Safeguarding Adult Review H: Stacey

Produced by Warrington Safeguarding Adult Board

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Acknowledgements

A multi-agency learning process is only effective when partners work together to reflect on missed opportunities. This can be a complex and challenging process for professionals and one which is emotionally demanding for families. The Safeguarding Board staff recognise this and would like to thank those who supported the process and enabled the team to progress the Review. The Board was able to compile this report following the receipt of the findings developed by Mick Haggar and would like to thank him for his contribution to this review.

We would also like to thank Stacey's family for their contributions to this Report, particularly as there have been some delays during the process. Their patience, during very difficult times for them, is very much appreciated.

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1. Introduction

1.1 This report records the findings of a Safeguarding Adults Review (SAR) undertaken on behalf of Warrington Safeguarding Adults Board, following the death of Stacey, an adult with care and support needs. Such a Review is required under Section 44 of the Care Act 2014. This states that a SAB must arrange a SAR when:

"…an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult." (14.162[1])

1.2 The circumstances of Stacey's death also met the criteria for a Learning Disabilities Mortality Review[2] (LeDeR), the national programme which aims to make improvements in the quality of health and social care service delivery for people with learning disabilities, through review of the circumstances of deaths of people with a learning disability. It was agreed at the onset of the SAR that information obtained during the process would be shared in order to support the LeDeR.

1.3 The intention of a SAR is to identify what agencies might have done differently that could in future prevent harm or death. The purpose is to learn lessons so that steps can be taken to prevent similar harm occurring to others.

1.4 The SAR is not a process to hold individuals or agencies to account, as other processes exist for that purpose. Instead the SAR sets out to encourage reflection on how agencies may work more effectively together to meet the needs and safeguard adults with care and support, in this case those with needs similar to Stacey's.

1.5 The SAR has been conducted subsequent to and in some cases, parallel with other enquiry processes. This includes a Serious Incident process under the NHS Serious Incident Framework, and a police investigation that determined no criminal prosecution for abuse or neglect would be taken forward.

1.6 It is not the purpose of this SAR to focus in detail on the moments leading to Stacey's death or to determine how she died. The Terms of Reference of the SAR have been shared with the Coroner and there are arrangements in place to ensure relevant information can inform the Coroner's inquest process.

1.7 Stacey's family were keen to engage with the SAR process and have been consulted at various stages in order to inform the review about Stacey and her experience of services and to capture their views on lessons to be learnt.

1.8 The SAR has been undertaken in cooperation with agencies from Trafford and those services which were commissioned by Trafford Council and Clinical Commissioning Group (CCG), to meet Stacey's assessed needs.

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[1] Care Act 2014 Statutory Guidance - https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

[2] This programme supports areas to review deaths of individuals with a Learning Disability. http://www.bristol.ac.uk/sps/leder/about/

2. Stacey

2.1 Stacey was described by her family as a kind, generous and loving person with a good sense of humour. They have explained that she wanted to live a life like other people, be an independent person and have her own place near to her family. After her death some members of the local youth club wrote a eulogy that described Stacey as:

"… An outdoorsy person. She liked cycling, kicking about a football, being on the park. She was a character. Bold, feisty, in your face, joyful, emotional, loving and caring…"

"She was a brilliant swimmer. She loved her pets. Her dogs and hamster meant the world to her."

"She loved it when the babies were born and would tell us with pride whenever there was a new addition in the family. She sometimes was a little embarrassed because she knew she was being out of order and sometimes totally unrepentant… "

"She was an independent girl liking to do what she wanted when she wanted and wasn't afraid to just walk away if she wasn't happy with something. She wasn't backward in telling you exactly what she thought about you on any given day especially if she was having a bad day but she also gave the sincerest apologies if she felt you deserved it. She wasn't keen on following the rules but she was a strong believer in things being fair… "

2.2 Stacey was born in July 1992 with bulbar palsy[3] and mild cerebal palsy[4]. She had a formal diagnosis of moderate learning disability with challenging behaviours and a full scale IQ of 54. Stacey faced challenges shortly after her birth needing to be PEG[5] fed and undergo a procedure to treat reflux disease and a hiatal hernia. At age 9 Stacey was given the diagnosis of Worster Drought Syndrome[6] (WDS), a type of cerebral palsy, known to impact on movement of the tongue, lips and jaw. For Stacey this meant she had lifelong difficulties in relation to speech, feeding and swallowing. Stacey's cerebral palsy affected her right leg and foot, limiting her mobility. Stacey also had Ocular Motor Apraxia[7], a visual condition, which meant that she had difficulty in controlling her horizontal eye movement. She had to turn her head in order to focus on or follow objects.

2.3 Stacey was described as having significant communication difficulties with problems of both understanding and communicating with others. Her adult vocabulary understanding was assessed at the 13-15 year level however her emotional state could reduce her understanding of what was being said. This meant that she often had difficulty evaluating situations and struggled to interpret the intentions of others. Her family described how she was often led by the situation she found herself in rather than making conscious informed

[3] A bulbar palsy refers to disease affecting the glossopharyngeal, vagus, accessory and hypoglossal nerves and is due to lower motor neuron pathology. https://www.sciencedirect.com/topics/medicine-and- dentistry/bulbar-palsy

[4] Cerebral Palsy is an umbrella term that describes a persistent disorder of movement or posture caused by an abnormality in brain development and ranges in its severity https://www.nhs.uk/conditions/cerebral- palsy/ https://www.nhs.uk/video/Pages/Cerebralpalsy.aspx

[5] Percutaneous Endoscopic Gastrostomy - A way of introducing food, fluids and medicines directly into the stomach by passing a thin tube through the skin and into the stomach. https://www.uhb.nhs.uk/pdf/PiHavingPegInserted.pdf

[6] WDS is a type of cerebral Palsy focused specifically around the mouth and throat https://www.gosh.nhs.uk/conditions-and-treatments/conditions-we-treat/worster-drought-syndrome

[7] Ocular Motor Apraxia refers to a condition that impacts the brains ability to control eye movement https://aapos.org/terms/conditions/138

choices. Although Stacey could verbally communicate, in short sentences and Makaton[8] sign language, her WDS meant that her speech was not easy to understand until the listener became used to her speech patterns. As a result Stacey required consistent care staff so that her needs and her communication were understood.

2.4 Stacey had a close and loving family. She was one of four children, with one older brother and two sisters, one older and one younger. Stacey's parents cared for her at home until she was 20 when she moved to supported living accommodation. Her family had frequent contact with Stacey throughout her community and hospital inpatient admission periods. Her parents seeking the best care for her advocated on her behalf (her father being formally her "Nearest Relative"[9] under the Mental Health Act processes). Due to differences of opinion about the quality of care and her needs, relationships between the family and the services seeking to support Stacey were at times strained.

2.5 Stacey died on 28th May 2017 after an incident of ingesting and choking on paper towels that led to a cardiac arrest[10] due to blocked airways and a hypoxic brain injury[11] from which she didn't recover. She was 24 at the time of this incident, detained under Mental Health Act section 3 within a psychiatric hospital whilst awaiting a community placement that could support her transition from inpatient to community based care.

2.6 This SAR has focused on the months preceding her death and the provision of care and treatment to Stacey during the time she was an inpatient in a psychiatric unit in Warrington. The primary purpose of the SAR is to identify any missed opportunities or learning for the way agencies work together to promote the wellbeing and safeguard adults like Stacey. The SAR team identified that it was also important to gain an overview of Stacey's history to provide a broader context to what happened in this time period and to understand the escalation in her needs and behavioural presentation. This had culminated in a detention in a psychiatric ward for almost 4 years, in a setting that was recognized to be inappropriate by all those responsible for her care.

[8] Makaton is a language programme that uses signs and symbols to aid communication - https://www.makaton.org/aboutMakaton/

[9] The Nearest relative should act on behalf of the individual to make sure their views are heard https://assets.nhs.uk/prod/documents/MH-CoP-Nearest-relative.pdf

[10] A cardiac arrest is when a heart suddenly stops pumping blood round a body, commonly because of a problem with electrical signals in the heart. When your heart stops pumping blood, your brain is starved of oxygen. This causes you to fall unconscious and stop breathing. https://www.bhf.org.uk/heart-health/conditions/cardiac-arrest

[11] A complete interruption of the supply of oxygen to the brain is referred to as cerebral anoxia. If there is still a partial supply of oxygen, but at a level, which is inadequate to maintain normal brain function, this is known as cerebral hypoxia. https://www.headway.org.uk/media/2804/hypoxic-brain-injury-factsheet.pdf

3. Method and Process

3.1 Concerns over Stacey's death formed the basis for referral as a Safeguarding Adult Review (SAR) by Warrington Borough Council in June 2017. A formal screening process in July 2017 considered that the statutory criteria were met and a recommendation was made to the WSAB Independent Chair that the case be taken forward as a statutory SAR[12]. This was due to indications that:

- issues were identified in relation to communication about Stacey's care, safeguarding incidents and the management of risk
- there had been serious problems leading to delays in identifying a suitable community placement
- due to lack of alternative placements Stacey remained in an inappropriate environment for a significant period of time.

3.2 The WSAB Independent Chair confirmed a decision to undertake a SAR. In doing so she noted that although there was no indication of any intentional neglect, the health and social care system had not been able to enable Stacey to live her life consistent with her wishes and human rights and effectively safeguard her.

