker was understood. The Practice was therefore asked to reflect upon its practice of seeing patients on their own for at least part of a consultation when accompanied by carers.

3.6.2 Despite the notifications on file regarding her self-harm, it did not appear that active enquiry was made about her current placement and general wellbeing nor about the self-harm which was bringing her to the attention of hospital and ambulance staff.

3.6.3 Shannon was not identified by the GP Practice as a vulnerable person. As a result, she did not benefit from being discussed at the multi-disciplinary team meetings and she was not allocated a named GP. No single GP in her practice was responsible for oversight of her care. At the same time, the practice was not invited to meetings regarding discharge or review nor alerted to any safeguarding concerns.

3.6.4 The Practice maintained Shannon's registration despite her being accommodated out of their catchment area, seemingly because they considered that they knew her history well and her placement being temporary. The review considered whether it would have been helpful to register Shannon with a GP within her new catchment area. Whilst in this case the advantage was not evident, a learning point for future practice was deemed helpful.

Learning Point: GPs to consider re-registration with local GPs when patients move into placements across boundaries.

3.7 Sandwell and West Birmingham NHS Foundation Trust

3.7.1 During the period under consideration, Shannon attended the Emergency Department at Sandwell General Hospital on five occasions and went onto to the Surgical Assessment Unit once. On each of these occasions she presented with self-harm and the severity of her self-harm increased over

time. They were not aware of her diagnosis of Asperger's throughout these presentations.

3.7.2 The Trust reflected that in earlier attendances there had been a focus on her medical needs and that professional curiosity was lacking about her reasons for self-harming. There was indication that the carers who accompanied her were spoken with and it was not until the last admission, in November 2018, that staff followed the self-harm policy; referred her for a mental health assessment; undertook a risk assessment; asked her what she wanted to do and spoke with her family and Oak House about her safety on discharge. During the timing of previous presentations, the mental health liaison service was not available as it has only since become a 24-hour service.

3.7.3 The Trust considered that there had been missed opportunities through a lack of professional curiosity over the context of Shannon's self-harm and why she was continuing to self-harm. Although the fact that Shannon attending with a member of staff from a mental health rehabilitation centre may have implied that her mental health needs were being addressed and she was being discharged to a safe place, the escalation of her self-harm; her level of supervision and her access to items with which to self-harm in a mental health placement was not questioned. Given her increasing risk of harm, they recognised that a safeguarding referral should have been made. It was also noted that Shannon's mental capacity was assumed despite her behaviour deteriorating on one occasion.

3.7.4 The Trust reflected that their understanding and response to learning disability had developed significantly in the intervening time and much work had gone into staff awareness of the identification of learning disability. Nonetheless, they have made recommendations for the Trust to raise awareness amongst their workforce of the mental health needs of vulnerable patients; to raise awareness around Mental Capacity Act and of the need to make reasonable adjustments for Learning Disabled patients. At the same time, they have recognised the need to enable greater professional curiosity amongst staff and awareness of Making Safeguarding Personal.

3.8 University Hospitals Birmingham

3.8.1 During the period in scope for this review Shannon attended the Emergency Departments of this Trust on five occasions: four times at Birmingham Heartlands Hospital and once at Solihull. She attended with her mother on each occasion and her mother's presence was viewed as supportive and a protective factor for Shannon. In the first three attendances, Shannon was under a section and attended with a carer from the mental health secure hospital.

3.8.2 The main focus of care on all attendances was the acute medical management of symptoms caused by Shannon's self-harm. Practitioners were aware of her past medical history and sought to engage Shannon in conversation about her self-harm but were unable to meaningfully engage with her. This was exacerbated by the short timescales that Shannon was in the hospital, together with the busy and noisy environment. However, they referred to psychiatric liaison staff on sight on two occasions where their concerns over her safety and well-being continued.

3.8.3 Although practitioners were aware of her residence at the time of attendance, there was no evidence of any discussions, with Shannon or her mother, regarding the health care setting where she lived or any concerns she may have had. It did not appear to have been acknowledged by staff that each of her attendances occurred following self-harming behaviour at the family home rather than in the residential setting and the Trust considered that there had been missed opportunities to consider the factors exacerbating her stress at these times. Whilst tools for the assessment of self-harm were used, it was considered that this should have led to more probing questions concerning the cause of self-harm and why she had left the residential settings at times against the care plan agreement.

3.8.4 Although it was documented that Shannon's mental capacity was accepted on all of her attendances, there is no evidence to suggest that a formal capacity assessment was considered in relation to her understanding of the risks and ramifications of her actions in terms of self-harm on her health and well-being. This would have been an opportunity to look at risk enablement: protecting Shannon from harm whilst allowing her to make her own choices and decisions.

3.8.5 Notwithstanding the pressures of working within the Emergency Department, it was recognised that further enquiry and liaison with Shannon's mother, other professionals involved in her care and with the residential setting directly could have enabled a review of her care plan as well as further consideration of the role that alcohol played within her self-harm and referral to services for support. As a result, the Trust has committed to:

- Review the training for Emergency Department and AMU staff to ensure that staff recognise and understand when to raise a safeguarding concern
- Review NICE guidelines regarding self-harm guidance for Emergency Department staff to ensure best practice
- Promote the self-harm policy/enhanced observation policy and associated assessments
- Review the need for providing a 1:1 conversation with patients with learning disabilities who self-harm and provide the opportunity to be seen alone to discuss any issues or concerns they may have.

3.8.6 Since this time, the Trust has introduced a new dedicated Vulnerabilities Team with a lead nurse and a named nurse for learning disability and established a Mental Capacity Act and Mental Health Steering Group. New detailed policies and procedures have been introduced trust-wide that include a learning disability passport, supported by training to raise awareness and support the roles and responsibilities of practitioners in caring for patients with learning disability and autism.

3.9 Camino Healthcare Limited

3.9.1 Despite repeated requests, Camino Healthcare Limited declined to complete a full Individual Management Review which would have enabled a focussed analysis in line with the terms of reference of this review. Instead, a partial and limited response to targeted questions was provided by their solicitors to questions asked by this review panel. As such, the analysis of their interventions is not complete but elicited from their solicitor's response; their Serious Incident (STEIS) report; Oak House staff's verbal testimony provided to the inquest and the judgement of the coroner.

3.9.2 We have seen that Camino Healthcare Limited described Oak House as providing:

> *"… residential accommodation and support for up to 16 adults with mental health needs. The service supports individuals on their recovery pathway and specialises in individuals who have a primary diagnosis of mental disorder or mild learning disability. The service has access to a multidisciplinary team to provide recovery focused support towards independent living."*

3.9.3 The STEIS Report concluded that "the service at Oak House is a Residential Home with nursing care and is not a hospital environment. It is clear from the complex case review that the clinical decision to not place [Shannon] in a hospital environment with physical and relational security was a complex one." (2019:23). Notwithstanding this, Oak House had a responsibility to undertake a robust assessment of the suitability of their unit for Shannon at that time.

