GLOUCESTERSHIRE SAFEGUARDING ADULTS BOARD

# SAFEGUARDING ADULTS REVIEW
# Re. Hannah


**Independent Reviewer:**

**Brendan Clifford**

**Date: May 2017**

# PRIVATE AND CONFIDENTIAL

**INSIDE FRONT COVER**

| VERSION CONTROL | |
|---|---|
| V1 2017 02 10 | V1 SHARED by BC |
| V2 2017 03 03 | V2 SJ amends accepted by BC |
| V3 2017 03 03 | V3 shared with Family / friends |
| V4 2017 04 01 | Changes made following above meeting. |
| V5 2017 04 06 | ToR naming made consistent |

**INSIDE FRONT COVER**

**CONTENTS**

**INSIDE CONTENTS PAGE**

**INSIDE CONTENTS PAGE**

## 1.0 INTRODUCTORY SUMMARY

1.1 Hannah was a young woman from Gloucestershire who died, aged 26, on 27th May 2016.

1.2 She died in hospital of natural causes as a result of a pulmonary embolism and venous thrombosis. Other health concerns prior to her death included what is described by clinical experts as "morbid obesity" and an on-going wound infection which she had had during the last six months or so of her life.

1.3 There was no further investigation about the cause of Hannah's death by the Coroner's office.

1.4 Hannah's funeral was arranged by friends and family. By all accounts not expecting or wanting to die so young, nevertheless Hannah had made known some wishes to friends who were identified as Next of Kin on her admission to hospital about music which she would want played at her funeral. Her wishes were followed. Use was also made at the funeral of Hannah's art work – similar to the butterfly on the front cover of this Report which she had designed for another purpose connected to her experience of her mental health needs. Butterflies were one of Hannah's loves.

1.5 Hannah was someone who had used support of a wide variety of mental health services and interventions to an increasing extent for some years prior to her death. This latter experience did not prevent Hannah from achieving a place at a University when she was 18, however.

1.6 With the circumstances of Hannah's experience of life in mind, two broader reflections are worth making at the outset of this Report, firstly, in relation to the causation of mental health needs or problems. Although this is a well-researched area, this does not make the experience of mental health needs which go beyond the expertise of oneself, family, friends or the local community any easier. The same can be said for people working as professionals in services supporting people living with mental health needs. People who work in the system inevitably share all aspects of being human.

1.7 For instance, secondly, many staff may have their own experience of mental health difficulties or trauma of one kind or another. They will know that explanations of mental health needs can be characterised to some extent as a continuum between two perspectives. One perspective emphasises "natural" or genetic causes of mental health needs and the other emphasises more social or "nurture" type explanations. This could be applied to anyone's experience, including Hannah's. So on the one hand, we might explain a mental health need being caused by something in our genes and/or brain which apparently determines our behaviour and may be something which can be changed. On the other hand, we might say that the mental health need is the result of social experience of birth, childhood, upbringing and wider social relationships which determine the course of our life such as a trauma of one kind or another. This explanation is perhaps more hopeful about the possibility of change and interventions such as therapy are built on that hope. The two perspectives are not mutually exclusive either.

1.8 In addition, during the time in which this Safeguarding Adults Review (SAR) has been undertaken, there has been renewed concern about deaths of people with mental health problems connected to suicide, neglect and misadventure.[1] This last word – misadventure – was one mentioned by a number of staff in talking about Hannah's situation.

1.9 These wider reflections are made because the Independent Reviewer believes they provide a framework for the analysis which follows in this Report. Dilemmas were faced by all concerned – by Hannah herself, her family and friends and the system of professional staff supporting her over a long period of time.

1.10 This SAR Report concludes with recommendations. These are based on the opportunities to learn from the experiences of Hannah's life in the system and network involving her friends, family, local community and the many professional staff as individuals, teams and agencies who worked with Hannah over the years. In making these recommendations, the aim is to ensure as far as possible that others who might be facing similar challenges to those faced by Hannah are supported to shape new, better realities for themselves in the area of the Gloucestershire Safeguarding Adults Board (GSAB.)

## 2.0 GLOUCESTERSHIRE SAFEGUARDING ADULTS BOARD AND SAFEGUARDING ADULTS REVIEWS

2.1 The GSAB was established in 2009 and became a statutory partnership from April 2015. *"The aim of the Board is to safeguard and promote the welfare of adults at risk to enable them to retain independence, wellbeing and choice and to access their human right to live a life that is free from abuse and neglect."* [2]

2.2 Part of the GSAB remit is to undertake a SAR where it determines there is a need to do so. [3] GSAB established criteria for decision-making about conducting a SAR, building on previously developed local and national practice. [4] Criteria included:

- To determine if there are lessons to be learnt from the case about the way local professionals and agencies worked together
- To review the effectiveness of the safeguarding adults policy and protocols

[1] Cf. http://www.bbc.co.uk/news/health-38852420 *accessed 06/02/17*
[2] http://www.gloucestershire.gov.uk/gsab/board
[3] http://www.gloucestershire.gov.uk/gsab/article/117699/Safeguarding-Adults-Reviews
[4] http://www.gloucestershire.gov.uk/gsab/article/110171/Multi-Agency-Safeguarding-Policy-and-Procedures--supporting-guidance and *The Care Act 2014,* Section 44 & *Care Act guidance* 14.136 at https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding

- To inform and improve local inter-agency safeguarding practice

2.3 As such, SARs emphasise learning to improve practice. SARs are not inquiries into how an adult suffered injury or died, or who is culpable.

2.4 Best practice now encourages Safeguarding Adults Boards to undertake SARs within a reasonable time period. This helps the Board recommend improvements across the partnership based on a shorter report provided in as timely a manner as possible in response to the events concerned. GSAB requested a smaller number of recommendations which were as "SMART" (specific, measurable, achievable, relevant and time-bound) as possible. In addition, they wanted recommendations which could be implemented locally without wider national change. The Independent Reviewer was also keen to ensure that learning could be mainstreamed into on-going GSAB plans.

## 3.0 SAFEGUARDING ADULTS REVIEW ABOUT HANNAH - PROCESS

3.1 Following a referral to the GSAB to consider whether or not a SAR concerning Hannah should be undertaken, the GSAB decided to do so based on Terms of Reference which were agreed with an Independent Reviewer engaged to lead the review. The Terms of Reference are included at Appendix 1. The experience of the Independent Reviewer encompassed both direct practice as a Social Worker in a mental health multi-disciplinary team and senior leadership of commissioning and partnerships for mental health and other adult social care services.

