

## CASENOTES MENTAL HEALTH

ANDREA ADAMS

# Suicide of care leaver Andrea Adams

By Kirsten Heaven, Garden Court Chambers

Name of deceased: Andrea Adams

Place of death: Stockport

Date of death: 12 June 2006

Date of inquest: 9 August 2009 –  
18 September 2009

Coroner: HM Coroner for Greater Manchester  
South District, Mr John Pollard

Solicitors: Fiona Borrill and Amy Nicholson,  
Lester Morrill Solicitors

Counsel: Kirsten Heaven, Garden Court  
Chambers

Counsel to the inquest: Leslie Thomas,  
Garden Court Chambers

Other parties represented at the inquest:  
Greater Manchester Police; Stockport  
Metropolitan Borough Council; Pennine  
Care NHS Foundation Trust; Manchester  
Mental Health and Social Care Trust;  
Stockport NHS Foundation Trust; the  
Together Trust.

Verdict: Suicide

This article 2 inquest related to a non-custody suicide of a vulnerable care-leaver. The inquest focused on the involvement of various state agencies having contact with Ms Adams in the weeks leading up to her death: Greater Manchester Police and various NHS Trusts (A&E departments and mental health facilities), Stockport Metropolitan

Borough Council's Children and Young Persons Directorate (SMBC), as well as the involvement of SMBC and Stockport mental health services in the seventeen months leading up to Ms Adams' death and, in particular, the extent to which SMBC complied with their Children Leaving Care legal duties.

### Background

In December 2004 (ten months before her eighteenth birthday), Ms Adams disclosed to her social worker that she had been sexually abused by her foster father from a very young age. Within a short space of time Andrea was removed from the family home, which she shared with her natural siblings. SMBC were unable to find a suitable replacement foster placement and opted to place Andrea with a private foster-care provider – the Together Trust – at an increased cost to SMBC. Normally an SMBC foster-carer would convert accommodation to supported lodgings when a young person reached the age of 18, thus offering continuity of care post-18. This was not possible with the Together Trust as they did not offer accommodation beyond the age of 18. SMBC did not appear to have given this fact detailed consideration prior to agreeing to contracting out with the Together Trust.

On entering the placement Ms Adams developed a positive but highly dependant relationship with her carer; her relationship with her foster-mother and brothers having broken down. However, her mental health started to deteriorate and she started to self-harm, overdose and abuse alcohol and drugs. As Andrea approached 18 SMBC made it clear that they would not fund her placement beyond 18, nor would the Together Trust turn it into supported lodgings. Consequently, 10 months after disclosing the abuse, Ms Adams ended up in independent living with SMBC enforcing the severance of contact with the foster-carer (who was overwhelmed). By this stage Ms Adams had dropped out of school, had lost her part-time job and was becoming increasingly vulnerable.

From December 2005-June 2006, Ms Adams' behaviour rapidly deteriorated

and she increasingly threatened suicide and self-harmed. She also reported being raped. There were attempts by her GP to get her into adult mental health services but these repeatedly failed as community mental health teams took the view that they could not help Ms Adams until she 'took responsibility' and gave up alcohol and drugs (similar comments were made nearer to Ms Adams' death by junior psychiatrists). Ms Adams was assessed by a consultant psychiatrist and he recommended psychotherapy but was told that there were no facilities in Stockport for young people of Ms Adams' age. She was given a tentative diagnosis of a personality disorder and referred to community mental health teams. Ms Adams failed to attend appointments with community psychiatric nurses, but they did little to attempt to engage her. Ms Adams was increasingly threatening suicide and repeatedly overdosing and was eventually admitted to a mental health unit on an informal basis. At around this time it transpired that Ms Adams did not have a social worker (a legal requirement up to the age of 21). By this stage there was a multiplicity of individuals from various agencies involved in her life but attempts to co-ordinate failed persistently. Ms Adams was discharged, yet again overdosed and was readmitted. She was further released with in-possession medication by a psychiatrist, and used this to overdose. In the weekend leading up to her death Ms Adams met her care-coordinator but was left in the care of the crisis team (who worked 9am-5pm) with an out of hours bleep holder.