Pre-Assessment

3.9.4 Before Oak House was accepted as a suitable placement for Shannon's rehabilitation and for her transition to independent living, Oak House provided assurance to the commissioners that they were able to manage Shannon's risks. The review therefore requested that Camino Healthcare Limited

analyse the effectiveness of the pre-assessment process that enabled that assurance to be given.

3.9.5 It was Camino Healthcare Limited's contention that, with "multi-agency involvement, that risks could be managed in supporting [Shannon] to recovery" (STEIS, 2019:25). However, they felt that they had been provided with insufficient information to enable them to effectively assess the level of Shannon's risks and needs. Their STEIS report advised that Oak House had followed its Pre-Admission Admission Policies (2019:25) but the unit was not set up to deal with personality disorder and the strict management of boundaries that they considered that this entailed. They recognised that staff had neither specialist training nor experience in dealing with personality disorder (2019:24).

3.9.6 Whilst Shannon's full file containing personal information had not been shared with Oak House, and this issue will be considered later in the report,[7] a social care assessment was shared with them. It appeared most likely that this was the Adult Social Care Needs Assessment, which contained diagnoses of Shannon's Emotionally Unstable Personality Disorder and Asperger's Syndrome, together with details of her regular and unpredictable self-harm through razors, ligatures and overdoses.

3.9.7 Oak House were also aware that Shannon would continue to be treated under the Solihull Enhanced Personality Disorder pathway and that these plans were in place prior to her discharge from hospital. It was therefore evident that Oak House had been made aware of the full extent of Shannon's diagnosis including her personality disorder before they agreed on her placement with them.

3.9.8 It was also noted that in preparation for Shannon's placement, the Oak House manager attended the multi-disciplinary team meeting and assessed Shannon as having "a high risk of self-harm and reported to regularly self-harm using razors, ligatures and overdoses" (Oak House Manager, 19/06/2018). In this way, it is evidenced that the level of risk that Shannon faced was known at the outset, and, as a result, the coroner concluded that Camino Healthcare Limited should review their policy in determining which patients they should admit as part of their pre-assessment process, and they committed in the STEIS report to:

- Develop clear exclusion criteria in relation to referrals and potential admissions.

[7] The matter of whether mental health services should share a patient's full file with a rehabilitation placement is addressed further in the report.

Managing risks

3.9.9 Having determined that Shannon's diagnoses and risks were known at the time before offering her a placement, the review went on to consider how Oak House managed those risks and worked with other agencies to manage and escalate risk concerns.

3.9.10 The nature and potential triggers of risk were documented at the outset in Oak House records that Shannon "…self-harmed to test boundaries and protocols. Including attempting to bring razors and alcohol onto wards or tying ligatures close to when she would be checked by staff conducting observations" (STEISS Report, 2019). As the placement continued, the coroner observed that there had been an escalating risk of use of ligatures and incidents of self-harm.

3.9.11 Shannon regularly self-harmed with ligatures whilst at Oak House. However, it did not appear that the room had been assessed for ligature risks. Indeed, pictorial evidence from the scene of the tragic incident demonstrated potential ligature risks being available. There did not appear to have been measures put in place to provide a ligature free environment despite their Ligature Risk and Management Policy (Section 4) requiring that a risk management plan containing ligature risks needs to be implemented.

3.9.12 In the final incident, staff did not appear to have ready access to ligature cutters and had to wait for the nurse in charge to arrive, as the only person on the premises with this equipment, which was carried upon their person. This led Camino Healthcare Limited to make the following recommendations:

- Access to ligature cutters should be available to all staff in a timely manner in the event of an emergency.
- A ligature audit should be carried out on the environment and reviewed annually or more frequently when required.

3.9.13 In addition, the review would also recommend that:

- if Camino Healthcare Limited accept service users with risks of self-harm, staff should be sufficiently trained in rescue from ligature, the use of ligature cutters and in the application of the policy and audit function around ligature.

3.9.14 Camino Healthcare Limited have advised the coroner that "changes were made to make the environment anti-ligature as far as is reasonably practicable" (Camino Healthcare Limited, undated).

5-minute observation regime

3.9.15 The Oak House Manager informed the inquest that it was standard practice for all new residents to be subject to 15-minute observation checks for the first three days of their placement. However, shortly after Shannon's placement started, Oak House initiated a 5-minute observation regime. The review has not been given the opportunity to consider the organisation's Therapeutic Observation Policy, if indeed one was applicable in this type of residential setting. However, the panel observed that:

- The intensity of 5-minute observation regime is more akin to an acute in-patient experience rather than a residential setting.
- As a result of various serious case reviews, 5-minute observations are not generally recommended even in acute in-patient settings where a risk higher than intermittent observations every 15 to 30-minutes (usually referred to as Level 2 observations) would normally warrant one-to-one continuous observations (usually referred to as Level 3 observations).
- The panel were not made aware of any written risk formulation that led to this intrusive observation regime.
- Neither the regime nor the risk assessment which led to it were shared with mental health services. Only the social worker was made aware of the observation regime.
- It appears that this ill-conceived 5-minute observation regime was not itself observed on the tragic night in question. The Oak House Support Worker advised that it was difficult to manage 5-minute observations for both Shannon and another resident who was on a different floor. The fatal incident is considered further below.

3.9.16 The STEIS Report considered that "a person-centred risk assessment in place that had been produced with the full involvement of [Shannon] and those involved in her care" (2019:22). However, in the absence of an explanatory Individual Management Review, it must be questioned how Oak House considered that they could responsibly manage risk at the level they considered Shannon to face, and there was no evidence provided to the review that the level of these concerns over risk were escalated through the multi-disciplinary team.

Testing Boundaries

3.9.17 Oak House were aware from the start of Shannon's placement that she would use self-harm as a means of testing boundaries, and it was recognised that staff were not trained or experienced in managing this level of complexity. Shannon often expressed her concern that Oak House staff were not observing her need for tight boundaries as they were not stopping her from bringing alcohol into the unit and mental health services fed back these concerns to Oak House. An agreement had been reached with Shannon that Oak House staff would search her bags for alcohol and blades each time she returned to the unit. However, it was evident that, at times, Shannon, would go to some lengths to test boundaries, such as hiding alcohol on her person, where staff were unable to search, and that this provided a difficult challenge for Oak House. However, testing staff boundaries within the context of the observation regime is considered further below.

Fluctuating Capacity

3.9.18 The panel identified that Shannon's frequent alcohol use meant that she had a greater disposition to self-harm. Alcohol use also impaired her ability to look after herself and gave rise to the potential for self-neglect. However, it was not always apparent that Oak House staff, who were more exposed to Shannon's alcohol use than other agencies, considered undertaking Mental Capacity Assessments to address her fluctuating capacity. This issue is considered further in the thematic section which follows.

Sharing Information

3.9.19 The STEIS Report recognised that "it was not always clear from the records how well the team updated the local safeguarding team following incidents that required medical attention" (2019:25) and made recommendations for Camino Healthcare Limited to strengthen their record keeping in this regard. In addition, mental health services did not appear to receive regular information from Oak House about the extent of Shannon's self-harming behaviour, particularly at those times when she did not go to hospital.