3.3 A panel was established in September 2017 to oversee the SAR process in line with local procedures. The constitution of the panel reflected the fact that Stacey had been placed and supported in Warrington by agencies external to the local area.

3.4 Contributors to this review were:

- Cheshire Constabulary (CC)
- North West Ambulance Service NHS Trust (NWAS)
- North West Boroughs Healthcare Foundation Trust (NWB) (previously known as 5 Boroughs Partnership)
- Warrington Borough Council (WBC)
- Warrington Clinical Commissioning Group (WCCG)
- Warrington and Halton NHS Foundation Trust (WHHFT)
- Warrington WSAB Third Sector Representative
- NHS England
- Trafford Local Authority
- Trafford Clinical Commissioning Group (TCCG)
- Cheshire and Wirral Partnership NHS Trust (CWP)
- Healthwatch Warrington
- Members of the Family

3.5 The agreed methodology included the use of Individual Management Reviews (IMRs)[13], a multi-agency chronology and interviews with practitioners. An Independent Reviewer was recruited to Chair panel meetings and to review and develop a summary of this information. Details of the Independent Reviewer can be found in Appendix 1.

3.6 The scope of this SAR was set out in the Terms of Reference (ToR) that were shapes as it

[12] WSAB SAR processes are available via this link, under the SAR section https://www.warrington.gov.uk/info/201189/warrington_safeguarding_adults_board_wsab/215/warrington_safeguarding_adults_board_wsab/3

[13] IMRs require agencies to reflect on their own practice and make proposals as to action they can take to address any missed opportunities identified. The individual actions identified by agencies participating in this review can be seen in Appendix 2.

progressed to ensure opportunities for learning remained in focus. The ToR were set by the Panel and reviewed with Stacey's family by the independent reviewer.

3.7 The period in focus for the SAR was agreed to be from Stacey's arrival in the Warrington area in April 2014 until her death in 2017. However, both family and professionals recognised that in order to understand Stacey's experiences an overview of her life preceding her placement within Warrington was important. Therefore, the SAR references her care from an earlier point in her life to give context to decisions and challenges faced. Subsequently, issues prior to 2015 will be noted as context to practice within the period in focus but not a source of findings due to the time that has passed.

3.8 The core focus of the SAR ToR was:

1) Why was Stacey detained in hospital for 4 years and were the risks and consequences of this admission sufficiently assessed and managed?
2) What does the experience of Stacey tell us about how well hospital and community agencies work (both individually and collectively) with young adults with learning disabilities and challenging behaviour?

3.9 The SAR also accessed the following information and reports and identified learning for insight into Stacey's care:

- The NHS Serious Incident Investigation report
- A resuscitation practice review by an independent expert commissioned by NHS England
- Court of Protection documents relating to Stacey's periods of detention under Best Interest frameworks
- An overview of Stacey's life and experiences provided by her family

4. Background to period under review

4.1 Stacey's early life challenges led to her having a statement of special educational needs at 12 years old. Despite the recognition of her additional support needs, she was excluded from school in 2010. This was as a result of behaviour which exposed her to potential risks through being unsupervised in the community. This included violence towards other children and her parents and going missing from supervised environments. This pattern of behaviour led to her first Section 2 detention under the Mental Health Act 1983 (MHA), a single night admission in October 2010 when she was 18 years old.

4.2 Stacey's parents felt that a social worker's assessment regarding Stacey's right, to make decisions now as an adult, had a significant impact on her subsequent attitude and behaviour. Stacey's parents' view was that Stacey did not have sufficient capacity to make informed choices about her safety and that transitional work was needed at this stage to support her to move to a state of more independence. A lack of effective transitional work from children's to adult services was subsequently acknowledged in an Independent Social Worker's report in September 2013.

4.3 Stacey experienced a range of living arrangements between 2010 and 2013 that included short periods of detention in psychiatric wards, respite placements, outreach care within her own home and supported independent living. Changes occurred as agencies attempted to identify suitable care arrangements at times of crisis as well as planned attempts to meet Stacey's accommodation wishes. In July 2012 Stacey moved to her own flat supported by staff from Imagine Act Succeed (IAS), a charity that supports adults with learning disabilities. Stacey's services were provided by Trafford Community Learning Disabilities Team (CLDT) which is an integrated health and social care team made up of Trafford Local Authority Social workers and Cheshire and Wirral Partnership NHS Foundation Trust (CWP) health professionals.

4.4 During the period 2012-2013 there were incidents of increasing disinhibition alongside challenging and violent behaviour and reported concern about sexual relationships with strangers. Some of the behaviours came to the attention of the police including stealing (alcohol), sexual misconduct (public masturbation) and threats of violence (waving a knife at carers) resulting in one formal police caution. Stacey's decision making put her in situations where she it was easy for others to harm her, including having sexual relationships with people who weren't known to her and sometimes for small amounts of money, cigarettes or alcohol. There were also multiple presentations to A&E (over forty visits) and Stacey alleged on one occasion that her father had physically assaulted her. Ultimately, Trafford Local Authority applied to the Court of Protection[14] to restrict her freedom so that she was accompanied by 2 staff when out in the community in response to the risks of exploitation. Staff found providing constant observation problematic and with an adverse impact on Stacey's behaviour including that she would make repeated efforts to escape their supervision. Whilst CCTV was utilised within the flat to monitor her behaviour from a distance there wasn't an effective alternative when she was in the community.

4.5 In response to the increased restrictions on her freedom Stacey went missing, made threats to self-harm and damaged her flat. In July 2013 after repeatedly attempting to place herself in front of cars on a road Stacey was detained under Section 2 of the MHA. A

[14] The Court of Protection makes decisions on behalf of those who lack capacity - https://www.gov.uk/courts-tribunals/court-of-protection

decision was made that independent living in the community, despite being Stacey's preference, was not an appropriate model of care. Stacey, now 21 years, was transferred to a local Independent Psychiatric Hospital (Jigsaw) in August 2013 where she remained for almost nine months.

4.6 During this period of detention, Stacey's family raised concerns about the effect of medication on her demeanor and observed changes in her weight, physical and mental health. Stacey's behaviour escalated to include using objects to self-harm. In April 2014 the first recorded instance of ingestion occurred when Stacey required hospital admission following ingestion of an excessive quantity of water and was diagnosed with Psychogenic Polydipsia[15]. A risk assessment by Trafford CLDT identified concerns about whether Stacey was receiving appropriate treatment at Jigsaw and a safeguarding concern was raised. Discussions were held with Calderstones Partnership NHS Foundation Trust, an NHS provider of low and medium secure and specialist of services for adults with learning disabilities or other developmental disorders. It was felt that Stacey met their criteria for service but the Trust was concerned about whether it was in her best interest to move out of the Trafford area. (Due to loss of Stacey's care records Jigsaw were not able to provide detailed information to the SAR Panel in relation to this period).

4.7 Stacey was also reported to be presenting with assaultive and disinhibited sexual behaviours at this time and her family were concerned that she was being over sedated. The Trafford Community Learning Disability team determined that further assessment and treatment in a secure facility was required in a placement for people with a Learning Disability. Stacey's "Nearest relative", her father, has explained that he did not agree with this decision but felt he was compelled by professionals to cooperate at that time. Due to an absence of low secure unit beds in the Trafford locality in April 2014, an alternative place was identified at Northwest Boroughs Healthcare NHS Foundation Trust (NWB) Auden Unit in Warrington. Stacey was apprehensive about the move and it was described as a short term placement whilst alternatives were sourced. On this basis, Stacey moved to the Auden Unit, a Learning Disability Low Secure Service on 28 April, 2014 under Section 3 of the MHA.

Period under Review (April 2014 – May 2017)

4.8 The previous background gives a context to the events which led to Stacey's placement at the Northwest Boroughs Healthcare NHS Foundation Trust, a specialist NHS Mental Health provider with inpatient services in Warrington.

4.9 Stacey's placement in the Auden Unit, in April 2014, had been commissioned by NHS England due to its low secure status. However in September 2014 a suitable community placement had still not been identified and the Auden Unit environment was found to be unsettling for her.

4.10 A multi-agency meeting in September 2014 and subsequent reassessment by Calderstones Trust had reported that Stacey no longer required Low Secure services and that the ward environment was exacerbating her behaviour. A number of aggressive incidents were recorded during her stay on the unit which had led to eight incidents of police involvement and had identified significant risks posed by Stacey to others. It is recorded that two alternate wards, Byron and Tennyson, were each considered and despite being seen as not able to be fully meeting Stacey's needs, were judged to offer a less stimulating

[15] An excessive or abnormal thirst leading to excess intake of fluids https://bestpractice.bmj.com/topics/en-gb/865

environment[16]. As a result Stacey was moved to the Tennyson ward, also a low secure environment whilst a suitable community placement was identified. Stacey continued with ingestive behaviours following the move. The risks of Stacey swallowing unthickened fluids was identified and she was put on a regime of thickened fluids and identified as high risk of swallowing nonfood items.

4.11 A series of professionals meetings, involving the NHS England commissioner, were held to consider the alternatives. Despite extensive searches, no suitable provider could be identified who would accept the high level of risk in the behavior that Stacey presented with. Whilst on one to one supervision, Stacey was able to continue to ingest items on several occasions. In September 2015 Stacey was taken to Warrington Hospital A&E after concerns of a further excessive water consumption event. She was found to have fluid on her lungs and received intensive care treatment before discharge back to the Tennyson ward.