3.2 *Systems approach*: In terms of overall approach, the GSAB wished to continue to trial the application of a broad "systems" approach to the review. Appendix 2 includes some broad points in respect of the systems-thinking approach. This approach is rooted in the response to well-publicised challenges in the children's services arena made by Dame Eileen Munro and the systems approach developed by the Social Care Institute for Excellence. It has been influenced by the development of thinking in other areas such as aviation and health services. Some of the key features of the approach include:

- Seeing people as being part of the system because their behaviour is shaped by systemic influences
- Noting that *"heroic workers can achieve good practice in a poorly designed system, but efforts to improve practice will be more effective if the system is redesigned so that it is easier for average workers to do so*."
- supporting an analysis that goes beyond identifying what happened to explain why it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken,

appreciating the views of people from different agencies and professions [5] and avoiding "*hindsight bias.*"

3.3 *Context:* It was clarified during the SAR set-up phase that the Coroner had not initiated any further investigation into the circumstances of Hannah's death and that no disciplinary action had been taken against any employee involved in the support of Hannah.

3.4 *Involvement of family and friends* is a key feature of the systems approach. Very often – but not always - families are the first line of relationship to an individual. In the conduct of the Review, the Independent Reviewer met one of Hannah's grandmothers and two friends.

3.5 Four meetings took place in total: two with Hannah's grandmother and one of Hannah's friends together to discuss their experience and views overall, then a further meeting to consider the draft SAR Report. The same happened with another of Hannah's friends, but separately. Thanks are extended again to the family and friends who met the Independent Reviewer for their participation. Renewed condolences are extended to them for their loss of Hannah.

3.6 Family and friends agreed to the use of Hannah's name in this Report i.e. Hannah is the real name of the person who is the subject of this Review. The Report seeks to maintain a balance between the GSAB's commitment to transparency to support learning, on the one hand and the need to respect certain elements of experience relating to Hannah, family, friends and staff involved, on the other.

3.7 There is a recommendation for the GSAB included in this SAR (see para. 7.1.1) which is a result of reflection on contact with families in mental health care situations and the overall information governance environment in which staff practice. This environment was generally linked to the specific experience of some family and friends as well as staff responding to their understanding of Hannah's wishes about their contact with her family.

3.8 *Involvement with staff and managers* is also key feature of a systems-style approach. A programme of interviews were set up with individual practitioners who worked directly or to some extent with Hannah as well as with managers from all relevant agencies involved in Hannah's care in one-to-one or small group meetings. Where required, further meetings were set up. A significant number of staff - about thirty in total - contributed either through face-to-face or telephone interview, email contact or attendance at one or both of two large-group meetings which were held either side of Christmas 2016 for challenge and learning. At the January 2017 Learning Event, it was stated that this review was probably amongst the most complex ones overseen by GSAB.

[5] Adapted from: At a glance 01: Learning together to safeguard children: a 'systems' model for case reviews (January 2012) http://www.scie.org.uk/children/learningtogether/resources.asp

3.9 The Independent Reviewer was provided with information as requested throughout. The positive approach of partners who participated in the SAR process was noted. Thanks are expressed to all concerned. The daily pressures which organisations are under is acknowledged as the context in which such positive response was offered. Not all agencies responded to the request to complete the GSAB's Chronology process. Some provided information in different formats which was more difficult to use.

3.10 *Style and Publication*: The names of health and care agencies are not used and neither are the names of individual staff members. Following consideration by the GSAB SAR sub-group, the final version of this report was presented to the GSAB in May 2017. The Care Act 2014 requires that SAR findings must be published in the SAB Annual Report and GSAB must act on the findings of the SAR. [6]

3.11 *Limitations of the SAR:* Hannah's situation was complex. As noted above (para 2.3) SARs are not inquiries into how an adult suffered injury or died or who is culpable. The main focus is on learning. The material of the circumstances is challenging for all concerned. Nevertheless, it is a very sad fact that in this instance, someone – Hannah – died. That strong emotions should be felt, therefore, is not surprising. The Independent Reviewer has not met every family member, friend or worker who had contact with Hannah. Likewise, the need to keep the SAR activity within a reasonable time limit so as to maximise learning drives the depth which can be attained in the review. Nevertheless, contact with a strong range of people has been achieved for clear recommendations for the GSAB partners.

## 4.0 EVENTS AND ANALYSIS

4.1 The Terms of Reference of this SAR require that focus be given to a time period of just under eighteen months - 01/01/2015 to the date of Hannah's death on 27/05/16. For overall understanding, there is occasional reference to time outside of this period, however. Likewise, given the complexity of the events and the use of a broadly systemic approach, analysis is weaved into the narration of the events.

4.2 So for example, it is helpful to understand, as has been mentioned (cf. para 1.5), that Hannah had been academically successful at school and won a place at a University. Hannah's Grandmother described her as *"highly intelligent, articulate, caring and multi-talented… [someone] who impacted positively on numerous people."* Hannah did not complete her course, however. A combination of challenges developed in her life connected to her on-going mental health needs such as self-harming behaviours as well as use of illicit drugs.

4.3 These challenges remained continued features of her life alongside developing physical health challenges such as living with the effects of increasing obesity. In terms of Hannah's experience of mental health needs,

[6] Care Act Guidance *op cit.* para 14.156

the general issue of causation of such needs mentioned above (cf. para 1.6) can be applied to her as an individual. In this context, there was significant discussion in the SAR process about the effects of "trauma" in conceptual terms as well as in Hannah's personal experience. This discussion had two elements. The first element acknowledged those situations where obvious, evidenced trauma had occurred at whatever stage in life and how professional practice can respond to support a person who has experienced trauma to reach whatever recovery was possible for that person. The second element relates to those circumstances where we cannot be sure that the trauma did occur as reported – sometimes referred to as "false memory." Comments made during this SAR process referred to evidence indicating that the effects of "false memory" can be experienced and observed as the same in their effects as events which really did happen. These two elements make the task of understanding the "truth" of a person's circumstance difficult for all concerned – family, friends, professionals and indeed, in the subjective experience of the person her/himself. For example, a person may learn that chest pain is a sign of a heart attack. They may then believe that an experience of chest pain caused by something else such as muscle strain or indigestion is a sign of a heart attack, albeit mistakenly in that circumstance. It's possible that for Hannah, therefore, the effects of her experience in terms of trauma would be the same whether the roots of the trauma was true or not. The interpretation of causation of mental health needs is significant in this context. On the one hand, one might see the cause of Hannah's mental health needs in terms of genetic disposition or else due to some incidents in her experience of life – a more social explanation. The overall issue of trauma and how it affected Hannah is an important part of this SAR, therefore.