3.9.20 During Shannon's placement at Oak House, it was recorded that they intervened when she self-harmed on 48 occasions, and 43 of those were managed without recourse to hospital. In November 2018, the care co-ordinator asked Oak House for a log of self-harming incidents, but none was received from them. Significantly, the care co-ordinator advised that they

were not informed by Oak House about the incident on 31.12.2018 when Shannon was drunk, assaulted a paramedic and Oak House staff were unsure of how to deal with her. In this way, it did not appear that mental health services had been furnished with sufficient information with which to identify the deterioration in Shannon's well-being.

The Fatal Incident

3.9.21 We have seen that Oak House were aware that Shannon would self-harm or ligature just before she knew that she would be checked by staff and that this pattern of behaviour continued at Oak House. The STEIS Report recognised that "the fatal incident of ligaturing was done in full view of the bedroom window ensuring any passing staff or residents would observe her, and she would be checked within the next 5 min..." (2019:27).

3.9.22 The chronology above reflects that the timings of events of events on 09.01.19 remain unclear. The inquest determined that the scheduled observation at 18:00 did not take place. In the absence of an IMR, the review was unable to establish with certainty what time staff undertook the next observation as there is information which appears contradictory: notes on Shannon were input at 18.09hrs to state no concerns but testimony to the inquest stated that she was found ligatured at 18:05hrs. Significantly, the review was unable to establish why there was a delay of at least 12 minutes in calling for an ambulance.

3.9.23 Evidence emerged during the inquest that there had been minimal training for Oak House staff in performing resuscitation on patients. The training received included general first aid training by e-learning. It was recommended that:

- first aid training should be provided to all staff and that this should include CPR training.

3.9.24 Camino Healthcare Limited have since assured the coroner that this has been done.

Deprivation of Liberty

3.9.25 On two occasions, Deprivation of Liberty Safeguards (DoLS) forms were submitted for occasions when Shannon was seen to temporarily lose capacity. On one occasion in September 2018, Shannon had become distraught following the bereavement of her father and her mental health had

suddenly deteriorated. It was not known why mental health services were not contacted for a Mental Health Act assessment.

Rehabilitation

3.9.26 Whilst the acceptance of a placement for which they unprepared and untrained had a manifest impact on the risks that Shannon faced, it was also seen to have an impact upon her rehabilitation. Oak House were contracted to prepare Shannon for independent living. By taking on a greater role in her care, it appeared that Oak House may have inadvertently undermined steps aimed at optimising her independence and self-reliance.

Recommendations for Camino Healthcare Limited

3.9.27 Shannon had some ambivalence towards her placement at Oak House: at times she reported that she liked the unit and staff were working well with her, and at other times she felt a deficit in their supervision of her behaviour. It was evident that staff were often doing their best but lacked the training and structure to deliver the expected standards of practice: they were unable to keep Shannon safe and were not alerting other agencies that they were unable to cope. Camino Healthcare Limited responded to the Regulation 28 Report to Prevent Future Deaths, issued by the coroner, by advising:

- that Oak House was closing
- that the staff and structures of the organisation had changed
- that clear communication is maintained with outside agencies
- that, where necessary, that issues are escalated to appropriate teams
- that intensive life support and basic first aid training has been undertaken
- that ligature risk assessment was undertaken immediately of the premises following the death.

3.9.28 Whilst Oak House has since closed, Camino Healthcare Limited retains two other establishments in other areas and the following recommendations over their practice at Oak House have been made to assist with their learning and to improve practice in the future:

- To provide assurance that they are able to manage the risks that patients face and systematically escalate their concerns to the relevant multi-agency team when they are not able to safely manage their care.
- To provide assurance that observation regimes are consistent with the expected level of care and support that is commissioned and do not breach deprivation of liberty safeguards.

- To introduce a clear admissions policy and procedure which involves a written plan of how they will meet the needs and risks faced by the individual; the responsibility of all parties; details of escalation policy.
- To provide assurance that staff are skilled, knowledgeable and supported to respond effectively when mental capacity assessments are needed, particularly in the context of fluctuating mental capacity.
- To provide assurance that that information concerning risks is shared fully and in a timely way with the care co-ordinator and multi-disciplinary team
- To provide assurance that that their staff understand when and how to make a referral to mental health services for a Mental Health Act assessment.
- To ensure that the organisation is able to meet the requirements of safeguarding adult reviews in the future.

3.9.29 The review was reassured to be advised that in the intervening period, "Camino Healthcare Limited has an entirely new management team in place and is working hard with commissioners and other stakeholders to ensure patient safety remains at the forefront of the care they provide."[8]

3.9.30 The Safeguarding Adults Board asked the CQC to consider the learning from this review and ensure that assurance is sought from Camino Healthcare Limited that the learning has been embedded across its wider organisation. The CQC advised the review that they have noted the contents of this review and have inspected the two other registered locations of Camino Healthcare Limited since first taking regulatory action against the provider in respect of Oak House in May 2019.

[8] response provided 28.09.2022

4 Key Themes

4.0 As well as the analysis of the individual agency responses, the review was able to identify some key themes around Shannon's journey through health care and services.

4.1 Suitability of Placement

4.1.1 The suitability of the placement at Oak House was guided by multi-agency recommendations and joint funding decisions undertaken by the Joint Mental Health Commissioning Panel which comprised Birmingham & Solihull CCG and Birmingham City Council and which was supported by the Mental Health Joint Commissioning Team comprised of the same agencies.

4.1.2 The role of the Mental Health Joint Commissioning Team, hereinafter referred to as the Joint Commissioning Team, was to co-ordinate the funding of support, treatment and care for people with mental health needs. In doing so, they sought to ensure greater co-ordination and greater fit of services across health and social care and reduce the gaps between services. The Joint Commissioning Team comprised staff from both the local authorities of Birmingham and Solihull and the Clinical Commissioning Group and was hosted by Birmingham and Solihull Clinical Commissioning Group. In Shannon's case, their role was to decide upon and monitor the suitability of the placement by assessing recommendations made by the range of professionals involved.

Choosing a provider

4.1.3 The review heard how the Joint Commissioning Team had identified six providers of accommodation for Shannon's discharge from hospital, of whom three declined as they were unable to meet her needs, and another withdrew prior to assessment.

4.1.4 The team were described as applying a needs-led process to determine the suitability of the remaining two. Costs were not the main determinant as can be evidenced by the fact that one provider was half the cost of the eventual provision agreed but that cheaper provider could not provide assurance of their ability to manage the risks that Shannon faced.

4.1.5 Although all records have not been available, it was apparent that much thought had gone into the nature of the placement that Shannon would benefit from. Nonetheless, the funding panel agreed to Oak House on the basis that clarity was included in the support plan about how Occupational Therapy would be delivered and what this meant for Shannon's recovery

plan. There was no indication that this was received yet the arrangements continued.