4.12 A safeguarding enquiry by Warrington Borough Council concluded that the incident did not meet the criteria of neglect but was an indication of care quality issues and recommendations were made for improvements to her safety. In the meantime whilst professionals meetings acknowledged that the placement was unsuitable, the relevant Trafford authorities were unable to identify an alternative provider. The use of 2-1 observations by ward staff was the main intervention to manage Stacey's high risk behaviours, including the risk of ingesting objects, a behavior that continued. NWB reported that Stacey had five A&E attendances for ingestion acts with fourteen further reports of attempts or actual ingestion of non-food items. Warrington & Halton Hospital NHS Foundation Trust (WHHFT) records showed 10 attendances for ingestion episodes between January 2016 and May 2017. As Stacey was being detained under Section 3 of the MHA, a Mental Health Tribunal should have reviewed her detention, but no details of this process were made available to the SAR panel. Her rights to an Independent Mental Health Advocate during this period of time, do not appear to have been met.

4.13 In November 2015 a community placement was considered and trialed with Cheshire House[17] under section 17 leave arrangements[18]. Stacey initially appeared to settle in the new placement but after several incidents of challenging behaviour including assaults, vandalism, running away and running in front of a car, Cheshire House requested she be returned to hospital. The decision was that Stacey should be recalled to hospital and she was admitted to the Byron ward at the NWB, a short stay assessment and treatment Learning Disability unit where funding was approved for Stacey to be supported on a 2:1 staffing basis keeping her under constant observation. Responsibility for commissioning a suitable service was to be transferred to Trafford CCG from NHS England, as care under secure services was no longer felt to be required. Stacey's family's reflection on the failed placement was that not enough transition work was undertaken to prepare Stacey for the new staff and environment. They submitted a complaint and voiced desires to remove the

[16] A secure unit can be regularly changing sets of residents, loud and unsettling environment for service users that need a level of consistency and calm to address their own challenging behaviour. In this instance staff felt it was not helping Stacey to progress.

[17] Cheshire House was one of a number of specialist support services placements provided by Consensus. Consensus had significant experience working with complex learning disabled adults using a PBS approach and were based in Sale, Greater Manchester.

[18] Section 17 leave is an absence from hospital authorised by professionals for someone detained under the Mental Health Act https://www.rethink.org/diagnosis-treatment/treatment-and-support/going-into-hospital/leaving

section 3 detention and return Stacey to their own care. At this time the family had lost confidence that services could care for Stacey and meet her needs.

4.14 In December 2015 NHS England scheduled a Care and Treatment Review[19] (CTR) as part of the process to transfer commissioning responsibility to Trafford CCG. The plan was to transfer Stacey to the care of a suitable community provider within 6 months from Byron ward. She was deemed too high risk of harm through choking to be allowed to go home to her parents at Christmas on Section 17 leave.

4.15 During the next six months Stacey had further attendances at A&E as a result of swallowing nonfood items (including a hair grip, lump of tissue, a piece of cellophane and a plaster). The incidents, or chain of incidents were not reported as possible safeguarding concerns. In addition NWB recorded a further 12 incidents of Stacey attempting to, or ingesting items which was managed on the ward following staff intervention. NWB records do not confirm who including Stacey's family, were made aware of the incidents and CWP and Trafford CCG have stated that they were not made aware of incidents.

4.16 A further Care and Treatment Review was held in July 2016. Trafford CLDT had approached over 20 potential providers, identifying just one, the care provider Cambian, as a potential option. They were planning to build a new community based service in the Trafford locality. This time an extended transition was proposed to enable Stacey to get to know the new staff before the move and additional funding was provided for Cambian staff to work with Stacey whilst still in hospital Stacey's family requested that she not be informed of this plan on the grounds it could destabilise her. There was a proposal for an extended section 17 leave followed by a Deprivation of Liberty Safeguard[20] (DoLS) application if leave was successful. This was felt to be the least restrictive option for Stacey.

4.17 From October 2016 up until her death in May 2017 Stacey was being introduced to staff members from Cambian within the Byron ward environment as part of transition plans. Incidents of ingestion continued and appeared to increase in late January and early February of 2017. This correlates with increased seclusion episodes and the use of IM[21] Lorazepam. Whilst Stacey was not meant to be informed of the pending transition it was noted in records that she was reporting anxiety about discharge and moving on.

4.18 The ward environment was not a therapeutic environment and there was no plan to reduce 2:1 observations. Behaviors that challenged were being managed by reactive use of PRN sedation, staff restraint (when deemed necessary) and extensive use of a seclusion facility within the ward. Whilst the belief of Stacey's family and the community staff was that over time this staff ratio might decrease after her discharge, it was evident that these types of approaches could not be replicated in a community environment.

4.19 There was evidence of efforts led by the Trafford CDLT Care Coordinator and Challenging Behavior Nurse to complete a PBS care and support plan that had been initiated prior to

[19] CTRs are a meeting to bring together professionals and an expert by experience to review decisions around care and treatment for a person with complex and challenging behaviour. They were developed as a means to reduce admissions to hospital and prepare for transition to community placements. https://www.england.nhs.uk/learning-disabilities/care/ctr/

[20] DoLS are the process that ensures that anyone who cannot consent to care arrangements is protected if those arrangements restrict their liberty https://www.scie.org.uk/mca/dols/at-a-glance

[21] IM refers to intra muscular injections that allow for swift absorption of medications often utilised with agitated and violent patients.

the unsuccessful move to Cheshire House. Stacey was visited several times on the ward in order to complete the assessment and her parents were also involved in this process. The plan included early indicators that Stacey may be becoming agitated and some triggers for this, as well as some positive strategies, which may reduce the risk of challenging behaviors such as additional time and communication support. Assessments of incidents occurring on the ward were requested to help develop this, however these were not completed during the period. The Byron ward, recognized as not being an appropriate placement for Stacey, was also not considered by NWBH to be being a suitable environment in which to apply a PBS approach.

4.20 In April 2017 Cambian withdrew their offer of a placement, reporting that due to the use of seclusion and ingestion behaviours they were not certain they could accept and manage the risks for Stacey.

4.21 Stacey made repeated attempts to contact her family in the days before the fatal incident, contacting her mother over 8o times during the weekend of 6/7 May. All of the messages were asking when they were going to visit her and telling them that she missed them. When asked about this, she said she was frightened about moving on from the ward indicating a level of awareness about the move, but not the withdrawal of the placement.

4.22 On May 8th 2017 Stacey was able to secrete and ingested paper towels despite being allocated 2:1 observations. Shortly after indicating to staff that she had swallowed something, she began salivating and subsequently in respiratory distress, became unresponsive. Paramedics attended to her and worked to clear her airways and revive her. Stacey was transferred by ambulance to Warrington Hospital, where she was admitted to intensive care in an induced coma. Subsequently following discussions with her family a decision was taken by the medical team to withdraw the ventilator support and provide end of life care. Stacey passed away on 28th May 2017.

Events of 8th May 2017

4.23 The SAR, commissioned by Warrington SAB focused primarily on the learning that can be identified from reviewing the care and support provided to Stacey, about how agencies might work better together in the future to minimize the possibility of a similar event reoccurring.

4.24 Parallel processes including a Serious Incident Investigation conducted by NWBHT under the NHS serious incident process, a police investigation conducted by Cheshire Constabulary, processes under the guidance of HM Coroner, the LeDeR process and a Resuscitation report commissioned by NHS England, all consider for their specific purposes, analysis of events that occurred on 8 May, 2017.

4.25 The following is a summary of the events of that day from the information that has been made available to the panel and which is considered to be particularly relevant in the context of the SAR. It needs to be noted that there are some discrepancies in the information given, which the SAR process is not in a position to fully resolve and which may be subject to further scrutiny during other legal processes.

75 On 8 May, 2017, WHHFT records suggest that Stacey interacted well with staff for the majority of the morning, then in the afternoon became 'agitated' initially about charging her laptop up, which she wanted to do in a communal area, and subsequently due to being unable to download music. She is described as

preoccupied with buying another laptop, pushing boundaries and unable to settle despite interventions from staff and activity with the Occupational Therapist.

76 Between 16:50-17.00, it is recorded that Stacey used the female toilet cubicle, observed by a female member of staff with a male member of staff waiting outside of the toilet area. This states that Stacey became challenging washing her hands and as a result, the male staff entered the toilet area to support his colleague. The Serious Incident Investigation reported that the male member of staff gently held Stacey's wrists to enable hand washing to take place and also to prevent her moving her hands to her mouth. The report states that Stacey shook her hands dry and had no access to the paper towel dispenser.

77 On the 8 May 2017, a Patient Led Assessment of the Care Environment (PLACE) was being undertaken with the five assessors given access to most areas of the ward including toilets. The Serious Incident Investigation Report starts that the assessment team were on the ward for approximately 45 minutes in the morning and concluded that there was no evidence to link the PLACE assessment to the incident that occurred later that day. In discussion with staff from NWBH, the SAR review team heard that the Hand Towel dispensers on the wards were normally left empty, due to a risk of swallowing, however that they were told to fill them up in advance of this inspection, with white towels. They advised that that morning the cleaner had filled the dispensers and speculated that Stacey may have noticed this.