4.4 There were indications of mental unease in Hannah's life before she went to University. These included some instances of self-harming (which was to remain a feature of her behaviour) and a reported eating disorder. It is acknowledged that mental health needs of younger people are as complex as at any other time of life and arguably more so. This can make it difficult for all concerned to know what is the best response to what they think they are seeing in the young person's behaviour in these situations. Families, friends or professionals may remain open to the idea that the young person might "grow out of it," for instance. In some circumstances, however, the consequences persist – based on real or false memory of trauma.

4.5 Hannah dropped out of university after about a year. From that time up to January 2015, her contact and use with state-provided or commissioned care services as well as some private professional mental health services extended considerably. This included compulsory admission to hospital under a section of the Mental Health Act 1983 whilst an in-patient, periods of residency in more supportive residential environments, use of numerous therapeutic interventions including attempts to overcome the effects of illicit drug use over long periods of time, contact with police services and over a hundred attendances at hospital over a twelve year period.

4.6 During this time, the phrase and diagnosis of “personality disorder” began to be used to describe the medical opinion of Hannah’s apparent symptoms.

4.7 Hannah’s experience and use of illicit drugs and “legal highs” was discussed in the course of the SAR from a number of perspectives. Firstly, from the current legal perspective, the legalities of drug use were noted i.e. that many / most are illegal. Secondly, anecdotal reporting was given about the extent of the illicit drugs situation in Gloucestershire which was noted as a serious on-going concern affecting the lives of many people and particularly some younger people. Thirdly, the subsequent experience of individuals in acquiring drugs including ones referred to as “legal highs” was highlighted. Repeated reference was made to the risk – including physical danger - that an individual might place themselves in by seeking to acquire drugs. This was true of Hannah’s experience.

4.8 Fourthly, however, specialist services are also commissioned which aim to apply evidence-based knowledge and practice to support people who have acquired a habit of drug use and Hannah was in contact with such relevant local services. The impression gained by the Independent Reviewer was that it could be difficult for the agency to corroborate evidence of the extent to which Hannah was using illicit substances as Hannah’s co-operation with the processes required to do this was not always forthcoming. An active programme working towards rehabilitation had been in place for sometime prior to Hannah’s death.

4.9 Finally, such services and other related ones such as specialist residential support establishments serving people with mental health needs, need to consider the boundaries to be applied for a person using that service where use of illicit drugs has been a feature of the person’s life before they use the specialist residential establishment. This can be a complex area when setting the current legal context in respect of drugs deemed illicit alongside a commitment to care and rehabilitation. Many services take a “zero-tolerance” approach when weighing up what they believe to be in the best interests of the person seeking further support and/or other people using the same resource. This is seen as an important aspect of working to encourage self-motivation of the person concerned.

4.10 The last point about the way in which services respond to use of drugs by people using their services is important because it was a key factor which resulted in a change of service provision for Hannah as far as her accommodation was concerned. She had been living at one Care Quality Commission registered residential service for the support of people with mental health needs in the company of others for a period of about a year. It is understood that many things went well for Hannah during that time. Part of the agreement for her stay there was not to bring drugs onto the premises or use drugs. This was part of a generally used approach to set “boundaries” in which the plan would be for the individual to grow and increase their independence as recovery was strengthened, as well as concern for others sharing the accommodation. Over a period of time however, events connected to Hannah’s drug use led to a decision by service providers in liaison with the commissioning agency that Hannah could no longer be supported in that environment.

4.11 It is recognised by all concerned that moving on from that resource may not have been what Hannah wanted. In working to make arrangements to move, family, friends and workers involved were all aware that Hannah did not want to live by herself. Efforts were made to identify a suitable resource which Hannah could share with others. No resource was identified into which Hannah could move with others already resident there. One resource was found, however, which could accommodate Hannah and up to two others should it also meet their needs. For the remainder of Hannah's occupation of that accommodation up to the time of her death, it did not prove possible to identify anyone else to share the new location and she was not joined by anyone else in living in the property.

4.12 In moving to the new location, Hannah continued to receive extensive support from the same commissioned care provider, albeit in a new location, with team members who were new to her. At the time of Hannah's death, she was receiving 35 hours of care per week with staff "sleeping-in" five times a week. There were three or four main carers and seven or eight altogether from the wider team who knew her. Hannah's family and friends have strong views about what they regard as the extent and nature of support for Hannah from the agency (see para 5.2) at the time.

4.13 As has been noted, there is a recommendation for the GSAB partners to reflect on the way staff might work with families, based on developing bodies of knowledge. This recommendation is being made because the Independent Reviewer found that, understandably in many respects, staff were guided by Hannah's wishes as far as contact with her family was concerned. There are important principles of self-determination, therapeutic objectives (where a family, generally, is perceived as part of "a problem" for an individual) and information governance to be considered by professionals working in this context. However, there is a growing body of evidence that involving families more closely where possible in the care of the person concerned can help support recovery. The use of "Consensus Statements," for instance, is seen as a way of achieving this. [7] The use of a "Consensus Statement" approach could be linked to "Family Group Conference" methods [8] already used in Gloucestershire in the children's services arena. It is important to clarify, perhaps, that the "Consensus Statement" tool and approach appears to have been developed more in relation to practice to counter suicide. Hannah did not commit suicide and by all accounts did not want to die. There was concern over a long period of time, however, that the effect of her behaviour might lead to her death by misadventure even though

[7] *House of Commons Health Committee Suicide prevention: interim report Fourth Report of Session 2016–17 Report, together with formal minutes relating to the report Ordered by the House of Commons to be printed 13 December 2016 From: https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news-parliament-20151/suicide-prevention-report-published-16-17/*

[8] For more information, go to: Family Group Conference method - https://www.frg.org.uk/involving-families/family-group-conferences/fgc-network

she did not actively seek death. It is recognised that this is a difficult area and many would argue that the views of the person with the mental health need about the nature of contact with their family – if any - should be paramount. This is accepted. However, the "Consensus Statement" approach might be one which would assist in some circumstances. We cannot be certain if Hannah would have agreed to be involved in such an approach or if it would have had any positive effect. But it may be something which helps others.

4.14 In due course, some months after Hannah's move to the new location, responsibility for her mental health care was transferred between localities and Hannah was allocated a new caseworker. Hannah continued to attend therapy sessions during the period of transition from one location to another until she appeared more settled. This was understandable and good practice to ensure continuity of care through a period of change.