Nature of placement

4.1.6 It was evident that from the start of the placement that different agencies had different expectations about what Oak House would provide. The review found an absence of clear records and organisational memory within the commissioning records[9] around what had been commissioned. It has therefore not been possible to determine with certainty whether this lack of clarity amongst practitioners, over rehabilitation or care that was supposed to be provided by the placement, had its root in the formation of the contract, although it appears to have at least been exacerbated by this. Thereafter, there appeared to be a mismatch between what Oak House was commissioned to provide and the approach that they adopted towards Shannon.

4.1.7 It was the opinion of Birmingham and Solihull Mental Health Foundation Trust that Camino Healthcare Limited were commissioned to provide a short-term supported living placement at Oak House for Shannon in order to prepare her for independent living. There was no indication that they expected Oak House to provide care or treatment for her mental health, either individually or in a shared-care approach. They considered her to be a resident and not a patient. Nonetheless, adequate provision was required for the setting to be able to manage the complex risks arising from Shannon's condition and behaviours and Oak House was chosen over another provider as it had been able to demonstrate that it was able to manage and mitigate these risks.

4.1.8 By taking on a greater role in her care, we have seen that it was considered, on reflection, that Oak House may have inadvertently undermined steps aimed at optimising her independence and self-reliance.

Reliance on Oak House to Manage Risk

4.1.9 As Shannon's self-harm escalated, there appeared to be a certain reliance upon Oak House to be able to manage the increased levels of risks that ensued and be providing the level of care that might accompany that level of risk. This reliance appeared to be based upon understandable misconceptions about the level of care that was supposed to be provided in this setting. For example, Shannon was always accompanied to Emergency Departments by members of Oak House staff, and records often showed

[9] In the context of rapid change in public services, staff involved have since left the organisations.

them to be carers and that she was being discharged to their care. Until the last presentation to Sandwell Emergency Department in November 2018, this appeared to imply that the setting was a safe place and the care provided able to meet the level of risk.

4.1.10 Likewise, the social worker (SW2) also heard how Oak House staff were subjecting Shannon to five-minute observations which, we have heard, was more characteristic of an acute in-patient setting, requiring only that staff seek assistance from other agencies when Shannon's need escalated. The social worker did not appear to question the nature of the care that was being provided and whether it was consistent with the risk assessments, care plan and suitable for the setting.

Learning Point: Observation Levels
Therapeutic observation should promote the safety for a service user during temporary periods of distress when they are at risk of harm to self or others or when they themselves are at risk from others. 5-minute observation levels are not normally recommended, even in acute in-patient settings, and higher than intermittent observations (every 15-30 minutes) would normally warrant one-to-one continuous observation.

4.1.11 The Out of Hours GP similarly appeared to have relied upon Oak House to be able to manage Shannon's access to razor blades. It appeared that Oak House staff had reassured the GP about their ability to manage ongoing risk.

4.1.12 Several practitioners appeared to be under the impression that Oak House was able to manage increasing levels of risk and was providing levels of care that were inconsistent with the placement contract. Whilst the opinions of Camino Healthcare Limited on this matter are not known, there were a several examples available of how Oak House staff provided reassurance to agencies, including the social worker, the Out of Hours GP and the Best Interest Assessor, that they could manage the high level of risk.

Learning Point: Nature of Placements
There was a mismatch between what the placement provider was commissioned to provide, what they were providing and what was expected of them to provide in terms of risk management. Practitioners should seek clarity and confirmation of the nature of residential settings before assuming risks can be managed.

Out of area

4.1.13 The review considered whether the placement being out of area provided any discontinuity of care for Shannon but, with the exception of occupational therapy, none was made specifically apparent to the review as a result of the distance alone. That is not to say that there were not delays in taking actions to follow-up concerns by both social work and mental health practitioners, but that the distance from the community services did not appear to be the cause.

4.1.14 Whilst attempts are normally made to try to avoid doing so, it is not uncommon for individuals to be placed out of area, particularly if they have specific complex needs. We have seen that the Solihull Enhanced Personality Disorder Pathway was designed to be able to meet the needs of carers and service users placed out of area. Moreover, it was noted that Shannon's care plan was not one requiring crisis responses or home treatment at the time it was arranged.

Occupational Therapy

4.1.15 Nonetheless, in the case of occupational therapy, the Community Mental Health team considered it unviable for this to be delivered by them due to the distance[10]. Having been specifically excluded from the contract on the advice of the clinical team, Oak House raised concerns that it was not being provided elsewhere and that they were having to provide it unfunded themselves in order to meet Shannon's programme of independent living skills and to reduce her high risk of harm through structured activities. It took three months before this matter was resolved, by which time several agencies had been alerted to the difficulties that it posed, indicating poor communication and a sense of diffused responsibility.

Distance from family

4.1.16 Significantly, being out of area meant that the cost of transport was placing considerable stress on Shannon and her mother. There was a lack of clarity about how these costs could be met within the aftercare plan and there was much toing and froing between agencies with no one agency taking responsibility for resolving it. Indeed, this issue was not resolved for the entire period of Shannon's residence at Oak House and before her death.

[10] See JCT IMR entry 02.10.18: CM1 - "N1 tells me that due to the distance from her CMHT, OT input isn't viable".

Contracting and record keeping

4.1.17 In this way, we have seen that the lack of clarity and communication over the contractual arrangements and expectations suggested shortcomings in the joint commissioning processes identified within this review. These shortcomings, alongside other factors, contributed to the future lack of co-ordination and responses of agencies which followed.

4.1.18 Moreover, the records of the Joint Commissioning Team and Joint Commissioning Panel were found to be inadequate in so far as they did not make it clear who had oversight of the process or how Shannon's placement was being monitored. There was also a gap in the records from when the funding was agreed to when the placement was reviewed, and no records were held demonstrating that the funding of occupational therapy input had been resolved.

Developments in Joint Commissioning

4.1.19 Since this time a Standard Operating Procedure has been introduced across this multi-agency commissioning platform which it is anticipated will address the suggested shortcomings identified within this review.

Recommendation 1: Joint Commissioning
Birmingham Joint Mental Health Commissioning Team to provide assurance to Sandwell Safeguarding Adults Board that the outcomes of the new standard operating procedure address:

- Contractual monitoring and review and record keeping
- The relationship of the contract with the Section 117 Aftercare Plan
- Clarity over levels of care or rehabilitation being contracted
- Clarity over who has oversight of the placement and how communications between partner agencies will take place
- Clarity over the service user, family and carer views and future engagement
- Clarity over continuity of care across boundaries

Sandwell Safeguarding Adults Board to share this assurance with Birmingham Safeguarding Adults Board.

4.2 Section 117 Aftercare Plan

4.2.1 The review went on to consider the impact of the Section 117 aftercare plan, and how it was reviewed in relationship to other assessments being undertaken including the Care Programme Approach, Best Interest Assessment and Commissioning reviews.

4.2.2 A Section 117 aftercare plan requires clinical commissioning groups and local authorities to provide or arrange for the provision of after-care to patients after they have been detained in hospital for treatment, in this case, under section 3 of the Mental Health Act.

