Learning Brief
Safeguarding Adults Review for Shannon

Background

Shannon was aged 24 when she died. She was a gifted artist and had ambitions to be an art therapist.

Mental health services had worked with her since she was a teenager and taken an overdose and she was diagnosed with anorexia, Asperger's Syndrome, dyslexia and self-harm. Then, whilst studying fine art at university, she started to misuse alcohol and left university after her second year. 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.

Aged 23, Shannon's discharge following detention in a mental health unit in Birmingham was delayed by six months whilst suitable accommodation was found. This was stressful for Shannon and her self-harm increased. As no suitable facilities could be found locally to meet Shannon's needs, arrangements were made to discharge her to a private mental health rehabilitation unit in Sandwell (The Unit) which was 15 miles away from her mother. Although they were reassured by the social worker that travelling facilities would be arranged for Shannon and her mother to visit each other, and Shannon agreed to the placement on that basis, this was never resolved.

The Unit had confirmed they could manage her needs and Shannon was to continue to be under the care of the community mental health team. It was evident from the outset that different agencies had different expectations about what The Unit would provide. Mental health services understood The Unit to be a relatively short-term rehabilitation placement to help Shannon transition to independent living close to her mother. As Shannon's self-harm increased soon after her placement began, The Unit considered that they needed to provide a significant level of care to Shannon. This confusion was exacerbated by a lack of clarity, monitoring and review in the commissioning arrangements which did not make it clear who had oversight of the process or how Shannon's placement was being monitored. Thereafter 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.

On reflection, The Unit considered that their staff did not have the specialist training or experience in dealing with personality disorder to manage Shannon's needs. Neither did they alert mental health services to Shannon's escalating self-harm. Indeed, concerned for her levels of self-harm, The Unit introduced a regime of 5 minute observations, which was

more akin to intensive care and this was not questioned by the social worker. As the care co-ordinator was not invited to the review, this meant that the significance of this observation regime, as well as the Unit's ability to manage Shannon's self-harm, was not well understood.

Whilst under the influence of alcohol, Shannon was often more impulsive and more likely to self-harm. However, services were not consistent in encouraging or enabling Shannon to access alcohol treatment.

On the vast majority of occasions, Shannon's self-harm was managed by nursing staff in The Unit, but she was taken to hospitals 5 times, including 3 times within one month having self-harmed with razor blades and digesting screws. She was not always seen on her own and there was a lack of professional curiosity over why her self-harm was escalating; the nature of the residential setting she was in and the level of care they provided. Reasonable adjustments were not always made for her Asperger's Syndrome.

In Shannon's final days, her mother contacted services concerned that The Unit was not able to manage her daughter's increasing self-harm and they discussed with Shannon moving to accommodation nearer to her mother. On the following day, Shannon died through having tied a ligature round her neck. The routine 5-minute observation was not undertaken as planned and when discovered, there were delays in removing the ligature and commencing resuscitation. The coroner concluded there had been a gross failing of care by a member of staff at The Unit and that neglect had been a direct contributory factor in her death.

Key Messages to Front Line Practitioners

1. 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.
2. Section 117 assessments and reviews should be multi-agency and benefit from shared expertise and co-ordination.
3. No worker should complete an assessment that they do not feel qualified for.
4. Therapeutic observation should promote the safety for a service user during temporary periods of distress when they are at risk of harm to self; 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.
5. Practitioners should seek clarity and confirmation of the nature of residential settings before assuming risks can be managed.
6. 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

7. 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
8. 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,
9. 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
10. 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.

Key Messages for Management and Strategic Development

1. Joint commissioning arrangements need to ensure that they provide:
    - Robust contractual monitoring and review and record keeping
    - Clarity over 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
2. 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.
3. Local authorities should 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.
4. Local authorities should 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.
5. Health and social care commissioners should use the learning from this SAR to review the effectiveness of commissioning and safeguarding cross boundary placements in the region
6. Safeguarding Adult Boards should systematically apply to their Coroners for interested party status where coronial proceedings overlap with safeguarding adult reviews
7. 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.