4.15 On moving to the new location, Hannah registered as a patient with a large GP Practice on 16th January 2015 and was seen for an initial consultation on 20th January. Between that time and the time of her death, Hannah had about thirty appointments at the Practice and probably consulted about six different doctors. (At the time of writing, the Reviewer cannot be certain if this included appointments for 'depot' injections.) Her pattern tended to be that she did not attend booked appointments but then used the "Urgent Appointment" system. The population average number of GP attendances is understood to be about seven times a year. All the appointments are not recounted in the remainder of the report but the Practice noted the frequency of attendance. The Practice was concerned about people with mental health problems and had arrangements for a targeted physical health-checks programme for people with mental health needs. This was one positive example in the locality of a wider issue of "parity of esteem" whereby physical health and mental health should be given equal priority. The presence of mental health liaison services in the hospital was another example. [9] The heading of "parity of esteem" is also used to support a recommendation in this Report on actions to support dignity in the response to people with mental health needs and/or drug-using problems by agencies, communities, families and friends. It also refers to the need for physical health services in the area of the GSAB to keep concern for mental health within their purview and likewise, for mental health services to recognise the need to be concerned about the physical health of people they work with as service users. Through the recommendation, GSAB partners are encouraged to ensure confidence in practice on this issue on the basis of an assumption that the human being is a whole person.

4.16 On 28th February, Hannah had the first of sixteen contacts with the Ambulance Service in the time up to her death. She made three calls on that one day: the first about apparent prescription supply which was responded to by the Service by arranging short-term supply. A second call later in the afternoon when Hannah reported breathing difficulties was responded to with advice but on receiving a further call identifying a "heart problem," the

[9] Health and Social Care Act 2012 https://www.centreformentalhealth.org.uk/parity-of-esteem

Ambulance Service attended and Hannah was conveyed to the nearest Hospital.

4.17 In the remainder of this Report, this nearest Hospital is referred to as H1 as the events also cover a second hospital which will be identified in the report as H2. The reason why two hospitals were involved in the scenario was due to a feeling on Hannah's part – supported by the friends who the Independent Reviewer met and Hannah's grandmother - that Hannah did not like attending H1 because of her view of the way she was treated there. This appears to have been at the level of relationships with staff and not in connection with clinical care. The implication appears to have been about views of how people with illicit drug use and/or mental health needs might be treated within a general hospital and whether or not any negative judgement or stereotyping was applied to Hannah.

4.18 The Independent Reviewer has discussed this with the H1 team. It was noted that there is a record of an incident in Hannah's hospital file where in response to a complaint made by Hannah about a member of the clinical team, an apology was given and accepted by Hannah. H1 accept that, firstly, in the many interactions which Hannah had with H1, it's possible that there were other instances of things which were said which Hannah did not like. Secondly, it was recognised as possible that in the midst of extremely challenging work in hospitals requiring response to a range of illnesses and situations, someone may have said something which, intended or otherwise, made Hannah feel de-valued. There did not appear to be any other further direct evidence of complaints in the hospital records. Friends and family drew attention to the need for people using hospital services to be treated with dignity. H1 have stated their commitment to this and this is taken up in the Recommendations.

4.19 On arrival at the H1 Emergency Department (ED) on 28th February, Hannah was accompanied by one of her care / support team. Between 2013 and the date of her death, Hannah had twenty presentations at H1, eight of them in the last five months of her life during 2016. Prior to March 2016, her presentations were mainly due to the effects of deliberate self-harm and drug use. The Review learned that H1 has arrangements for an ED Consultant-led review to be undertaken when triggered by twelve presentations by an individual in a given period of time. Such a review would be aimed at ensuring stability in a health condition or ensuring appropriate arrangements and signposting where necessary, depending on the opinion. This is good practice.

4.20 During Hannah's admission to H1 starting on 28th February 2015, a mental health risk assessment was undertaken and Hannah was allocated special 1:1 care in view of concerns for Hannah's mental health. She was admitted to an acute care unit early on the morning of 1st March. Further clinical actions were initiated as a diagnosis of sepsis[10] - a life-threatening condition which arises when the body's response to infection injures its own tissues and

[10] It is understood that there is on-going national work on the condition and treatment of sepsis.

organs - was also queried. Hannah remained in H1 until 3rd March as her needs were clarified. During that time, Hannah's behaviour shifted to increased compliance with treatment in the context of an action which she took which wasn't compliant with hospital requirements.

4.21 Initially, on this occasion, prior to being seen as more co-operative with treatment, Hannah was judged not to have the capacity to make sound decisions. There was much recorded concern for her health and well-being from H1 as at many other instances by other professionals. The issue of Hannah's mental capacity overall and at various specific points during the time under consideration has been another key factor for consideration through the SAR. A "presumption of capacity" is one of the five principles of the Mental Capacity Act 2005, as is a person's entitlement to make "unwise decisions." Professional judgement is exercised in the space between these principles. As has been noted, everyone was aware of Hannah's understanding, intelligence and how articulate she could be. Given this, the general presumption of capacity seems an entirely reasonable one to have been made. However, staff, friends and family may have continued to have thought that Hannah could still make unwise decisions over which they had no control. It was also raised in the SAR reflections about the overall effect illicit drug use may have on the brain as an organ and the possible effect on the individual about the decisions they might make. These considerations are at the heart of debates and practices about liberty in the encounter between an individual and those who care for them as family, friends or professionals. Professionals in the system were clearly aware of the dilemmas raised by application of mental capacity tests.

4.22 Hannah was declared medically fit and discharged from H1 on 3rd March 2015 but re-admitted on 6th March 2015, remaining there until 12th March 2015. Hannah had been complaining of chest pain and there were a number of wounds caused by some self-harm which required dressing. There was continued concern and reporting about her mental health and at one point during the admission, 15 minute checks were undertaken by the ward in response to their assessed concern. Specialist mental health liaison staff located within the hospital offer a point of contact, advice and action in contact with the mental health care trust, which was also involved.

4.23 Arrangements for transfer of responsibility between locality teams in the mental health trust were completed in April 2015. Hannah's Care Plans were updated at the time. Hannah was included in the "Care Programme Approach" used to support those with more serious and enduring mental health needs. This meant that her care arrangements would be formally reviewed at least every 12 months.

4.24 Hannah contacted the Ambulance Service again on 6th April 2015 as she stated that she did not have enough medication to last until the GP surgery opened the next day. In the course of the day, the issue was clarified and the service understood Hannah was happy to wait and see the GP the following morning. A couple of days later, Hannah made a similar call about her medication and a changed prescription for sleeping tablets.