4.2.3 After-care services should be viewed broadly and include all services which meet a need arising from, or related to, an individual's mental disorder for the purpose of reducing the risk of a deterioration of their mental condition or re-admission to hospital for treatment for mental disorder. It should be noted in relation to aftercare:

> "As well as meeting their immediate needs for health and social care, after-care should aim to support them in regaining or enhancing their skills, or learning new skills, in order to cope with life outside hospital." (DoH, 2015)

4.2.4 Although the aftercare plan has not been made available to the review, we have seen that aftercare arrangements fell short in certain areas. For example, it was not clear how the plan informed the decisions of the Joint Commissioning Team in the first instance. There were also numerous references to funding the provision of Oak House occupational therapy services, which appeared to be disrupting Shannon's transition to independent living, but no reference to reviewing this need under the Section 117 aftercare plan.

4.2.5 Neither was it clear how the plan was being reviewed in relation to other plans. Whilst it is not the expectation that an aftercare plan is the vehicle for monitoring responses to mental health conditions, it does need to be informed by clinical assessments and CPA. A more rigorous adherence to the Section 117 aftercare plan would have had the effect of ensuring that all key agencies were aware of information and changes as they arose and may have had the effect of identifying much earlier any potential shortcomings of this placement.

4.2.6 The panel considered that in view of the complexity of Shannon's needs and self-harming behaviours, a comprehensive Section 117 aftercare plan could have been the most appropriate plan to inform Oak House of the support needed to meet her needs. This plan could also clearly detail agency responsibility for the varying services and support which had been agreed. We have seen that Oak House received the Adult Social Care assessment and detailed reports from BSMHFT.

Learning Point: Section 117 Aftercare
Responsible agencies need to consider their duties under Section 117, not only to meet the immediate needs for health and social care of an individual after a period detained in hospital, but also to promote independence and cope with life outside of hospital. The Section 117 Aftercare Plan should be at the heart of planning, dovetail with other plans and be subject to review as needs emerge or change.

Recommendation 2. Section 117 Aftercare
Sandwell Safeguarding Adults Board to seek assurance from Birmingham Adult Social Care and Birmingham & Solihull ICB Joint Commissioning Team that the Memorandum of Understanding for Section 117 Aftercare has been embedded, is effective and that any necessary actions to update the MoU arising from implementation have been made.

4.3 Hearing her voice

4.3.1 The review heard good evidence that Shannon was actively involved in the type, duration and intensity of her therapy, actively involved in person-centred risk assessments and that her voice was heard within her care plans. In this context, she was mostly engaged "…in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety." (DH, 2018: s14.15). It was evident that key mental health practitioners and teams had fostered strong, consistent, long-term relationships with Shannon and built trusting relationships with her.

4.3.2 However, there were significant incidents when her voice was not heard or taken into account. For example, Shannon described how she felt that she had not been fully listened to in the choice of her placement at Oak House, yet had mixed feelings about it: describing it as too far away, but being nice and a chance to be out of the hospital. Ultimately, she agreed to the placement on the basis that it was temporary, that she could retain her mental health services, which was done, and that the funding of transport could be arranged in order for her to see her mother, as her principal carer, as it was cost prohibitive for them both. This matter was not addressed before her death.

4.3.3 In the context of escalating self-harm, it did not appear that some agencies were always providing Shannon a voice to express herself. For example, beyond those providing long term care and support, professional curiosity was lacking with some agencies around the cause of Shannon's emerging pattern of self-harm, and she did not appear to be being given the opportunity

to discuss this fully with them. Hospitals missed opportunities to ascertain if Shannon had any thoughts or insight into any potential triggers for her self-harm; how her mental health was being managed or if any additional support could have been offered both as an inpatient or once back at Oak House. There was no apparent professional curiosity at these times to probe about how she was feeling, the events that had led up to her self-harm and how she felt her mental health was being managed. In this way opportunities were missed to identify how she may potentially come to harm as result of neglect of supervision or that Oak House may not be coping and not be able to adequately meet her identified risks and needs.

Learning Point:
Although an individual may already be receiving long term care and support, all professionals need to be curious and alert to the causes and triggers of self-harm, no matter how brief their intervention.

4.3.4 In this context, there were times when Shannon was also not given the opportunity to speak with practitioners or clinicians on her own.

Learning Point: Seeing people on their own
Notwithstanding the important role that carers provide in accompanying individuals to appointments and providing them with support, individuals should be given the opportunity to talk with professionals about their care and support needs on their own.

4.4 Service co-ordination and review

4.4.1 This review observed shortcomings in the multi-agency approach to Shannon's care and the risks that she faced. We have seen above that once Shannon was placed within Oak House a sense of diffused responsibility between agencies and practitioners emerged on a number of fronts. However, shortcomings in multi-agency working extended also to information sharing, multi-agency assessments and holistic working.

4.4.2 At times, relevant information sharing was undertaken appropriately. For example, there was mostly good communication to the GP surgery from other services in relation to A&E attendances, mental health care and reports from the Ambulance Service. In other regards, critical information sharing appeared to be lacking. For example, the commissioners of the placement were not updated by Oak House about escalating risk; the care co-ordinator was not notified by the GP concerning potential dependency upon codeine;

Oak House support workers did not inform Sandwell Hospital about the diagnosis of Asperger's Syndrome.

4.4.3 Beyond information sharing, assessments were not always taken undertaken holistically and with awareness of other assessments being undertaken. For example, the 3-month review of the placement appeared to lack knowledge of the recent Best Interest Assessment.

4.4.4 Relevant agencies were not invited to join assessments that should be multi-agency. For example, the 3-month review of the placement was undertaken by the social worker with Oak House staff **(10.10.18)** and it was significant that key partner agencies involved in Shannon's care, including the care co-ordinator, were not invited. Had they been, concerns may well have been raised about the intensity of the observation regime that had been put in place by Oak House in response to Shannon's escalating self-harm. Knowing about the potential for this intrusive regime, had not raised the concerns of the social worker from the outset and an understanding of risk was lacking. Recommendations on information sharing and joint assessments are included in the individual action plans for each agency affected.

4.4.5 The GP, who had not taken responsibility for the particular vulnerability of Shannon, was receiving each of the notifications from hospital and was the holder of key information. However, they were not invited to the multi-disciplinary team meetings and not made aware of raised safeguarding expectations. It was recognised that GPs may often struggle to attend such meetings and other agencies therefore have become less likely to invite them. However, being invited and receiving minutes will enable the GP to appreciate changes in their patient's presentations and respond accordingly.

Learning Point: Information sharing with GPs
Where an individual is supported in the community, GPs should be invited to multi-disciplinary meetings and minutes of the meetings shared with them.

