

- My name is Julie Magee and I have been a member of Belfast Mental Health Rights Group since March 2012.
- My brother Jonny took his own life on 29<sup>th</sup> January 2011 after leaving Belfast City Hospital A&E while waiting to be sectioned.
- I would like to tell you a little bit about what happened that day at A&E and my experience of going through a serious adverse incident review in April 2011 and the changes we have tried to get since then so families are treated better than mine were.
- Jonny hadn't been well for a while before that. Jonny told us that the psychiatrist had told him that he had been diagnosed as being psychotic in 2010; for us we could see that he had been paranoid and depressed. That morning, I rang the police because my tablets were missing and so was Jonny.
- All that day I didn't know anything. At 6pm the police rang me to tell me they had found him and that he had injuries. I didn't know at this stage that he had slit his wrists.
- I rang the A&E reception at City Hospital and told them to make sure that Jonny didn't leave until my dad arrived. He had a habit of walking out so I needed to make sure he was safe.
- Despite finding out later that the hospital classified Jonny as high risk, they still let him out to go for a smoke and to get food unsupervised during this time.

- The hospital stitched Jonny up but I don't think they looked after his mental health. He was there until 1am and he should have been sectioned under the Mental Health Act but this never happened. They couldn't section him until another doctor signed off on this happening. The doctor never arrived to do this and Jonny left without the help he needed.
- After leaving Belfast City A&E Jonny made his way to Lisburn. I found out later that he also went to Lagan Valley hospital that day to get help. They didn't help him either and have since told me that they don't have any record of him even being there. Despite all his attempts for help and all the time he spent in A&E, Jonny died that day.
- Jonny was failed by both the health service and the police service. I've been through both systems trying to get changes put in place. I'd like to tell you about trying to get change in the health service now.

### **Serious Adverse Incident**

- The Trust contacted my mother about having a Serious Adverse Incident Review. I didn't even know what that was until all this happened.
- I felt that we did not get much information about the Review from the Trust – certainly no written information, it was all verbal.

- I said to the Trust that I would be bringing a notetaker, I brought Stephanie with me from PPR. However, on the day the Chairperson was very unhappy about Stephanie being there. I said I had already told them that I was bringing a notetaker. Then a big argument started.
- I demanded that I was not going in until the notetaker was allowed in. I felt really angry and frustrated. **You shouldn't have to go through that when you are going in to hear what happened to your brother.**
- when we got in there, they had about 20 people there who had been responsible for the care of my brother and they also had people there to take notes. Why was it one rule for them and a different rule for me?
- I felt very intimidated and nervous because I'd never been through anything like this before and *so many people* were round the table.
- I knew my brother for 29 years but felt that my voice was not as important as we had to wait to the end to speak – and it's hard to remember all the things you had wanted to say by then.
- Coming out of the room the whole family were upset and to me the rest of the people there just went on with their lives.
- Following all this - I wrote a letter to complain about what happened at the Serious Adverse Incident Review – about the argument that took place in the public hallway. I received a

letter back **which I was not happy about at all.** It made things worse for me at that time.

- It took a lot of months and struggle - including meetings with MLAs and the Chief Executive of the Trust - plus using the press and also taking part in a review of how families are involved in serious Adverse Incident Reviews
  
- **but we finally got changes:**
  - families going through Serious Adverse Incident Reviews are allowed to bring a notetaker.
  - A Family Liaison Officer was appointed by the Trust to support families,
  - a pack was developed to give to families more insight into what serious adverse incidents are about
  - Finally it was agreed that families could speak more often during the meetings and that better venues would be found for the meeting themselves.

The last point I would like to make is that Serious Adverse Incidents are important for families as they give families answers.

BUT they are also important for Trusts to make sure they learn lessons and to make sure other families don't have to go through what mine did.

I would like to see greater evidence that this learning is actually happening.

Thank you.