78 Between 17:00-17:40 that evening it is recorded that Stacey declined her evening meal and went instead to sit in the main lounge, with the two health care assistants (HCA) observing her. One HCA arranged for another colleague who was already in the main lounge area to take over observations, whilst she left the lounge area to get a drink. The replacement HCA stated that he sat opposite Stacey who subsequently approached him and indicated by pointing to her throat that she had swallowed something. He stated that he escorted Stacey from the main lounge to the nursing office where she was able to inform the nurse in charge (NiC) that she had swallowed a paper hand towel.

79 It is reported that Stacey identified to the NiC by pointing to the male toilet outside the office where she had accessed the towels, but was not specific about the time she actually did this. The door was reported to be fully open. NiC spoke with staff on shift and nobody had observed Stacey secreting or swallowing hand towels whilst on their observations throughout the shift.

80 The records state that the nurse in charge then guided Stacey to a de-escalation area at 17:40 and spent approximately 15 minutes with her, during which time she was reported to be agitated, but breathing and talking normally, before she began salivating excessively. The Serious Incident Investigation report states that she told the nurse in charge that she "just wanted to die" and that she thought the nurse in charge also wanted her to die, which he assured her was not the case. When she began to salivate excessively it is recorded that her BP and SATS[22] were tested and were within normal range (138/78 and 95%) and that Stacey sat crossed legged on the floor at this point leaning forward and continuing to salivate. It is also recorded that these behaviors were consistent with other incidents of "actual" and "stated" swallowing incidents.

[22] Blood Pressure and Oxygen saturation in the blood.

81. It is documented that the NiC left de-escalation to contact the SHO, while in the office staff in de-escalation activated the alarms as Stacey became unresponsive and her lips had changed colour. The NiC returned and started chest compressions with another member of staff, bag and suction – it is recorded that no obstructions were visible and a finger sweep of the mouth also revealed none. The SHO arrived during this period and an ambulance was called.

82. The call to the emergency services was made directly to 999 Emergency services (North West Ambulance Service - NWAS) and not using 3333 protocol via Switchboard. Therefore only NWAS records can report times. Ambulance records indicated that paramedics arrived on the ward and took over emergency care at 18.00. The initial finding by the ambulance crew was; "of a patient, in a collapsed state, with reduced level of consciousness and having some difficulty breathing". The ward staff told the ambulance crew that Stacey had been in a common area of the unit, she had felt down so they decided to segregate her for some "Quiet Time". "The patient was reportedly left for 40minutes and when checked was found to be in the toilet area of the segregated room"[23].

83. This account was as recorded by the ambulance crew as reportedly told to them by ward staff, but differs from the above account given by ward staff when interviewed during the SI investigation. No one who was spoken to for the SI, recalled seeing the toilet door open, or seeing Stacey go into the toilet, despite her being on 2:1 obs all day.

84 ***It is not possible to resolve these incongruent views on Stacey's management immediately prior to the incident as there is no evidence for the review to identify which is the correct account. Therefore, this matter has been reported to the Coroner's investigation to be explored further by the inquest process.***

85 The review is also aware of an independent resuscitation review requested through NHS England as part of the NHS Serious Incident process. This was completed by an independent Anesthetic Consultant and its focus is the management of the resuscitation process and the Trust's arrangements in place at the time. This concludes that there was no issue with lack of equipment at the time of the incident and it seemed fairly clear from the records that the resuscitation attempt followed Resuscitation Council UK guidelines and that a standard ABC approach was taken; highlighting that it appeared that the staff acted appropriately as soon as there was evidence that the patient had ingested a foreign material, that basic life support measures appeared in line with standard guidelines, that the commencement of CPR was appropriate, and that the use of suction was appropriate and almost certainly necessary. However it makes a number of recommendations for improvements, including mandatory training compliance audits and ensuring that patient notes provide an accurate and detailed record of significant events including timings.

86 This SAR notes that had more detailed notes been made regarding resuscitation attempts this would have helped clarify the current confusion over incongruent accounts from the ward and ambulance staff.

[23] As reported by ambulance crew and recorded in North West Ambulance Service IMR.

87 At approximately 18:00 to 18:04, with paramedics in attendance, Stacey went into cardiac arrest. The initial actions of the crew were to make attempts to clear Stacey's airway whilst utilising the hospital staff to perform CPR. This took some time and Stacey's pulse was not palpable. She was given adrenaline and IV fluids and with suction, two paper towels in the form of balls reportedly the size of "golf balls", were extracted from her throat. Stacey's ECG, pulse and SATS were in normal range and she was transferred to WHHFT for further treatment.

88 No concerns were raised by the review in relation to NWAS immediate responses to secure Stacey sufficiently for transfer to the local acute trust. Stacey left Hollins Park for Warrington hospital at 18:31. The senior clinician and a Paramedic travelled in the back of the vehicle along with a member of the hospital staff. Stacey was handed over to hospital staff at Warrington Hospital at 18:45. In line with Duty of Candour expectations, Byron Ward staff contacted Stacey's family to inform them of the incident, although the gravity of the situation was not passed on at this time. The ward team remained in contact with Stacey's family during the period she was in Warrington Hospital. When the 5BP Assistant Director, became aware of the incident, he took on the role of Family Liaison Officer and made a number of contacts with Stacey's family by telephone and a home visit to offer support and advice.

89 **Key Events following the Incident until Stacey's death**

90 Stacey was admitted to an Intensive Care Unit (ITU) on 09/05/17, as she was critically ill. She was sedated, placed in an induced coma and had support with ventilation. During the next two days, a plan to reduce the sedation and bring Stacey out of the coma was tried unsuccessfully, resulting in seizures. When sedation was reduced Stacey was only minimally conscious with no positive response to stimuli.

91 Byron Ward Manager then raised a safeguarding concern about the incident on the ward internally to the hospital safeguarding lead and also alerted the Trust Serious Incident Investigation process, however no referral was made to the Local Authority, an issue which was only rectified on 22/5/2017 when the Trust Safeguarding Lead reported the concern directly. This omission had also been observed by Trafford CCG in discussion with Stacey's father and they also made contact with the Local Authority at around the same time.

92 Following identification on the 15/05/17 that there were no positive signs with regard to Stacey recovering it became clear that Stacey had severe hypoxic brain injury as a result of her cardiac arrest, from which she would not recover. Following discussions with her family, ventilatory support was eventually withdrawn and the focus of her care changed to a palliative approach. Stacey was subsequently transferred, to a general ward setting, where tragically she lost her life on 28/05/17.

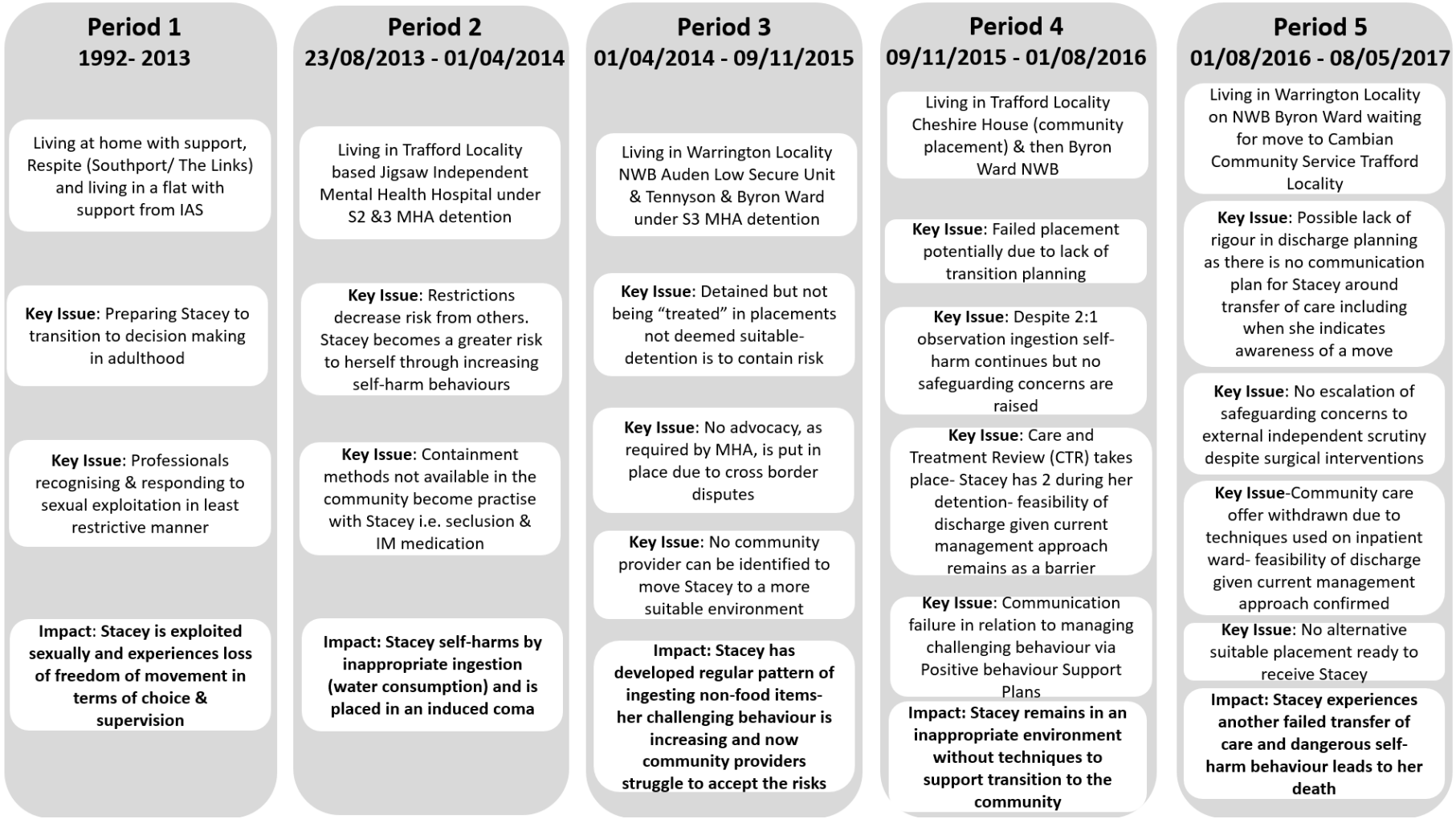
Serious Incident Investigation

93 NWB initially undertook a local review of the incident. The panel noted that this had not adhered to expected timescales nor the guidelines within the NHS framework. A Level 1 concise investigation which concluded on 16/8/2017 highlighted a number of failings and made recommendations for the Trust (these are attached in the appendix to this SAR).