4.4.6 The inquest concluded that agencies needed to review their approaches to the sharing of multidisciplinary/agency medical records and risk assessments for community patients with complex needs. Agencies involved have already responded to the coroner's recommendations in this regard. However, the review was aware that Oak House expected Shannon's medical records to be shared with them rather than the handover records which were provided by BSMHFT. In the absence of Camino Healthcare Limited's meaningful engagement with the review, it is not possible for the review to determine with any certainty whether Oak House received sufficient information to be able to deliver the services for which it was commissioned. It was considered that sharing of full medical records, even with patient consent, would unlikely be

appropriate in a setting of supported accommodation which was contracted only to enable an individual's transition to independence.

4.5 Alcohol, fluctuating capacity and self-neglect

4.5.1 Whilst under the influence of alcohol, Shannon was potentially more impulsive and therefore more predisposed to acts of self-harm. At such times, her capacity could be seen as fluctuating due to her alcohol misuse. Shannon also used alcohol to test boundaries and she was surprised when staff let her sneak alcohol into Oak House, albeit she hid alcohol on her body where they were not permitted to search.

4.5.2 Mental health services encouraged her to engage with alcohol treatment services and the Dialectical Behavioural Service worked with Oak House to provide support and advice in developing boundaries and a consistent approach around Shannon's alcohol misuse.

4.5.3 The social worker encouraged Oak House to enable Shannon to access alcohol treatment services in October 2018, but it is not known whether this was done or, if not, followed up thereafter. On other occasions, recognising her potentially fluctuating capacity and impulsivity around alcohol, mental health practitioners encouraged her to engage with alcohol treatment services However, it was not evident that all services were consistent in encouraging or enabling Shannon to access alcohol treatment services.

Learning Point: Enabling access to alcohol treatment
Where an individual experiences problematic alcohol use practitioners need to be consistent in their use of every opportunity to encourage their access to alcohol treatment and, where barriers exist, explore the possibility of co-working to overcome these barriers,

4.5.4 Neither was it evident that practitioners were considering how alcohol may be affecting Shannon's fluctuating capacity and self-neglect. Across agencies there was little documentation to suggest that Shannon's capacity to make decisions was being doubted and no evidence that practitioners had considered undertaking a Mental Capacity Assessment specifically around Shannon's frequent alcohol use in the context of her greater predisposition to self-harm; impairing her ability to look after herself and potential for self-neglect. Oak House staff were in the best place to identify this concern and there was no indication of inter-agency discussion taking place on the issue.

Learning Point: Fluctuating Capacity & Self Neglect
If under the influence of alcohol, an individual is more predisposed to acts of self-harm and potential for self-neglect, practitioners need to consider whether they have fluctuating capacity and consider whether a Mental Capacity Assessment needs to be undertaken.
Assessing capacity for problematic alcohol users is complex and decisions may well require multi-agency discussion and professional challenge (Alcohol Change, 2017). Organisations should ensure that their workforce is knowledgeable and skilled in this area.

4.6 Working with family

4.6.1 Shannon's mother was her principal carer and actively involved in her care: alerting the care co-ordinator to escalating risk; taking her to hospital and being involved in care planning.

4.6.2 Under Section 10 of the Care Act 2014, carers should be active partners in key care and support processes, including the assessment, support planning and review with the person they care for. There was good evidence provided that, through much of the time, mental health professionals included Shannon's mother in the assessments of her daughter's treatment.

4.6.3 However, it was not evident that all agencies were identifying her role or considering her needs in her own right. One of the key strengths in the introduction of the Care Act 2014 was that carers were to be given the same degree of recognition, respect and parity of esteem as those they support (Department of Health and Social Care, 2016). Although mental health services referred her to a carer's group there was no indication that any agency had offered Shannon's mother a carer's assessment.

4.6.4 As an example, the absence of this consideration exacerbated the failure to address the issues of transport for both Shannon and her mother to see each other in an out of area placement. As a result of her own disability, Shannon's mother had to pay in the region of £60 per visit to see her daughter. Despite raising it frequently with different practitioners, this issue was not resolved for the entire period of Shannon's residence at Oak House before her death. As well as providing further indication of poor communication and diffused responsibility it exacerbated stress for Shannon and her mother and put at risk the placement itself.

4.6.5 Significantly, carers are usually the first to be aware of a developing crisis. Indeed, during the last days of Shannon's life, her mother was able to alert

the care-co-ordinator and arrange a swift meeting with Shannon and plans were being put into place to move Shannon closer to her mother.

Learning Point: Carers
Practitioners need to be aware of the benefits of a carer's assessment and seek to promote a carer's assessment in order to strengthen the whole family's resilience

Learning Point: Listening to Carers
Carers are usually the first to be aware of a developing crisis. Carers should be active partners in key care and support processes, including the assessment, support planning and review with the person they care for.

Recommendation 3: Carers and the Community
Birmingham City Council to raise awareness of the benefits of a carer's assessment, both internally and with partner agencies, as well as responsibilities to carers under the Care Act 2014.
Birmingham City Council to use the learning from this SAR to review guidance on carers assessments and support to family carers where the individual is in supported residential placements.[11]

4.7 Safeguarding Adult Reviews in the context of privatisation

4.7.1 The difficulties faced within this review in securing the meaningful engagement of a private service provider have been challenging to the point of preventing a fully rounded view of the services provided to Shannon.

4.7.2 Attempts by the Board to escalate non-compliance through two Section 45 notices, under the Care Act 2014, had little effect. The CQC advised that they have no powers to compel such action themselves.

4.7.3 These challenges are not particular to Sandwell but are being replicated across the country in the context of the increased privatisation of health and social care. In order to ensure that this potentially powerful system of safeguarding adult reviews maintains its ability to strengthen safeguarding responses, it was the panel's opinion that the responsibilities of private care providers to engage fully in safeguarding adult reviews needs to be strengthened in law.

[11] A similar recommendation was made in a recent Solihull Safeguarding Adult Review (Stephen)

Recommendation 4: Enforcing Compliance with Safeguarding Adult Reviews
In view of the inability to enforce compliance with Section 45 notices under the Care Act 2014, Sandwell Safeguarding Adults Board should consider bringing this review to the attention of the Secretary of State for Health and Social Care, through the National Safeguarding Chairs Network.

4.7.4 The review noted that without the assistance of the coroner, this review would not have been able to consider in any depth the role of Oak House in Shannon's care.

Learning Point: Coroners and SARs There is a great value for Safeguarding Adults Boards in building relationships with their local coroner in order to ensure all information is available to both bodies for their discreet functions.

Recommendation 5: Coroners and SARs
Sandwell Safeguarding Adults Board to recommend to the National Task and Finish Group on SARs of the National Safeguarding Chairs Network that Boards systematically apply to their Coroners for interested party status where coronial proceedings overlap with safeguarding adult reviews.

4.8 Parallel Proceedings

4.8.1 Safeguarding adult reviews often dovetail with a number of different proceedings, including those which seek to attach blame or culpability for tragic events. A safeguarding adult review's contribution to the examination of critical incidents is to examine past events in order to strengthen safeguarding practice for the future. In this way, where gaps emerge in legislation, policy and guidance that impact upon agencies ability to strengthen their safeguarding practice, it is incumbent upon the review to provide recommendations for addressing these gaps. For this purpose, the review examined how the regulator considered their response to the events in question.