4.25 Staff have commented that overall Hannah's self-confidence appeared so low that she felt that she deserved bad things to happen. They thought that to some extent, Hannah had been through so many things that she felt she was invincible and did not recognise the risk she was increasingly putting herself under. Her drug use appeared to increase by the end of the summer 2015. She was admitted to H1 direct from attendance at the GP Practice on 11th September following an overdose and she was admitted to the acute care unit. It appears that around this time she was purchasing medication and "legal highs" over the internet. By the evening of 11th September, Hannah was assessed as fit for discharge.

4.26 In the round, by October 2015 there was increasing concern amongst professionals about Hannah's behaviour which was appearing to professionals as increasingly risky. Hannah's package of care was reviewed on 1st October 2015.

4.27 There was an apparent mis-match in expectations about the tasks for which the providers were commissioned to complete for Hannah. As Hannah appeared to deteriorate, her friends noted that Hannah did not seem to be assisted to wash her hair, something which they said was difficult for her to do latterly. The dilemma here is how best to support a person to be in control and independent, to be motivated to care for themselves. There was no difference in interpretation between staff accounts and those of Hannah's grandmother and friends about how the process of working to motivate others such as Hannah might be best approached. The Independent Reviewer noted that Hannah's Grandmother was very clear about who the provider was when talking about Hannah's care. It was less obvious to her, however, who the commissioner was. Staff could clearly articulate those arrangements which appeared to be effectively a form of sub-contracting. On balance, the Independent Reviewer could not be sure, however, that it was really clear who was responsible for the care package and responding to potential areas of disagreement. For instance, it is understood that care staff were concerned about used needles being in unexpected places within the accommodation. This is an understandable health and safety issue for staff. The wider commissioning role and responsibility in clarifying the health and safety issues was not as clearly articulated on this point.

4.28 Hannah's grandmother and friends did not think that the belief that there were needles lying around was a problem in the way it appeared to be painted. It was less clear to the Independent Reviewer how the commissioning and care coordination process influenced the decision of the care provider in this respect, along with some other difficult issues which the providers faced. For instance, responding to Hannah as someone with mental capacity meant that providers were often guided by Hannah's view of things and they faced the challenge on a moment-by-moment basis of trying to motivate Hannah to take responsibility for her own care and welfare. There was gathering concern over a period of time, however, prior to Hannah's death and consideration was being given to the use of a "cleaning contract" which Hannah's Grandmother stated that she initiated. It was less clear to the Independent Reviewer how commissioners were involved in this consideration. Therefore, there is a recommendation that partners consider the “line of sight” of commissioners in respect of individual experience of mental health service provision and how changes to care plans and disagreements are addressed, in case there is opportunity or need to refine current arrangements still further.

4.29 On 1st November the Ambulance Service was called twice when it was reported that Hannah had taken an overdose. They attended at Hannah’s home but, according to records, Hannah refused the offer of conveyance to hospital. The issues referred to earlier of mental capacity were at play here and on this occasion a professional judgement was made that Hannah was safe to stay at home without being taken to hospital.

4.30 By the end of November 2015 there was considerable concern about behaviour being displayed by Hannah which appeared to the professionals involved to be putting her at risk. An allegation made to Police at this time by Hannah was not pursued as she declined to take the matter further. A Safeguarding referral was made by the providers at this time due to the level of concern for Hannah’s well-being. What appears to have been a second safeguarding referral by the providers remained “open” until the time of Hannah’s death. The link between safeguarding and the nature of the circumstances faced by Hannah is an interesting but challenging one. When thinking of her drug use, her situation may be thought of as one in which she fundamentally neglected herself. There has been a lot of research done on the effect on children whose parents abuse substances in terms of the safeguarding of the children.[11] There appears to be relatively less work on adults who abuse substances and the safeguarding implications for themselves, which could help reflection required for this report.

4.31 Around this time, in the course of actions possibly connected to the administration of drugs, a needle broke whilst inserted in Hannah’s arm. She was encouraged to attend the GP Surgery by all staff, aware of the danger of possible infection. Just before Christmas, 2015, on 21st December, mental health specialist staff visited Hannah. Hannah said that she would have an x-ray, but not treatment. She said that she did not want to go to the hospital, H1. She also shared aspects of her behaviour which alarmed the team further and Hannah appeared more vulnerable to them. Hannah was offered respite care around this time but she refused. Later that evening, an ambulance attended Hannah’s home following a call from one of her carers and Hannah refused the offer of transport to hospital.

4.32 Staff from the care agency provider often contacted the ambulance service themselves and accompanied Hannah to the hospital. They were the ones who were most often in Hannah’s company. However, Hannah did not usually want staff to come in with her to the doctors’ and nurses’ appointments. These direct caring roles can be very difficult and challenging. At its best, such care works well. The challenge of such work is being able to work in a system in which incremental changes are noted and

[11] https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/parents-misuse-substances/ accessed 06/02/17

different directions assumed in the provision of the care in response. In the general run of things for Hannah, there was evidence that this occurred. There was some contrasting evidence about the multi-agency working which on the whole was perceived to have been good. However, contact between the care agency and the specialist drugs agency was less clear and is further evidence, perhaps, of the general issue of care co-ordination and commissioning overall where it is possible that lessons might be learned so that communication is as strong as is needed in each situation.

4.33 Hannah was admitted to an orthopaedic ward at H1 on 8th January 2016 due to the broken needle located in her arm. Good multi-agency working across partners was noted on this occasion. Use of mental health services was made on this occasion as a registered mental nurse (RMN) was allocated to be with Hannah on one-to-one basis for the initial period of hospital admission due to concern for her wellbeing. A retained needle was evident on x-ray. Hannah stated this was as a result of her drug use, that she had visited her GP three weeks previously and then did not want to come to hospital. The primary care team were satisfied that there was an orthopaedics plan in place throughout this part of the episode; it was believed that the infection was responding to antibiotics and that at that time it was not judged appropriate to surgically remove the retained needle. On this admission, Hannah told staff that she did not feel that she had enough support in her accommodation and she also stated she had no next of kin. By 18th January she was declared medically fit for discharge. During this stay in hospital, Hannah was found to be in possession of legal highs which were handed over to staff. This will have been a management challenge for the hospital as they had to consider the well-being of other very sick people as well as Hannah.

4.34 There was a further re-assessment of Hannah's mental capacity with a special focus on her ability to decide what medical treatment to accept around this time. This was good practice and responding to the observations of changes appearing to occur at the time. At this time, Hannah made it clear that she understood the risks of amputation with regard to her arm and even death as a possible result of the health problems she was encountering. It was at this point that concern for Hannah by the professionals involved became more focussed on her physical health needs.