During this weekend Ms Adams claimed again to have been raped. She was admitted to A&E after taking an overdose and collapsing at a rape crisis centre. The police, whilst investigating the rape allegation, also arrested her for criminal damage (after she threw a stone through her alleged abuser's window) apparently not realising that she was also a rape victim. After being released from custody Andrea went into crisis and called the crisis number indicating to a nurse she was going to kill herself. Police officers found a young female drunk on the street and she was sectioned in >>

>> part because it was believed she was Ms Adams. Separate officers attended Ms Adams' flat, saw a suicide note, and empty pills. Ms Adams expressed a wish to die at some stage but they felt they could take no action. There was no communication with mental health services nor, it seems, between the police officers.

On Monday morning the care-coordinator, unaware of the weekend's events, received a suicidal call from Ms Adams, but after speaking to the consultant psychiatrist felt Andrea was attention-seeking and so took no action. Co-incidentally a care-worker from SMBC and the police attended Ms Adams' flat regarding the rape. The police left and Ms Adams threatened the care-worker with some knives. She was calmed down and the care-worker left Ms Adams, who then climbed on to a window-ledge. The police arrived but attempts to get her off the window ledge failed. Ms Adams jumped. She died instantly as she had been placed by SMBC high up a high-rise tower block with windows that opened like a door.

At no stage did Ms Adams have a personal advocate or an independent personal adviser, despite making numerous complaints to SMBC about her treatment and the lack of help to facilitate contact (as she perceived it) with her siblings. The allegation of sexual abuse was not pursued by the police after investigations but Ms Adams felt disbelieved and was not returned to her foster carers and only reconciled with her brother weeks before her death. At no stage did she receive professional psychological or psychiatric help.

### The inquest

Prior to the inquest the coroner was persuaded that article 2 ECHR was engaged, given the multiplicity of state agents involved in both the long and short term and the proximity of police custody to Andrea's death and the strong warnings she gave shortly before taking her own life. Emphasis was placed by the family on the decision in *Platts v HM Coroner for South Yorkshire (East District)* [2008] EWHC 2502 but whilst awaiting a decision from the coroner the

House of Lords handed down their decision in *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74; reliance was placed on Lord Scott's comments at paragraph 11:

*As to persons known to be a suicide risk, the State has no general obligation, in my opinion, either at common law or under article 2(1), to place obstacles in the way of persons desirous of taking their own life. The positive obligation under section 2(1) to protect life could not, for example, justify the removal of passport facilities from persons proposing to travel to Switzerland with suicidal intent.*

**Children may need to be protected from themselves, so, too, may mentally ill persons but adults in general do not...** [emphasis added].

State's obligations to children leaving care and article 2

Once a child reaches the age of 18 the state no longer has extensive duties and cannot be said to exercise coercive power (a key indicator post *Savage* to whether or not article 2 is engaged). Hence it is difficult to argue that for care-leavers the state is always accountable for safety and well-being such that any failure to protect against suicide triggers the article 2 investigatory obligation. However, care-leavers are often extremely vulnerable and leave care with mental health problems and so frequently fall into the categories indicated by Lord Scott. Further, the state does have legal duties towards such young people until they reach the age of 21. The Children Leaving Care Act 2001 (which amends the Children Act 1989) requires local authorities to advise, assist and befriend with a view to promoting the young persons welfare after they turn 18. It was introduced to provide care-leavers with support in the form of a pathway plan and a personal adviser from 18-21 – which helps them plan and prepare for adulthood before and after the age of 18. The personal adviser should advocate for the young person and co-ordinate the services available to them.

As a result of the inquiry into the death of Victoria Climbié, the Children Act 2004 was enacted which imposes

further duties on local authorities, one of which includes a duty to promote co-operation with other agencies to improve the well-being of children. Where there are clear failures in co-operation and support of a vulnerable young person there could conceivably be instances where those failures possibly (or even probably) contribute to a self-inflicted death. In such instances there are strong arguments to be made on article 2 being engaged and/or the need for a wide-ranging enquiry.

### Verdict

In the Andrea Adams inquest the verdict was to be delivered the Friday before the case of *Lewis*<sup>1</sup> was to be handed down by the Court of Appeal. There were the inevitable causation difficulties facing HM Coroner but despite submissions on behalf of the family, the coroner did not agree to an adjournment. The verdict delivered was a short form verdict that Ms Adams took her own life but was accompanied by 23 rule 43 recommendations relevant to all the state agents having contact with Ms Adams prior to her death.

1. *R (on the application of Lewis) v HM Coroner for the Mid and North Division of Shropshire* [2009] EWCA Civ 1403 – see pp.8-11.