The report found that in some instances there appeared to have been no formal

investigation into how Stacey had been able to ingest nonfood items whilst on a 2-1 observation or of any learning, other than discussion at the multi-disciplinary review. It also found that there was a serious failing by the ward team collectively in their use of level 3 (2:1) observations. The report identifies a number of environmental and staffing factors that may have influenced this which include over familiarity that may have lowered staff's guard and the fact that staff were required to undertake level 3 observations in excess of the Trust's policy.

5. Significant Events Overview



6. Multi-agency Learning Opportunities

6.1 The purpose of the SAR is to identify missed opportunities for effective multi-agency working that may have produced better outcomes. As part of the process, individual agencies also are asked to reflect on their practice in order that single agency issues, learning and improvement actions are identified. These can be seen at Appendix 2 where a combined single agency action plan is available for information. Primarily the focus of this section will be the issues that the WSAB partnership have identified a key for them to monitor and can take forward for improvement action.

Application of the Legal Framework

6.2 A key area of focus throughout this review has been how agencies identify, understand and respond to risk. From the onset, the screening panel for the SAR identified potential concerns about how fears about Stacey's safety or that of others had been balanced with her choices about how she lived her life including reference to her human rights. The SAR found evidence of agencies utilising the Mental Capacity Act, the Mental Health Act and the Court of Protection alongside considerations of Stacey's views and wishes. However there were also some discrepancies in application of the legal frameworks.

6.3 As a young adult there were assessments of capacity in relation to Stacey's ability to make decisions about where to live, her supervision in the community and compliance with a care plan. There were differences of opinion in relation to Stacey's capacity between providers, family members and commissioners. In 2013, an Independent Social Worker's report identified that some of the issues stemmed from a lack of transitional work for Stacey to move from the structured support provided by Children's services to less restrictive support from Adult services. As this was not within the period of focus for the SAR it has not been examined further. However, there were discrepancies in capacity assessments whilst Stacey was detained by NWB, including differing views on Stacey's capacity to be held to account for assaulting staff or other patients. There was an absence of clear Best Interest processes for a number of key decisions taken on Stacey's behalf. Consistent and robust application of the Mental Capacity Act is critical to underpinning the Human Rights of adults with care and support needs and can be instrumental in supporting defensible decisions by practitioners that are understood by both families and health and care professionals. The absence of assessments and decision making processes not only falls outside of expected practice but can exacerbate effective partnership working.

6.4 Stacey was detained under section 3 of the Mental Health Act at NWB from April 2014. However she did not receive an Independent Mental Health Advocate[24] (IMHA) until September 2016 due to a dispute between Trafford and Warrington local authorities in relation to responsibility to provide an IMHA. (This was eventually resolved and the misunderstanding regarding the national guidance subsequently clarified).

6.5 Independent representation to which she was statutorily entitled would have enabled an independent view of Stacey's wishes and consideration of a Mental Health Review Tribunal[25]. Whilst Stacey's parents had rights as "Nearest Relative" that could potentially have triggered reviews and challenged placements, they did not feel this would be

[24] IMHAs are specially trained to represent and support people detained under the MHA - https://www.mind.org.uk/information-support/guides-to-support-and-services/advocacy/imhas-england/#.XBufC-a7LIU

[25] Tribunals exist to review detentions and their appropriateness - https://www.mind.org.uk/information-support/legal-rights/leaving-hospital/mental-health-tribunal/#.XBugfOa7LIU

meaningful due to their sense that there were no viable alternative placements. They have also expressed feeling compelled to accept the detentions at times. The IMHA is the independent professional who can focus solely on championing the individual's rights under detention. Therefore, the failure to ensure Stacey's right to advocacy was upheld at a key period is an important point of learning for all agencies.

6.6 Stacey's family also questioned the purpose of detaining Stacey under the Mental Health Act when she was not diagnosed with a mental health disorder and they perceived no beneficial impact from the use of antipsychotic medication. The purpose of Section 3 of the Mental Health Act is to enable treatment within hospital that cannot be received elsewhere. It was recorded in a professionals meeting in September 2015 that the hospital detention was preventing the risk of sexual exploitation in the community. There was no treatment offered and the detention created other risks including escalated risk from high intensity self-harm behaviours and aggression towards others. The failed discharge to Cheshire House in 2015 and Cambian's withdrawal of the offer of a placement in 2017 indicate serious unintended consequences from the prolonged detention in the inpatient facility. Stacey's detention at Jigsaw and NWB inpatient facilities recorded frequent violent and self- harming incidents. Her family expressed concerns about institutionalisation. The evidence shows that a prolonged detention had not effected a positive change in Stacey's behaviours but instead may have exacerbated her tendency to seek attention through negative events such as self-harm. It was important that this situation was noted and the impact on Stacey along with any benefits and burdens regularly reviewed.

6.7 NHS England have published expectations that Care and Treatment Reviews (CTRs) should occur every 6 months for those detained in inpatient settings to ensure good progress is made towards a community placement. In this case there were two in the period under review up until May 2017; in December 2015 and August 2016. Trafford CCG outlined a flexible approach taken to CTRs whereby other multi-professional meetings were utilised by commissioners to support discharge planning and resolve problems. An example given of this was a professionals meeting in February 2017, where a decision was made to transfer Stacey to a specialist facility for individuals with a Learning Disability to support a behaviour management approach that would better enable discharge to the community. This approach to practice was described as an aspiration to be driven by need and not process. Whilst this aspiration may echo tenets of person centred care[26] it was indicated in the SAR that not all agencies agreed that professionals meetings were a robust alternative to a CTR. This was due to the roles and remits of staff involved in the two different processes. It is key that there is communication between those involved to agree approaches (this is discussed further below).

6.8 Overall, the independent reviewer did find regular use of the legal frameworks by professionals within Stacey's case. The Court of Protection was appropriately used to authorise a greater restriction of Stacey's freedom and there was evidence of aspirations to achieve less restrictive options for her. However, opportunities were noted for more robust approaches using these legal frameworks. In relation to the Mental Capacity Act a reflection point for multi-agency practice is to ensure consistent use of decision specific capacity assessments and well documented Best Interest processes and decision making. Stacey's case also questioned the benefit of utilising the Mental Health Act as a means of

[26] Person centered care is the concept that each person may require a different response for their individual needs to be made. It has implications for how professionals practice, think and commission - https://www.health.org.uk/sites/default/files/PersonCentredCareMadeSimple.pdf

depriving someone with complex support needs of their liberty when no apparent benefit or therapeutic treatment beyond restriction is apparent.

Barriers in Transition to the Community

6.9 Professionals faced an inherent tension between keeping Stacey safe and enabling her to develop better self-management techniques in relation to her risks. Stacey's admission to Jigsaw and then NWB inpatient facilities was triggered after a period of self-harm behaviours that resulted in her community support staff reaching a point where they felt unable to continue to provide her care safely. This signified the start of a prolonged hospital stay, where greater restrictions triggered escalating behaviour including self-harm and ingestion of non-food items. This was managed by the use of restrictive practices, not easily replicated in a community setting, such as seclusion, IM injections and greater staff supervision. This resulted in 2:1 staffing in an attempt to prevent dangerous ingestion behaviours. Community providers, with free choice on who and when they offer placements, identified an incongruence with the care and support they were able to offer, particularly their inability to legally and practically replicate some of the risk management approaches. Not unreasonably, they declined to offer an alternative community placement. This resulted in Stacey being locked in a damaging cycle of escalating behaviours triggered by the restrictions imposed upon her which in turn, triggered greater restrictions. Stacey's family recognised the barriers that IM injections and seclusion were potentially creating and raised their concerns, requesting that professionals discuss and consider alternative approaches.