4.35 Hannah was readmitted to H1 on 2nd February due an infected right arm and discharged on 6th February. She presented at the Emergency Department again on 8th February with the same health issue and was admitted again until 18th February. During this stay Hannah said that she would like the needle to be removed from her arm and an RMN was again allocated to her care for a time in the hospital.

4.36 There was growing concern amongst staff working with Hannah and a professionals meeting was convened for 11th February 2016. This forum appears to have been a very positive attempt to bring together all staff who might be working with a person. There was tremendous concern that Hannah might die as a result of what was described as "misadventure." Through the professionals meeting process, there was a wish to balance encouragement of Hannah as a young person in charge of her own life and a feeling that a further residential care option might be something of a “defeat” for her at this stage in her life. However, residential or more supported care was the clear direction of plans at that stage.

4.37 Hannah attended a planned orthopaedic follow-up appointment on 23rd February, when plans for an operation were discussed. She presented again at H1 Emergency Department on 26th February with an infection. She again stated that she had no next of kin and was discharged on 29th February. Hannah attended a further planned Orthopaedic follow-up appointment on 8th March. A call to the ambulance service on 11th March, when Hannah was complaining of breathing difficulties and palpitations, resulted in her conveyance to hospital, H1. At the hospital, a pulmonary embolism was suspected. The needle in Hannah’s arm was not considered to be the source of the infection at that presentation. A “respiratory” bed was requested but Hannah self-discharged without medication on that occasion. A couple of days later, on 11th March, Hannah was admitted to H1 with a presentation of Sepsis. Historical self-harm marks were noticed and she received clinical care and treatment in response to her apparent acute care needs of pulmonary embolisms. Surgical and Orthopaedic Team assessments and reviews were done. There was also the involvement of a Critical Care Team. There was a planned discharge for 13th March and records indicate that a Carer collected Hannah from the hospital, but it appears that Hannah left without medication. Hannah presented again at H1 Emergency Department on 14th March but did not wait to be seen on that occasion. On 15th March, Hannah attended a planned orthopaedic follow-up appointment with her Support Worker. She was advised to attend the Emergency Department, which she did with her Support Worker and she was admitted to hospital. The notes stated she was alert and able to give consent. Hannah stated she had recently used illicit drugs. She did not want to be admitted to the acute care unit and it was recorded that Hannah stated that staff there were “rude” to her. She received another apology about her previous discharge home when Hannah reported that at her previous admission she had not received a discharge prescription. Staff initiated action to check on the nature of the discharge at the time.

4.38 During this admission, Hannah was assessed by a Consultant Psychiatrist on 17th March, and reduced medication for Hannah’s drug reliance was prescribed. On 22nd March, Hannah was unhappy with the reduced medication and stated she wanted to go home. She was considered to have capacity. She would not wait for the doctor to review her and left the ward at 20:40 with an intravenous cannula (thin tube inserted into a vein or body cavity to administer medication, drain off fluid, or insert a surgical instrument) still in place. Police, the GP, the specialist community drugs service and care provider were all contacted. At 22:00, Police reported they had located Hannah who stated that she did not want to come back to hospital. Hannah stated she had removed the cannula herself. The discharge letter which was written was judged as thorough.

4.39 Within about a month, Hannah had a further hospital admission but this time at another hospital further from her home, H2. This led to a referral to local community nursing services on 20th April. Hannah's situation appeared somewhat unusual to the community nursing team in that Hannah was much younger than most of the patients on their caseload. Moreover, in view of changing care practices, greater reliance on the patient as an "expert" even to the point of self-administering prescribed drugs through injection e.g. in diabetics managements, was expected. Questions were asked about why it was believed Hannah required the assistance of a qualified community nurse. These questions were clarified and the service began to visit. The contact between H2 and the nursing service again raises some learning in relation to the "parity of esteem" issues identified earlier. As far as the Independent Reviewer could tell, it did not appear that Hannah's mental health needs were identified in the first contact with the community nursing service by H2. There are perhaps at least three possible interpretations to this fact. One interpretation is that Hannah's mental health needs should not have affected the request for a physical health-orientated action i.e. someone with mental health needs is entitled to the delivery of an equal service irrespective of their mental health needs. Another interpretation, however, is that Hannah's mental health needs were not mentioned because they were not thought to impact on the situation. If the latter interpretation was the intended one in this instance, then there is room for reminder of the need for individuals to be seen as a whole person. The final interpretation is that the issue was simply overlooked or forgotten about, but again a commitment to holism would support a worker in bringing the issue to mind as significant for information transfer.

4.40 It is acknowledged that in the system we have now, a lot is expected of people as patients in the responsibility they are expected to take. This often works well and the community nursing service was able to show how people often care for themselves through administering injections e.g. for diabetes. One respondent noted the challenge for teams when a person has seen a number of different practitioners. In other words, this can have a "fracturing" effect as colleagues concentrate on their part in their system. Acknowledging the challenge, it is nevertheless asserted by the Independent Reviewer that all staff within the system should aim to take a holistic view in all interactions and this is mentioned in the recommendations.

4.41 Further contact with ambulance services on 7th May 2016 relating to apparent breathlessness were responded to by conveyance to hospital – H1. During this admission, Hannah underwent surgery on 08/05/16 and was discharged home on 10th May with a follow-up appointment. Ambulance colleagues attended Hannah's home that evening following a 999 call re-routed from 111 and treated the wound as required on that occasion. Community nurses continued to visit and the situation appeared fairly static until 16th May when it was apparent that the wound was not healing. Unsure how to respond to what they were seeing, community nurses referred Hannah to adult social care on 18th May but were advised that the referral was more appropriate for the Mental Health services. The community nursing service also sought advice regarding Hannah from the Multi-Agency Safeguarding Hub (MASH) about Hannah's needs. From information shared after Hannah's death at the Safeguarding Information Gathering Meeting of 18th July 2016, it subsequently became clear that the community nursing services were unsighted on the contribution and role of mental health services in supporting Hannah. No one is suggesting that such knowledge would have altered the outcome of these events, but it is a further reminder of the need for a broader way of bringing the whole multi-disciplinary team together in the interests of the whole person and in this way guaranteeing parity of esteem.

4.42 Still seeking improvement in the healing of the open wound, the community nursing service advised that they would refer to a "tissue viability nurse" on 23rd May if there was no improvement. By now, responding to overwhelming concern from all concerned, a social worker had been appointed to begin the assessment of Hannah for a higher level of care provision. A social worker met Hannah on 25th May 2016 and a "FACE" (Functional Analysis of Care Environments) assessment was completed with a more supported care environment in mind in the first instance.

