BIRMINGHAM SAFEGUARDING ADULTS BOARD

Sandwell Safeguarding Adults Board

Safeguarding Adult Review for Shannon
Press Statement

Today, 12th December 2024, Sandwell Safeguarding Adults Board (SSAB) is publishing the Safeguarding Adult Review (SAR). Our thoughts remain with Shannon's family, and we want to express our thanks to them for their contributions and for helping us to keep Shannon's voice at the centre of the review.

This review explores the circumstances leading to the death of Shannon, from Birmingham, who was aged 24 when she was found dead in a mental health rehabilitation unit in Sandwell. The placement was commissioned by the Birmingham Mental Health Joint Commissioning Team. 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.

Shannon was a gifted young artist. She had Asperger's Syndrome and a Personality Disorder and, as a result of a range of mental health concerns, she had been supported by mental health services since she was a teenager. Whilst she had self-harmed significantly and repeatedly throughout this time, and made previous suicide attempts, an inquest in 2019 found there had been a gross failing of care by

a member of staff at the residential unit and that neglect had been a direct contributory factor in Shannon's death.

In the intervening years, this review has explored how each of the agencies involved in Shannon's care worked to support and protect her, finding shortcomings in each service, some more serious than others. Lessons identified include the joint commissioning of placements and safeguarding within and across local area boundaries, the statutory duties of local authorities and health services for the aftercare of people discharged from mental health hospitals, the need to listen and respond to family carers and the need for professionals to be curious and alert to the causes and triggers to self-harm, no matter how brief the intervention.

It is now more than five years since Shannon's death during which time, the affected agencies have been putting in place systems and safeguards within their services in order to prevent similar tragedies from happening in the future. Sandwell Safeguarding Adults Board is holding agencies to account for these changes.

The COVID-19 pandemic and the SSAB's decision to defer the review until after the coroner inquest were factors which contributed to the timescales for the completion. We accept the review has taken longer than SSAB would ordinarily expect, the reviewers recognised the need, in this important case, to be thorough and meticulous in their assessment of all agencies. We included the Inspectorate and private companies, whose services are rarely analysed in these reviews, and have sharpened our review processes as a result to avoid unnecessary delays in the future. We also crossed boundaries, covering services not only in Sandwell but also in Birmingham, Solihull and Dudley and its lessons have a local, regional and national significance.

The key purpose of a review is to secure learning and make positive changes. Below are some examples of changes made by Birmingham City Council Adult Social Care (ASC) who are a partner in this SAR.

“Birmingham ASC have developed detailed guidance and process maps to promote data quality, including specifically related to Section 117 processes, and these have been communicated to the workforce and embedded via a robust training roll out and ongoing support offer.”

“Birmingham ASC have worked in collaboration with health partners to produce a S117 Memorandum of Understanding (MoU). The MoU outlines how key stakeholders across the local mental health system will deliver their statutory responsibilities with regards to provision of mental health aftercare under section 117 of the Mental Health Act 1983 which includes assessing, planning and delivering mental health aftercare services.”

In addition, The Care Quality Commission (CQC) have agreed to develop a MoU to support the working relationship between CQC and Safeguarding Adults Boards in England. This is a positive practice change and a direct consequence of this SAR.

The report is published alongside an impact statement from Shannon’s family, together with a Learning Brief which summarises the findings and recommendations and which forms the basis for training and development that practitioners across the region will be invited to and which Shannon’s sister will help us to deliver.

Words from the Independent Chairs of Sandwell and Birmingham Safeguarding Adults Boards

Firstly, we wish to also add that our thoughts are with Shannon's family, and hope in some way this review gives them some hope that agencies have heard and have taken action to improve.

In the intervening years we have been assured that all the agencies involved have taken actions to address the issues and concerns raised and much has changed in the five years.

The Birmingham based Partners will continue to provide any outstanding assurance to Sandwell Board and ensure improvements are maintained.

To access the report, visit https://sandwellsab.org.uk/wp-content/uploads/2024/12/SHANNON_FINAL4PUBLICATION_26.11.24.pdf

Notes for Editors

Sandwell Safeguarding Adults Board's SARs can be found:
https://sandwellsab.org.uk/safeguarding-adult-reviews/