6.10 Positive Behaviour Support[27] (PBS) is a recommended best practice with people who challenge. Evidence can be found within professional practice documents (Royal College of Psychiatrists, British Psychological Society & Royal College of Speech & Language Therapists) and in national policy statements (Meeting Needs and Reducing Stress, Positive and Proactive Care, Ensuring Quality Services and A Positive and Proactive Workforce). All of these identify the role of PBS in providing effective support to people who challenge[28]. The independent reviewer considered how PBS had been used to support Stacey, including how agencies had addressed the risks identified and in the multi-agency working between hospital and community services. Trafford CLDT reported attempts to develop a PBS approach for Stacey towards the latter part of her initial admission to NWB (2015) and Stacey's care coordinator visited the ward and developed a plan as part of discharge preparation. Whilst this plan did not aid the first discharge attempt to Cheshire House, this may have been as a result of limited discharge preparation. There is evidence that CLDT continued to develop the PBS plan however there was a missed opportunity for all agencies to work together on this around the next discharge attempt.

6.11 The care provider, Cambian, had expressed the intention to support the PBS plan approach but by February 2017 there was no PBS plan in place to support discharge. This was the trigger for a decision to identify alternative placement options in February 2017 with CWP (the provider of Community Learning Disability Services for Trafford) as Trafford CCG were concerned Cambian was not ready for the planned discharge.

[27] Positive Behaviour Support is a person-centred approach to people with a learning disability who may be at risk of displaying behaviour that challenges. It has developed from and is backed by evidence from behavioural science. For more information please see https://www.skillsforcare.org.uk/Topics/Learning-disability/Positive-behavioural-support/Positive-behaviour-support.aspx

[28] Page 10 PBS Competency Framework 2015 http://pbsacademy.org.uk/wp-content/uploads/2016/11/Positive-Behavioural-Support-Competence-Framework-May-2015.pdf

6.12 It is notable that NWB ward staff did not participate in providing information or support to the PBS plan approach. NWB reported within the review that this was not an approach that was applied within the short term treatment and assessment ward. This raises a fundamental question about how all the agencies were communicating and working together with Stacey and her family in order to develop a realistic programme of support to help prepare and move Stacey to a less restrictive setting.

6.13 Both the independent reviewer and the SAR panel members acknowledged that the issues identified above also sat within the context of a national issue around the Transforming Care programme designed to support a move away from hospital to community care for adults with behaviours that challenge. This includes a shortage of suitable community based placements that can accept the risks inherent with managing people with a range of complex behaviours similar to those exhibited by Stacey. It is beyond the remit of a Local Safeguarding Adult Board to change the level of availability of either low secure beds or community placements. However, the SAR has to take into account the significant impact these issues had in Stacey's case. She experiences 'out of area' placements away from her family, with the added complications of cross local authority border working and a prolonged detention in an unsuitable environment. Systems that were focused on protection, could not ultimately safeguard her and ultimately her right to life.

6.14 Systems and professionals were challenged by the conflict between trying to keep Stacey safe and promoting her quality of life. The Care Act Statutory guidance is clear that:

"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action."
(14.7[29])

6.15 The initial safeguarding concerns about Stacey were in relation to the identified risk of sexual exploitation. Subsequently they also included potential risks to others from her violent reactions to restriction as well as the risks of serious self-harm. Arguably the restrictions placed on her posed the greatest risk to her overall wellbeing. The potential for this impact is recognised within the Transforming Care agenda:

"Behaviours that challenge occur as a result of complex interactions between a person and their environment but are typically associated with a person having either acute or chronic unmet needs and/or an impoverished quality of life."
Transforming Care Service Specification 2017[30]

6.16 Stacey's experience of detention in psychiatric settings ultimately meant that her desire to live near her family in the community became unattainable. Arguably attempting to secure her safety from sexual exploitation came at a cost to her liberty and her life. Whilst the SAR panel could not be certain what an alternate care and support pathway could have led to and understand that at the initial point of decision making, there is no benefit of hindsight; the panel identified missed opportunities throughout the period for agencies to work alongside Stacey, her family and independent representatives, to consider and

[29] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
[30] https://www.england.nhs.uk/wp-content/uploads/2017/02/model-service-spec-2017.pdf (Section 2, Page 12)

review the balance of risk and her wellbeing. The family have reflected that they would have welcomed open conversations that reconsidered risk in the community given the impact of detention on Stacey. They recognised the additional challenges for discharge as a result of years as an inpatient. They questioned whether a discharge to a different specialist facility, where she could have received interventions to better enable her to manage within the community would have been more appropriate.

6.17 This matter of balancing risk and wellbeing in relation to capacity to consent to sexual relations has been debated extensively in the Court of Protection. A recent court case29 demonstrates how even experienced Judges are navigating through the careful balancing of rights, quality of life and protection and being required to reconsider previous judgments. Similarly to Stacey the young woman at the heart of this court case was considered at risk of sexual exploitation and deemed to have varying levels of capacity in relation to decision making about sexual interactions. The judgment so far indicates that professionals face an almost impossible task of identifying a satisfactorily safe and proportionate response. Professionals are required to consider and weigh a number of relevant factors, including as well as risk, less tangible concepts such as happiness. Judge Munby has historically led the case law in this arena stressing the importance of this balance:

"Physical health and safety can sometimes be bought at too high a price in happiness and emotional welfare. The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person's happiness. What good is it making someone safer if it merely makes them miserable" Munby 2007[31]

6.18 Positive risk taking is not a new concept, research[32] can be found outlining the need to consider this in practice especially with adults with care and support needs. Morgan reports in his article from 2004 on the importance of being able to take risks and withdraw services inappropriate to need, in order to achieve positive outcomes. Whilst this seems like a simple concept it requires a cultural shift and as the Joseph Rowntree Foundation reported in 2011[33] the balance between empowerment and regulatory demands is still in development. In Stacey's case the hospital placements were recognised as inappropriate with no community option available. Community providers withdrew offers of support believing they were unable to accept the risks.

6.19 The SAR process has the benefit of hindsight in putting into context the tragic outcome for Stacey remaining in an inappropriate placement. It is clear that professional's opportunities to intervene constructively were hampered by limited availability of appropriate community providers and the available environment not supporting evidence based approaches to alternative behaviour management techniques, such as PBS. The opportunities for learning in this area appear to be around developing a positive risk taking approach across organisations and considering implementation of PBS in complex cases to facilitate successful discharge between hospital and community settings. This is not a unique case in this regard, as indicated above these are challenges for practice nationally.

[31] Munby J cited from in Local Authority X v MM & Anor (No. 1) (2007)
[32] http://static1.1.sqspcdn.com/static/f/586382/9538512/1290507680737/OpenMind-PositiveRiskTaking.pdf?token=ElVKhX4Soz6TlFbuppAGcJTsZVI%3D
[33] https://www.jrf.org.uk/report/risky-business

Communications Issues

6.20 It was apparent from conversations with both professionals and family members that good communication was going to be imperative in the effective management of Stacey's care. Where placements involve people with complex care needs and especially across local authority areas, it is vital that all parties, including the service user and their Carers, are effectively engaged in planning and decision making. There was evidence of multi-disciplinary meetings being utilised to discuss risks, resolve problems and make planning decisions. However, there was also evidence of less effective communication in certain areas which are outlined below.

Communication between Professionals

6.21 Although individual agencies believed they communicated well, communication gaps were identified that the review considered to be important. It was apparent from the IMR submissions that different agencies had different interpretations of information that had been shared. As noted, the commissioning services had by requesting PBS plans be developed, intended that a PBS approach be utilised. Although one of the three commissioned services responded, the others did not. It later emerged that NWB were not able to facilitate PBS within the ward at that time and so had not supported this approach. This compromised and was critical to the lack of success of the approach and yet was not something the CLDT staff seemed aware of (despite staff not being able to progress the PBS plan).

6.22 In some instances it was stated that agencies were not aware of certain significant information. Cambian noted that they withdrew their offer of a placement due to not being fully informed of the risks involved in Stacey's care. In contrast NWB reported reiterating Stacey's risk management plans and needs and believed they had been clear in relation to how she was supported on the ward. Complex discharge planning requires clear communication and assessment along with oversight from the commissioner.

6.23 There was also an issue in relation to Stacey's IMHA appointment that was centred on a dispute between the two local authorities over which had the accountability for funding. Had the fundamental right for independent advocacy been sufficiently acknowledged and given priority, the resource should have been identified and the funding issue resolved quickly. It is recognised that cross local authority area placements can complicate customary local area commissioning arrangements but the length of time taken to resolve this issue points to communication issues.

6.24 The ineffective communication created the potential for the development of tensions between professionals as well as drift in the care plan. The review team noted that escalation could have been used to help clarify and resolve issues including where appropriate use of the local WSAB Escalation Policy.

Communication of Incidents

6.25 A particular area for focus in the SAR was the sharing of information in relation to self-harm incidents. This related to whether agencies had been transparent and clear about Stacey's risks and the ability of agencies to mitigate and manage these. Whilst some incidents were reported to either Trafford CCG and / or Warrington Borough Council not all of them were and on several occasions serious incidents did not appear to have appropriately triggered the Serious Incident Framework process. There was a lack of clarity across agencies in relation to triggers for independent scrutiny in relation to serious incidents that may have provided an opportunity to scrutinise the suitability of the current

care arrangements. For example, one incident of ingesting excessive water triggered a safeguarding referral to WBC made by staff from the acute trust hospital[34].

6.26 The SAR identified that not only significant events but also the frequency of other ingestion attempts should have triggered safeguarding referrals to WBC by a number of agencies involved. This was a missed opportunity for independent scrutiny of Stacey's care that may have aided professionals to recognise the growing volume of incidents and reflect on the care practices within provider organisations. Similarly contractual requirements and NHS Serious Incident Framework would require transparent and consistent reporting of serious incidents.