4.43 By the following day, the community nursing service found the abdominal wound to be necrotic and on 26th May they advised Hannah to seek urgent medical attention. In the first instance, Hannah declined due to her discomfort with H1. The respect for this decision was in response to the on-going positive approach to Hannah's assessed mental capacity to make her own decisions. At the time of the community nurses' visit, Hannah's condition was not deemed as life-threatening – they would have contacted the ambulance services themselves in that situation. However, community nurses explained to Hannah that she was at risk of dying and following further discussions and phone calls, she was taken to H2 by her friend.

4.44 Hannah was admitted to H2 via the Emergency Department on 26th May 2016. Sepsis had been queried at Hannah's previous admissions during the year and it is understood that this was diagnosed on this occasion. By 03:30 on the morning of 27th May, Hannah was transferred to the Intensive Care Unit where she went into cardiac arrest at about 05:20. By 06:21 attempts to resuscitate her were stopped. She was pronounced dead shortly afterwards.

4.45 Her friends who were identified as her next-of-kin were informed of Hannah's death at approximately 08:30.

## 5.0 VIEWS OF HANNAH'S FAMILY AND FRIENDS

5.1 One of the recommendations to this SAR focuses on ways in which staff might work more closely with family and / or friends through the use of a "Consensus Statement" approach. There is no way of knowing if Hannah would have agreed to such an approach in her own situation. A friend believed that Hannah would not have agreed to this. However, the approach is suggested simply because in practice staff followed what they believed were Hannah's wishes with regard to communications about her own needs and any associated contact with her family and the method may help them and families in other circumstances.

5.2 In a letter to the Independent Reviewer following their first meeting, Hannah's Grandmother made five main points which were also used by Hannah's friend who the Reviewer met separately for her own reflections:

- She likened "boundaries" which are set for people who self-harm i.e. not to self-harm, to be like telling an alcoholic *"you must give your solemn word that you will never take another drink."* Her implication was that this is too high an expectation. This observation goes to the heart of the best methods to support a person to change their life. Theory has developed about this over time. Professionals make judgements based on knowledge and experience of an individual. Some latitude may well be given and the Independent Reviewer heard evidence that such latitude was given to Hannah with regard to self-harming. Balancing the needs of an individual and others sharing a resource is not easy, and it is possible that some room for failure might be given dependent on the circumstances and the nature of the work of the organisation concerned. The specialist community-based drugs rehabilitation provider which worked with Hannah accepts this philosophy, for instance. It is accepted by the Independent Reviewer that a different type of service may not do so and this may be especially difficult for residential-type provision, especially where a home is shared.
- She was concerned about standards of care and linked possible infection of Hannah's open wound to the condition of the accommodation. One of Hannah's friends described the accommodation as "a tip." There were other instances described which have led the Independent Reviewer to recommend that commissioners re-assure themselves that the issues described did not fall below the minimum required.
- Knowing that living alone was Hannah's "worst fear" as she put it, Hannah's Grandmother commented that people with mental health problems are not able to make their voice heard and wondered how this came to be the case for Hannah.
- With regard to Hannah's hospital experience, Hannah's Grandmother asserts that Hannah may still be alive had she not had an eight hour wait which resulted in her admission to a hospital further away from the area in which she lived.
- She had the impression that there did not appear to be a lead professional for Hannah.
- She also made a point about recommendations of SARs not appearing to be as strong as they are for other related activity such as OFSTED inspections.

5.3 In addition, one of Hannah's friends, when reflecting on all that had happened, asked for the following in work with people with mental health problems:

- More empathy
- Treat people with respect even if you don't like them personally
- Better communication between agencies

5.4 In this SAR, the Independent Reviewer is mindful that communication with Hannah's family and friends was governed by Hannah's wish. The issues connected to this were discussed earlier. Although the Independent Reviewer believes that it is impossible to be certain, it may have been that had Hannah agreed to the "Consensus Statement" type of approach, there may have been a clearer view of what was happening and the aims which were being sought between Hannah's family and friends and the professionals who were concerned for Hannah's welfare. This may have affected the kind of view expressed by Hannah's Grandmother as outlined above. A recommendation has been made to consider how such approaches might be brought into the practice arena.

5.5 A further letter was written by Hannah's Grandmother following the second meeting with the Independent Reviewer in which the first draft of this Report was shared prior to consideration by the GSAB SAR sub-group and GSAB itself. This set out a detailed version of the chronology, her judgements on aspects of the service and her interpretation of the information included in the first draft of this Report.

**6.0 GOOD PRACTICE EXAMPLES** – were noted at the Learning Event. For example:

6.1 The GSAB noted that this Review has been amongst the most challenging which it has undertaken. This is surely due to the complexity of the circumstances for Hannah, first of all, her friends and family and for those seeking to support her through their work and practice. For the latter group, it is important to know that the Independent Reviewer has noted a range of good practice pointers which included:

- The system showed artefacts through which growing and escalating concern for Hannah could be routed e.g. the professionals meeting convened in February 2016 to respond to the developing concern that Hannah might die as a result of her decisions and lifestyle factors.
- The safeguarding referrals and enquiries made by the care provider around December 2015 and the community nurses show concern for Hannah, awareness of the procedure and attempts to link the experience of drug-use with safeguarding matters.
- Staff were "asset-based" in their approach to Hannah in assessing Hannah's mental capacity in a positive way and being concerned that her possible use of residential care might represent something of a "failure" in the actions taken to support her.

- The approach taken by the ED at H1 where special meetings could be triggered to ensure best management of people attending the ED frequently.
- With the principles of the *National Mental Health Strategy* in mind (see Appendix 3) it was encouraging to note:
    - Primary care: routine physical health checks for people with mental health needs
    - Mental Health liaison in the hospital setting
- Innovation: the Recovery College model is a named instance of a resource and approach which appears to combine a number of positive attributes to support people experiencing mental health needs to move to a new and better phase in life based on an empowerment model. This is mentioned in the Recommendations.
- Staff appeared committed, very knowledgeable and expert practitioners who benefited from supportive teams. The supervision process was used to good effect in helping colleagues determine the issues which they were facing and agreeing ways forward
- A "Wellness Recovery Action Plan" is in place for use of the person with mental health needs alongside the practitioner. However, the version seen by the Reviewer appears somewhat dated in style of presentation, and so is included amongst the actions in the Recommendations section.

## 7.0 RECOMMENDATIONS

The GSAB sought recommendations which were as "SMART" as possible. With this in mind, the following issues are drawn from the analysis of events as outlined above

### 7.1 *RECOMMENDATION 1 – Models and methods*

7.1.1 For the GSAB to request Gloucestershire Suicide Prevention Partnership to consider the feasibility of embedding the "consensus statement" approach in professionals' practice to mental health practice and to keep the GSAB updated of their monitoring of national requirements.