4.8.2 The CQC undertook an investigation on whether any regulatory offences by the Registered Provider, Camino Healthcare Limited Ltd., could be proved to a criminal standard with particular regard the Health and Social Care Act 2008 (Regulated Activities) Regulations (RAR) 2014. They concluded that there was not sufficient evidence to prosecute for any offences.

4.8.3 The panel noted that the length of time taken by the CQC to conclude its investigation. It should be noted that the CQC did not request that the SAR be delayed pending their investigation. It was also appreciated that criminal investigations can be lengthy, and the review heard how the CQC "spent considerable time and resource in completing a full, thorough and

independent investigation and review. This included seeking the professional views of experts and legal counsel external to CQC to determine whether a successful prosecution was likely." The CQC also advised that their inspection team focussed on intensive inspection and civil enforcement activity to protect the service users who were still living at Oak House. Nonetheless, the review panel considered that the judgement over whether criminal proceedings were to be taken, and the nature of those proceedings, was an important consideration for the review. Camino Healthcare Limited reasonably considered that they could not provide some of the information that the review had requested, about the response of Oak House, whilst the criminal investigation was ongoing, although this may not necessarily have impeded their involvement. The length of time of the criminal investigation therefore, in effect, compromised the timeliness of the review. The CQC advised that they have since introduced a separate enforcement team to carry out criminal investigations and that this has improved criminal enforcement processes and reduced delay.

Recommendation 6: Delays
Sandwell Safeguarding Adults Board should seek evidence based assurance from the CQC that the measures that they have introduced to improve the progression of cases has had the effect of reducing delays in decisions to proceed with criminal investigations.

4.8.4 Although the CQC was aware of the safeguarding adult review from the outset, in terms of the process of the review, they commented that they had not been invited to join the review panel or submit an Individual Management Review concerning their involvement in this case. Although the Board Manager maintained contact with the Care Quality Commission, and they were invited to comment on the later drafts of the report, the absence of the regulator on the panel was recognised to be an oversight.

Learning Point: Involvement of the Regulator in the SAR
Whenever a Safeguarding Adult Review involves a Care Quality Commission inspected resource, the Lead Reviewer and the Board should ensure that the Care Quality Commission are invited to participate at the start of the review.

4.8.5 It also came to the attention of the review panel that there had been previous safeguarding concerns about Oak House, and that Sandwell Council ended other placements at this establishment before this fatal incident.[12] The review heard how, in the intervening time, the introduction of Integrated Care Boards

[12] A summary of safeguarding concerns from 30th May 2018 and 30th May 2019 was presented to the Senior Strategy Meeting – Serial, Institutional or Complex Historical Abuse on 07.06.2019 held in accordance with Sandwell Safeguarding Adults Procedures and Practice Guidance.

with their ‘place-based’ focus, has strengthened collaboration and commissioning across the region.

Recommendation 7: Commissioning and Oversight of Placements
Sandwell Safeguarding Adults Board seeks assurance from Sandwell’s health and social care commissioners concerning the effectiveness of commissioning and safeguarding cross boundary placements in the region.

5 Conclusion

5.1 Shannon was a gifted young woman who struggled with multiple needs and faced significant risks arising from her self-harm.

5.2 Mental health services worked with her for many years building up strong, consistent relationships which carried through into her out of area placement at Oak House which had given assurances that it could manage Shannon’s needs and risks. However, from the outset, there was confusion between agencies over what the placement at Oak House was to provide and this confusion was exacerbated by a lack of clarity, monitoring and review in the commissioning arrangements.

5.3 Mental health services understood Oak House to be a rehabilitation placement to help Shannon transition to independent living and were providing her care and mental health services directly. Nevertheless, shortly after the placement started, Oak House staff implemented an intrusive observation regime indicating that they were ill-equipped to manage Shannon’s risks. As Shannon’s self-harm continued and escalated, it became apparent that other agencies, including Adult Social Care and staff at Emergency Departments, considered Oak House to be providing more care and risk management than they were able or contracted to do.

5.4 Shannon’s self-harm was often tenacious and un-predictable, but it was known that she would test how much staff cared for her through self-harm. The neglect involved in having implemented an observation regime, and then not keeping to it, for a vulnerable person who would test staff in this way, was found, by the coroner, to have contributed to Shannon’s accidental death.

5.5 Notwithstanding the seriousness of these judgements, the review found shortcomings for many of the agencies involved in the way agencies worked individually and collectively to share information, commission, manage, assess, monitor and review the needs of Shannon whilst in a rehabilitation placement which was ultimately unable to keep her safe from harm.

Recommendation 8: Accountability
It is recommended that Sandwell Safeguarding Adults Board shares an update with the family of Shannon in a year's time on what has changed as a result of the SAR learning and subsequent action plans.

6 Recommendations

6.1 Overview Recommendations

Recommendation 1: Joint Commissioning
Birmingham Joint Mental Health Commissioning Team to provide assurance to Sandwell Safeguarding Adults Board that the outcomes of the new standard operating procedure address:

- Contractual monitoring and review and record keeping
- The relationship of the contract with the Section 117 Aftercare Plan
- Clarity over levels of care or rehabilitation being contracted
- Clarity over who has oversight of the placement and how communications between partner agencies will take place
- Clarity over the service user, family and carer views and future engagement
- Clarity over continuity of care across boundaries

Sandwell Safeguarding Adult Board to share the assurance provided with Birmingham Safeguarding Adult Board

Recommendation 2. Section 117 Aftercare
Sandwell Safeguarding Adults Board to seek assurance from Birmingham Adult Social Care and Birmingham & Solihull ICB Joint Commissioning Team that the MoU for Section 117 Aftercare has been embedded, is effective and that any necessary actions to update the MoU arising from implementation have been made.

Recommendation 3: Carers and the Community

Birmingham City Council to raise awareness of the benefits of a carer's assessment, both internally and with partner agencies, as well as responsibilities to carers under the Care Act 2014.

Birmingham City Council to use the learning from this SAR to review guidance on carers assessments and support to family carers where the individual is in supported residential placements.

Recommendation 4: Enforcing Compliance with Safeguarding Adult Reviews

In view of the inability to enforce compliance with Section 45 notices under the Care Act 2014, Sandwell Safeguarding Adults Board should consider bringing this review to the attention of the Secretary of State for Health and Social Care, through the National Adult Safeguarding Chairs Network.

Recommendation 5: Coroners and SARs

Sandwell Safeguarding Adults Board to recommend to the National Task and Finish Group on SARs of the National Adult Safeguarding Chairs Network that Boards systematically apply to their Coroners for interested party status where coronial proceedings overlap with safeguarding adult reviews.

Recommendation 6: Delays

Sandwell Safeguarding Adults Board should seek evidence based assurance from the CQC that the measures that they have introduced to improve the progression of cases has had the effect of reducing delays in decisions to proceed with criminal investigations.