Communication with Stacey and her family

6.27 Two aspects in particular became a focus within the review regarding communications with Stacey. Firstly, in relation to the decision not to inform her of the move to Cambian. Secondly, in relation to identifying Stacey's wishes and feelings around her care plans.

6.28 The independent reviewer queried the decision by the CCG and her family to not tell Stacey about the plans to discharge her to Cambian's care in 2016. The decision was made at the request of Stacey's family who felt this would be a less destabilising approach to take. The reviewer's concerns centred on the apparent lack of a robust Best Interests process in relation to this which if done may have supported agencies and family to plan together for an honest and closely managed discussion with Stacey. Not surprisingly, Stacey displayed behaviours that she was aware of planning for discharge in the final 6 months on Byron ward. NWB staff reported that once Stacey started to comment on the additional staff supporting her she was informed by them that plans were being made. This created two issues; the family were frustrated that information had been shared and there was subsequently no plan in place to support Stacey and manage any destabilising impact. When Cambian withdrew, this was also not shared with Stacey.

6.29 During crisis periods where swift reactive responses were required, key decisions were not always communicated well across all involved parties. For example, Stacey's unsuccessful discharge to Cheshire House identified the need for greater planning by professionals around transition to a new placement in order to support Stacey to understand what was happening, why and to address any anxieties this may create. This discharge was in response to a safeguarding incident which created a level of urgency and swift decision making. The impact of this was that Stacey and her family were perhaps not as aware and prepared as they could have been. Subsequently in the second planned discharge professionals addressed this and ensured Stacey could get to know new staff in advance of a move.

6.30 Another area raised was in relation to food. Concerns were raised in relation to both supporting a safe swallow procedure and actions to manage Stacey's weight as it was affecting her mobility. A Speech and Language Therapy (SALT) assessment stated that Stacey lacked capacity in relation to her category C recommended diet, to minimise her risks of choking. Stacey's family noted that Stacey had seemed more settled before her diet was restricted and reflected that decisions in this area may have impacted on her ingesting behaviour. This challenging decision making falls under the Mental Capacity Act and requires a Best Interest decision in relation to diet. It is difficult to identify retrospectively how these decisions impacted on Stacey. The independent reviewer noted

[34] https://www.nhs.uk/using-the-nhs/about-the-nhs/nhs-authorities-and-trusts/

that whilst there was detailed recording of Stacey's behaviour and responses, there was no evidence of reflection on these in terms of what they may reveal about Stacey's views, particularly in relation to her care plan.

6.31 The family have also shared that their experience of communication was not always satisfactory. As noted in relation to legal frameworks, the family perspective was that processes were not meaningful as they did not feel empowered to advocate for Stacey through either Nearest Relative role or Best Interest meetings. There was evidence that where disagreements between family and professionals occurred this created tensions that impacted on relationships. For example, in relation to IAS and their approach to supporting Stacey at home and in relation to the unsuccessful discharge to Cheshire House. Recent case law highlights how in cases with significant restrictions of liberty tensions between professionals and families need swift resolution or represent a barrier to effective communication. In the case of SR vs. a Local Authority Judge Buckingham noted:

> *"…tensions and dispute between professionals and the family have been building up since at least January 2017 over the care and contact arrangements for SR. When it became clear that the family did not support the care or contact arrangements, the matter should have been referred to the court."*

The judge in this case recognised the role of the Mental Capacity Act in making decisions about restrictions and the clear role of the Court of Protection when there is disagreement in relation to Article 8[35]. In Stacey's case there may have been merit in seeking independent scrutiny regarding her detention, given the disagreements and dissatisfaction of involved parties. This may not have led to a change in arrangements but may have afforded the opportunity to resolve developing communication barriers.

Care Quality

6.32 The SAR noted that there had been concerns in relation to care quality within Stacey's detention at NWB. The initial identification of these was in 2015 at the time of the reported safeguarding incident of water ingestion. The NHS Serious Incident Framework[36] led to NWB undertaking a review after Stacey's death which highlighted further care quality issues.

6.33 It was known by agencies involved in her care and placement that Byron Ward was not a suitable environment for Stacey as it was not possible to create a sterile environment and remove all items that posed a risk of ingestion and self-harming. However NWB recognised that some practices were not as robust as they should have been in mitigating these risks.

6.34 The level of close observations required by all staff was identified as a key issue, including the level of responsibility placed on the single qualified staff member on duty and the number and level of enhanced observations for other patients in that particular ward area. NWB noted that staff were not given a "clean break" of one hour between enhanced observation duties as set out in their own Policy. NWB have reflected that during Stacey's extended stay on the ward, staff may have become somewhat desensitised to her behaviours and this may have impacted on their vigilance. These factors combined to create an environment where although many incidents were prevented, Stacey was

[35] Article 8 is part of the European Convention on Human Rights and relates to the right for "private and family life" https://www.equalityhumanrights.com/en/human-rights/human-rights-act

[36] This is an NHS framework that sets out the investigation standards and processes into events that occur within NHS settings. https://improvement.nhs.uk/resources/serious-incident-framework/

repeatedly able to access and secrete items to ingest. This occurred despite Stacey's placement criteria requiring observation by 2 staff members at all time in close proximity.

6.35 The expectations of those involved with Stacey were not all the same and this raised questions to the Review Team about how clearly they had been articulated and shared. Trafford CCG stated that as the commissioner, they had expected Stacey to be safe as a result of the high levels of staff observations they had commissioned. Stacey's family expected her to have a personalised approach to care that kept her safer than in the community. NWB as the 24 hour care provider organization expected there were likely to be ongoing near misses with some incidences of ingestion as they were not able to remove all potential sources of non-food items.

6.36 Wider agencies also had expectations as have already been noted above such as the engagement with PBS and reporting of safeguarding incidents. As a result, there did not appear to be a clear and shared understanding of Stacey's lived experience and day to day risks potentially due to agencies operating under different assumptions.

6.37 NICE guidance[37] did appear to be followed in terms of having a care coordinator who arranged regular multi-professional meetings involving a range of stakeholders to review Stacey's care. The family were part of these processes. However, these had not resulted in a consistent, well understood, personalised approach across the parties involved. Some of these challenges stemmed from the issues already noted such as cross locality border commissioning, communication barriers and limited available community placements.

6.38 This would seem to be a key learning point for the SAR. In order to monitor and improve care quality issues in relation to safety and personalisation agencies and families need to be able to communicate effectively. In Stacey's case whilst the framework to facilitate this was in place, i.e. regular meetings, these did not seem to achieve or articulate a shared understanding and appreciation. Subsequently, Stacey remained in an environment where her self-harm behaviours increased as professionals and family members became increasingly frustrated and concerned about the risks.

[37] National Institute for Clinical Excellence are the body that produce practice guidance and standards for health and social care services - https://www.nice.org.uk/guidance/ng93/chapter/Recommendations#enabling-person-centred-care-and-support

7. Findings and Recommendations

7.1 Finding 1

The application of legal frameworks was not always as consistent or robust as it should have been and agencies could have explored the use of less restrictive frameworks to manage Stacey's challenging behaviour.

7.2 Recommendation 1

Professionals need to robustly and consistently apply the legal frameworks within which they work to enable clarity for the individual, their families and other professionals. The WSAB should seek assurances that agencies are addressing legal literacy within their safeguarding training and agencies should monitor the impact of this on practice. Alongside this local practice guidance should be established to support professionals and families to navigate and challenge appropriate use of frameworks.

7.3 Finding 2

Stacey's behaviour and incidents were recorded but there was a lack of reflection and enquiry regarding the triggers and feelings that underpinned them. This was not consistently reviewed and explored in terms of its indication of her response to care plans and decisions being made.

7.4 Recommendation 2

In line with NICE guidance professionals should seek to record not just events and behaviours but also share reflection on these with the service user and their families/representatives to reach a mutual understanding of their underlying meaning for the service user. Agencies working with service users with communication challenges should ensure they are using reflective supervision approaches that facilitate professionals exploring underlying meaning of presenting behaviours.

7.5 Finding 3

Stacey experienced a prolonged period of detention within an environment where she was unable to develop and exercise some controls other than through negative behaviours. That this continued was partly due to attitudes to risk and a lack of joined up formal reflection and planning by agencies on what could be done differently to create an environment where transition to a more positive adulthood might be more likely such as PBS or an intermediate placement.

7.6 Recommendation 3

The WSAB should explore options for promoting "Positive risk taking" within practice across the partnership that builds upon the evidence based models of practice such as strengths based and making safeguarding personal approaches.

7.7 Finding 4

There is insufficient community based accommodation with skilled staff support to meet the needs of people who are complex and have risky and challenging behaviours, to live a good life safely.

7.8 Recommendation 4

The WSAB should seek assurances from commissioners around the implementation of the Transforming Care agenda locally and escalate issues beyond the local areas control to central government via the national SAB Chairs network.

7.9 Finding 5

There were multiple incidents of ingestion and harm that did not receive independent scrutiny from a safeguarding process.

7.10 Recommendation 5

The WSAB should clarify local safeguarding referral expectations around self-harm incidents in terms of thresholds for reporting due to volume or severity of an incident.

