



GLOUCESTERSHIRE SAFEGUARDING ADULTS BOARD

**EXECUTIVE SUMMARY
SAFEGUARDING ADULTS REVIEW
Re. Hannah**

Independent Reviewer:

Brendan Clifford

Date: May 2017



PRIVATE AND CONFIDENTIAL

EXECUTIVE SUMMARY

- ES1 Hannah ¹ was a young woman from Gloucestershire who died, aged 26, on 27th May 2016. She died in hospital of natural causes. Health concerns prior to her death included the effects of obesity and an on-going wound infection which she had had during the last six months or so of her life. There was no further investigation about the cause of Hannah's death by the Coroner's office.
- ES2 Hannah was someone who had used a wide variety of mental health services and interventions from her teenage years and to an increasing extent prior to her death. This latter experience did not prevent Hannah from achieving a place at a University when she was 18 but she dropped out after the first year.
- ES3 The Safeguarding Adults Review undertaken about Hannah's support and care generally focussed on last eighteen months of Hannah's life. One of Hannah's Grandmothers and two of Hannah's friends participated in the Review along with staff who worked to support Hannah.
- ES4 In reflecting on Hannah's experience, the Review thought about the cause of mental health needs or problems and the best way to respond to those needs. An important aspect of this was seen as the motivation of a person to change their behaviour. This was seen as important in view of the worrying incidence of young people facing similar challenges in their lives in Gloucestershire today as those experienced by Hannah. Everyone wanted to learn from what happened so that these other young people could be helped even more effectively.
- ES5 In terms of the best way to respond, Hannah's use of illicit substances was a case in point. Noting the legal aspects of drug use, the Review saw how some drugs services adopt methods which, whilst aiming for the person to change and stop their drug-using behaviour, accept that a person may continue to use drugs or relevant substitutes for some time on their way to stopping eventually.
- ES6 Other services take a "zero-tolerance" approach to drug-use. This was the case of a residential home for people recovering from mental health problems used by Hannah which she was asked to leave in view of a re-occurrence of drug use. The decision to ask her to leave was taken, firstly, out of consideration for the other people living in the same building who were also trying to change their lives and, secondly, due to the wish to see a positive change in behaviour by Hannah so that she could move on to more independent living and live as many others do. Hannah moved to another location with support but she was generally living on her own – something which she did not want to do.

¹ Hannah is the real name of the person whose support and care are the subject of this review. Her family and friends wanted Hannah's real name to be used.

- ES7 Everyone who participated in the Review accepted that the effects of trauma can make it difficult for anyone to change their life if the trauma has had a negative effect. Concern for Hannah deepened in due course and it was thought that Hannah might die as a result of her lifestyle. There was extensive consideration of Hannah's capacity to make her own decisions and the judgement was that, in the round, she could do so. For instance, staff were led by Hannah's views about contact with her family. For this reason, the Review has recommended that consideration be given to adopting an increasingly used approach to give the opportunity for greater family support to occur. It can't be known if Hannah would have co-operated with such an approach.
- ES8 There were some examples of good practice in the response by various services to Hannah and her needs. For instance, the Hospital and the GP's surgery had some good arrangements to support better healthcare for people with mental health problems. In addition, a meeting of professionals was held to share increased concern about Hannah's well-being and a clear direction for next steps was planned for Hannah to move to another even more supportive environment and accommodation.
- ES9 During her extensive use of Hospital services, Hannah felt that some staff in the Hospital were (to use her words) "rude" towards her which made her feel de-valued. Hannah's Grandmother and friends also felt in general that the quality of care Hannah experienced in the last eighteen months of her life was not the standard required. The practicalities about this have been considered and the review has recommended that steps to encourage greater "parity of esteem" or equality between the response to mental health needs and physical health needs, be strengthened. Also, it has been recommended that efforts be made to promote a wider availability of different accommodation for people with mental health needs.
- ES10 Hannah used a lot of services and on many occasions - both mental health and physical health services. The Review showed how much is expected of people as patients today where they are expected to cooperate with and be "in control" of their own care. This isn't always straight-forward for anyone who may be more vulnerable. In general, however, there were many things which worked sufficiently well for Hannah. On occasion, it was harder to see who the lead professional in the situation was due to the arrangements for acquiring and monitoring care. Therefore, an aspect noted for further consideration was the overall working arrangements between commissioners and providers of domiciliary care service
- ES11 Hannah's Grandmother described Hannah as "*highly intelligent, articulate, caring and multi-talented... [someone] who impacted positively on numerous people.*" Everyone who participated in the Review wants to learn from the sad events which have occurred so that others might be helped through the changes which are made in the system. Everyone believes that this is what Hannah would have wanted.