Recommendation 7: Commissioning and Oversight of Placements

Sandwell Safeguarding Adults Board seeks assurance from Sandwell's health and social care commissioners concerning the effectiveness of commissioning and safeguarding cross boundary placements in the region

Recommendation 8: Accountability

It is recommended that Sandwell Safeguarding Adults Board shares an update with the family of Shannon in a year's time on what has changed as a result of the SAR learning and subsequent action plans.

6.2 Individual Agency Recommendations

Birmingham City Council Adult Social Care

- Heads of Service across the directorate are to reiterate the need to make use of Section 117 classifications on CareFirst 6 (our case management system). A briefing note to staff, informing them of how to use these classifications, is to be developed and distributed by Heads of Service to their respective teams by 31/10/2020. (Head of Service – Safeguarding & Specialist Services) is to oversee this action.
- Heads of Service across the directorate to develop appropriate communication, to be distributed to their respective teams, to reiterate to staff that Section 117 plans are to be uploaded to our case management system. Where workers identify eligibility for Section 117 but there is no plan stored, a protocol should be referenced (see "4") to ensure we work with partners to obtain this, when it is evident we were involved in the planning itself and/or the delivery of services. This will need to be actioned by 31/10/2020. (Head of Service – Safeguarding & Specialist Services) to oversee the progress of this outcome.
- Additional training on Section 117 to be developed and delivered to the workforce by The Learning and Development Service. Where issues have been identified within this report about the knowledge of specific members of staff this will also be addressed by way of supervision (by 31/08/2020) and it mandated that they undertake the additional training on Section 117. This training needs to be made available to the relevant social work teams by 31/12/2020. (Head of Service – Safeguarding & Specialist Services) to oversee the progress of this outcome.
- (Head of Service) to BCC's Adult Social Care lead in the development of a joint Memorandum of Understanding with Birmingham and Solihull CCG (to include relevant partner agencies) around Section 117 aftercare. This is to ensure partnership working is strengthened in this area, with initial discussions to have taken place by 01/09/2020. Again, this action is to be overseen by (Head of Service – Safeguarding & Specialist Services).

Birmingham and Solihull Mental Health Foundation Trust

- The Trust will ensure that in all complex cases, a detailed handover will be provided. In circumstances where a placement requires more information, practitioners to ascertain from the service user if they are content for their full records to be provided. (Note: this was made in response to the coroner's comments in the Prevention of Future Deaths report where the panel agreed with the Trust that the coroner appeared to be implying that full files should be shared with placement providers irrespective of the level of care/support/rehabilitation/resettlement to be provided. The Trust at the time felt that they needed to make a recommendation which clarified the process)

- To continue to adapt and train staff to utilise the carers engagement tool to promote positive engagement with carers and family and enable the needs of the carer(s) to be considered independently of the patient's needs.

Dudley Group NHS Foundation Trust

- Raise awareness of potential signs of neglect of adults who self-harm in a care and residential setting.
- Raise awareness of Making Safeguarding Personal (MSP) and professional curiosity.
- To provide assurance that the DAMA and Patient Access Policy are being adhered to.

GP Practice

- The practice to reflect upon its practice of seeing patients on their own for at least part of a consultation when accompanied by carers.
- The practice to review how they identify and flag vulnerable people who are then discuss at their MDT meeting.

Sandwell and West Birmingham

- Raise awareness of mental health needs in vulnerable patients via training including the need for professional curiosity and how to escalate concerns.
- Raise awareness of reasonable adjustments in patients with learning disability (with an underlying mental health condition) via training.
- Raise awareness around Mental Capacity Act (MCA) and Mental Capacity Assessments.

University Hospitals Birmingham NHS Foundation Trust

- Review training for Emergency Department Acute Medical Unit staff in collaboration with safeguarding team, safeguarding educator and mental health services/Vulnerabilities Team to ensure that staff recognise and understand when to raise a safeguarding concern.
- Reviewing NICE guidelines on Self Harm guidance for Emergency Department staff to ensure best practice.
- Promotion of the self-harm policy/enhanced observation policy and associated assessments.
- Liaise with the Vulnerabilities Team to promote their assessment process when a patient attends Emergency Department.
- Review the need for providing a 1:1 conversation with patients with learning disabilities who self-harm so that they be given the opportunity to be seen alone.

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Appendix 1: Key Lines of Enquiry

The review will seek to answer the following questions:

- **Individual Agency Practice**
  - How did each agency identify and assess the care and support needs of Shannon and how were these needs addressed?
  - How did each agency identify, assess and respond to Shannon's risk?
  - How was self-neglect guidance applied?
  - How was mental capacity assessed and best interest tests applied
  - How were safeguarding procedures implemented?
  - How effective was practice in Making Safeguarding Personal?
  - How were Shannon and family members engaged with? How were their concerns and wishes understood and to what degree they were met?
  - How effective was record keeping?
  - How effective was management oversight?
  - Did resource issues impact upon services offered?
- **Placements:**
  - What considerations influenced the placement of Shannon at Oak House?
  - How was the placement organised and reviewed?
  - How was it ensured that the skills were available to meet Shannon's needs?
  - What was the role of other agencies to support Oak House?
  - How did an out-of-area placement affect the planning, oversight and delivery of Shannon's care?
- **Inter-agency: How did health and social care professionals work together, including across borders?**
  - How aware were agencies about care and treatment plans?
  - How effective was the co-ordination of services and use of multi-agency/ multi-disciplinary meetings?
  - Was there a shared ownership and approach?
  - How effective was communication, information sharing and sharing records?
  - How effective was escalation between agencies?
  - How was the transition between services, settings and local authority areas managed?
- **Improving services**
  - What lessons can be learnt by individual agencies and recommendations made?
  - What are the system-wide, multi-agency recommendations?

- **Specific questions from the bereaved family for Camino Healthcare Limited Ltd.**
    - What was earliest point by when Camino Healthcare Limited Ltd ('CHL') could and should have made clear that Shannon was not checked at 6pm on 09.01.19.
    - Did CHL and its advisors comply with their duty of candour in that regard.
    - Did [the author] comply with her professional obligations in that and other respects when preparing her report.
    - Did CHL comply with its duty to preserve all relevant evidence by allowing Shannon's 'Fit Bit' and iPad to be taken from her bedroom after her death by persons unknown, which had been locked by the police and identified as a crime scene.
    - Was that removal of evidence reported by CHL to the police? If so, on what date?
    - If so, what action was taken by the police?
    - Why did the timings on the electronic alarm system at Oak House not match GMT? The purpose of the accurate timings on alarms systems is surely to assist investigation of untoward incidents.
    - Is it possible to cross-reference the timings on the alarm system against GMT, in order to identify the precise time on which the alarm was actually activated in relation to Shannon?
    - Why did it take Camino staff 12 minutes just to call 999 for Shannon? Can this timing be double-checked? If accurate, how can such an egregious delay be prevented in future in order to protect life?
    - If Shannon was found ligatured at 6.0**5**pm, why did [redacted] make no mention of this highly distressing fact in her entry in Shannon's notes at timed at 6.0**9**pm? Can both timings be correct?