7.11 Finding 6

Stacey did not receive independent advocacy whilst detained under the Mental Health Act. This impacted on her rights to appeal the detention and ensure her wishes and views were promoted.

7.12 Recommendation 6

Warrington Borough Council should assure WSAB that it has developed a clear protocol for advocacy provision in cases of detention either under the DoLS or MHA to ensure advocates are in place at the earliest opportunity. The WSAB should communicate this protocol and identify mechanisms to monitor its use and impact.

7.13 Finding 7

Despite regular meetings and multi-disciplinary case discussions there were evident communication issues. This was between professionals and with Stacey and her family. The professional communication issues in this case created a sense of no shared plan across the agencies involved guiding interventions and transition activity. Recommendation 1 will aim to support effective communication where disagreements are apparent. However, agencies will need to explore how they receive, record and process information to ensure that their own internal practice is not impacting on the quality of their communication with others.

7.14 Recommendation 7

All professionals have a responsibility to effectively share information in relation to safeguarding and providing care and support. The WSAB, in partnership with TSAB, should develop and deliver a lessons learnt workshop for SAR H that promotes multi-agency roles and responsibilities in relation to sharing, recording, receiving and clarifying information and decision making.

7.15 Finding 8

Northwest Boroughs have identified single agency care quality issues within their practice in this case in relation to the quality of care that Stacey experienced. This related to aspects such as staffing levels and adherence to internal policies and procedures. (attached)

7.16 Recommendation 8

The WSAB should seek assurances that NHS England and CQC are satisfied that NWB have adequately addressed their action points from the Serious Incident Report to effectively respond to any care quality concerns for adults with Learning Disabilities within their inpatient areas.

7.17 Recommendation 9

WSAB should seek assurance from NWBH Trust and Knowsley CCG (as lead

commissioner of NWBH Trust) that Serious Incident processes comply with the NHS framework and that there is an effective system in place to ensure that they inform learning and future developments.

7.20 Recommendation 10

WSAB should seek assurance from NWBH Trust and Knowsley CCG that staff undertaking serious investigations are adequately trained.

8. Appendices

Appendix 1 – Independent Reviewer

Mick Haggar was appointed to chair the review panel and review the individual agency submissions of information.

For the last 8 years he has worked as an Independent Specialist Trainer and Consultant, mainly in the field of Safeguarding Adults. He has a registered limited company (MSH Training & Consultancy Ltd) and has substantial experience as both the chair and author of several other serious case reviews (SCRs/SARS) undertaken both pre and post the Care Act 2014. He is accredited to undertake SARs by SCIE using the Learning Together Methodology. Prior to establishing his own company he worked for 5 years as a Safeguarding Lead in 2 London Boroughs. As a qualified and experienced Senior and Approved Social Worker, with a background of 8 years working in Community Mental Health Teams and Learning Disability Services he also has significant experience with these client groups, as a practitioner. He is fully independent of any agency that was involved in this case.

An Associate of MSH Training & Consultancy Ltd, Chris Hart, was also involved in this review as an expert clinical advisor. Chris has a background as a Consultant Nurse Specialist in Forensic Mental Health Services and was able to provide additional expertise and scrutiny of the inpatient mental health nursing care delivered during this case. Chris Hart worked in mental health for over 30 years in a variety of roles, including clinician, senior manager and, for the past 16 years, as a consultant nurse. He has extensive experience in forensic and secure settings, psychiatric intensive care units and is currently leading a project to reduce deaths in custody in London's prisons. He has also written extensively about mental health nursing and risk assessment, led inquiries into serious incidents and acted as an expert witness in a number of cases, while also carrying out developmental work with mental health teams in different parts of the country.

Appendix 2 – Single Agency Actions from IMRs

Agency	Actions identified
Trafford CCG	1. Review local commissioning processes including the TOR of IMHaD and MH +LD RAP to ensure that these processes remain robust and flexible enough to react to the changing needs of vulnerable patients 2. That a locally agreed Transforming Care protocol should be agreed to reflect national and local practice and provide a framework for variance from agreed protocols where such variance is in the best interests of the patient. This should summarise the changes to guidance and how these should be reflected in clinical and commissioning processes 3. Continue to support and where possible provide leadership to GM Transforming Care and other relevant
Cambian Care	The action we have taken is our admission criteria for the community services.
WBC	1. Reiterate through team brief; training has been delivered to administrative staff regarding effective minute taking. 2. We will continue to emphasise the breadth of the local advocacy service and support the promotion of the advocacy hub. 3. Multi-agency actions around protocol. 4. Local, single agency actions to consider the role of s42 enquiries when an adult at risk has died or is expected to die, during the process. 5. Our internal audits which have been developed around MSP continue to focus and monitor the centrality of the adult at risk, including the clarity of

	recording, and naming a key point of contact for communication with the family.
Cheshire and Wirral Partnership NHS Foundation Trust	1. A formal escalation pathway to be used with commissioners and CLDT to utilise CWP escalation policy 2. CLDT to ensure the care coordinator clarifies expectation especially with out of area placements at point of admission 3. CLDT manager to ensure staff are aware of nearest relatives rights, understand the importance of IMHA and Mental Health Tribunal.
WHHFT	1. A/E to review their current system of meetings in which frequent attenders and mental health patients are reviewed separately. They should be pulled together and have a multi-disciplinary approach and function in order to address how to best support our patients. 2. A/E to work with the IT department to review and develop the Lorenzo system (electronic patient record) to help include and highlight key information staff. 3. Staff (nursing and medical) require level three Safeguarding education as a priority. 4. Staff (nursing and medical) require MCA training as a priority 5. For the dept. team to achieve 85% compliance with level three safeguarding training and MCA training 6. Staff (nursing and medical) require level three Safeguarding education as a priority. 7. There needs to be a system that enables the monitoring of the number of patients who are referred for self-harm, this should be monitored as part of the A/E meeting that reviews the frequent and high risk attendances. Processes are required to audit this in order that improvements can be demonstrated
NWBH	1. Review of observations policy by ward manager and matron to identify if a bespoke observations package/system can be introduced onto Byron ward to assist in managing the level of risk presented by a number of very complex individuals with very different management needs, risks and behaviours. 2. Where patients are required to be observed on level 3 or level 4 observations for more than a period of four or more continuous weeks, then there should be a review of the observations for that patient undertaken by staff with appropriate LD training and wherever possible a doctor , both of whom should be unconnected with Byron ward with app 3. Discussion with staff through weekly team brief of requirement to ensure that observations policy is followed. 4. Review of all the observation charts for patients currently on Byron ward to ensure compliance with current observation policy 5. Review of all RAMP documentation for all current patients on Byron ward to ensure:- a. That it specifically reflects the interventions required to manage the current behaviour of each individual and the risk that this poses. b. That it should incorporate any positive behavioural approaches identified in the positive behaviour functional assessment, if these have been undertaken c. That any specific instructions in respect of how observations are undertaken to manage the current behaviours and level of risk (e.g. staff must be positioned in front of the patient to see their hands/mouth at all times) are clearly documented d. That the RAMP is updated regularly to reflect the current behaviours and level of risk posed 6. All staff whose period of life support training has expired will be booked on a life support training course appropriate for their job role. 7. Temporary staffing/ Workforce management team to ensure that agency staff

	have appropriate and current life support training before commencement on wards 8. Ward managers on Hollins Park site to be advised of need to speak with teams about use of 3333 Emergency contact number. 9. Discussion during team meeting about correct way to contact Emergency Services at Hollins Park site 10. Discussion around the use/appropriateness of non-Trust supported techniques needs to take place at Borough senior management level and actions identified cascaded to teams 11. Review of all care plans for patients currently on Byron ward to establish if there are any non –Trust supported techniques documented in the care plan 12. Where any non-trust supported techniques are identified in a care plan, the appropriateness and use of these techniques needs to be discussed by the multi-disciplinary team (based on decisions made following senior management meeting) 13. Sign to be placed on airlock door advising visitors to sign in 14. Staff to be reminded during team meeting of need to ensure that all visitors to the ward must sign in 15. Team manager to review visitors book on weekly basis to ensure compliance-discussed with matron through supervision process
Trafford LA	1. Develop MoU between host authority and out of area placements 2. Update Local Advocacy Contract 3. Explore GM wide advocacy model to support people out of area 4. Colocation of all staff in complex needs service 5. Ongoing update of the dynamic risk register 6. Maintenance of joint database for individuals 12 and above (across Health Education and Social Care) 7. Adult social care staff to attend year 9 reviews 8. Further embedding of escalation process (adult social care) to Principal Social Worker for high risk / complex individuals 9. Launch GM ethical Framework 10. Commission - assessment and Outcomes Service -Transition Pathway Service
NWAS	None
Washaway Road GP	(Nothing included in their IMR)
Jigsaw Hospital	(Nothing included in their IMR)
Cheshire Police	Whilst a VPA submission was not mandatory in these circumstances, however it has been acknowledged that a holistic VPA submission for collective incidents would have been good practice. As a result of this, a proposal has been made (yet to be ratified) regarding a 3 criteria for a VPA submission. This 3 criteria would be utilised where it has been identified that 3 incidents have taken place in a 6 month period and there appears to be an escalation in behaviour, demand etc. The incidents will be reviewed holistically and a rational placed on the VPA for any further referral to agencies or safeguarding authorities, any action to be taken or for no further action to be taken.