7.1.2 For GSAB to request Gloucestershire mental health commissioning and mental health partners to develop their work on broadening the range of accommodation available and pathways for people with mental health needs, e.g. shared care or similar models, to allow a greater choice of more supported environments for people with mental health needs and to keep the GSAB up-dated.

7.1.3 For GSAB to request Gloucestershire mental health commissioning and mental health partners to support their work on broadening the use of innovative models of mental health support such as the "Recovery College" methodology and to advise the GSAB of progress.

## *7.2 RECOMMENDATION 2 – commissioning and care co-ordination*

7.2.1 For GSAB to seek further assurance from mental health commissioners about the integrity of current case holding / care co-ordination processes across the commissioner-provider continuum in mental health services, to be sure that there is holistic understanding and practice amongst their teams about the nature of the care-coordination process.

## 7.3 *RECOMMENDATION 3 - Parity of esteem and dignity*

7.3.1 For GSAB to seek assurance and updates from mental health commissioners and partners about the implementation of the National Mental Health Forward View with regard to “parity of esteem” under the “Core 24” standards and specifically in the H1 Emergency Department.

7.3.2 For GSAB to seek assurance from the Mental Health and Wellbeing Partnership Board about the progress of its roll-out of the training programme on mental health awareness to include reference to parity of esteem and dignity in care.

7.3.3 For GSAB to request the Mental Health and Wellbeing Partnership Board to oversee updating of its Wellness Recovery Action Plan to ensure the development of a product which is easy to use and meaningful to people who use mental health services.

## APPENDIX 1

### 1. Terms of Reference – Safeguarding Adults Review – Hannah

**General**:

1.1 To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk.

1.2 To review the effectiveness of procedures (both multi-agency and those of individual organisations).

1.3 To inform and improve local inter-agency practice.

1.4 To improve practice by acting on learning (developing best practice).

1.5 To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

**Specific:**

1.6 To examine how the circumstances leading up to the death of Hannah, who died in hospital on 27$^{th}$ May 2016, were handled and whether the policies and procedures in place across various agencies during that time were followed.

1.7 To consider whether all opportunities to ensure Hannah had received appropriate care and support within the overall delivery system were identified up to the time of her death.

1.8 To review the effectiveness of multi agency communications across the many agencies that were involved in her care.

1.9 To review the appropriateness of the accommodation arrangements since moving to Gloucester.

1.10 To review the effectiveness of the commissioning, monitoring and inspection of services being provided to Hannah and the funding arrangements.

1.11 To review agencies' responses to Hannah's decisions not to seek medical treatment.

### 2. Reason for the Review

2.1 This review was commissioned by Gloucestershire Safeguarding Adults Board (GSAB). The subject, Hannah, lived in Gloucester and was in receipt of a care package of 3 hours support every morning, 2 hours support at teatime and 5 sleep-in nights. A friend took Hannah to hospital on 27$^{th}$ May 2016 and she died the same day from a Pulmonary Embolism, Venous Thrombosis, Obesity and wound infection.

2.2 The time period covered by the review is 01/01/2015 to 27/05/16. The Terms of Reference set out the particular issues agencies are asked to consider.

## Appendix 2

**What is a systems approach?**

The systems approach in social care is rooted in the work led by Professor Eileen Munro and developed in the Social Care Institute for Excellence (SCIE.) [12] The key features of the approach are that it:

- has been adapted from the systems approach used in other high risk areas of work, including aviation and health
- supports an analysis that goes beyond identifying what happened to explain why it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken
- involves moving beyond the basic facts of a case and appreciating the views of people from different agencies and professions
- is a collaborative model for case reviews – those directly involved in the case are centrally and actively involved in the analysis and development of recommendations
- sees people as being part of the system because their behaviour is shaped by systemic influences
- includes all the possible variables that make up the workplace and influence the efforts of frontline workers in their engagement with people… (from) procedures, tools and aids, working conditions, resources and skills, (to) team and organisational cultures *(and design)*
- acknowledges that heroic workers can achieve good practice in a poorly designed system, but efforts to improve practice will be more effective if the system is redesigned so that it is easier for average workers to do so
- helps identify which factors in the work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely
- provides a way of thinking about front-line practice … and produces organisational learning that is vital to improving the quality of work with (adults and families) and the ability of services to keep (adults) safe.[13]

---

[12] *http://www.scie.org.uk/children/learningtogether/resources.asp*

[13] *Adapted from: At a glance 01: Learning together to safeguard children: a 'systems' model for case reviews* ***(January 2012)***

## APPENDIX 3

### SOME RELEVANT RESOURCES

Consensus Statements for sharing information with families:

- Forthcoming Updated National Suicide Prevention Strategy 2017
- DH Jan 2014 *Information sharing and suicide prevention Consensus statement*
- *House of Commons Health Committee Suicide prevention: interim report*
- *Fourth Report of Session 2016–17 Report, together with formal minutes relating to the report Ordered by the House of Commons to be printed 13 December 2016*
- *From:*

*https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news-parliament-20151/suicide-prevention-report-published-16-17/*

**Family Therapy -** Association of Family Therapy: http://www.aft.org.uk/view/index.html?tzcheck=1

Family Group Conference method –

https://www.frg.org.uk/involving-families/family-group-conferences/fgc-network

*No Health Without Mental Health - A cross-government mental health outcomes strategy for people of all ages* 2011 https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

Extracts from 2011 mental health strategy *No Health Without Mental Health* tells us that:

- *at least one in four people will experience a mental health difficulty at some point in their life*
- *half of those with lifetime mental health difficulties experience symptoms by the age of 14 and these can carry on through life*
- *mental illness is the largest disease burden upon the NHS - up to 23% of the total burden of ill health*
- *mental illness is the largest cause of disability within the UK costing as much as £105 billion a year*
- *physical health is inextricably linked to mental health*
- *poor mental health is associated with obesity, alcohol and substance misuse, smoking, and possible related diseases*

The 2011 Strategy asserts, therefore, that:

- *Mental health is a vital element of the of the quality of life, physical health, emotional, social well-being, economic success and educational achievement of individuals, families and communities*
- *mental health is 'everyone's business' and*
- *the Government aims to 'mainstream' mental health within England, to establish and develop parity of esteem between mental and physical health*

Also see updated material in: *Implementing the Mental Health Forward View* (2016) at https://www.england.nhs.uk/mental-health/taskforce/imp/

**END OF REPORT**