Safeguarding Adults Review

In respect of

‘April’

June 2024

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1. Introduction

1.1. This review has been commissioned in respect of a young, white British woman who, for the purposes of anonymity and at the request of her family, we refer to with the pseudonym “April’. This is a meaningful name for her and reflects her ethnic and cultural background. As a teenager she was diagnosed with Asperger’s syndrome, but until recently struggled to come to terms with this diagnosis. Her parents explained to the review that too often, because of her diagnoses and presentations, people underestimate her intelligence. They describe her as extremely bright, but often overwhelmed by her environment and by trying to mask her needs. They explained that throughout her life she has pushed herself to act in a way she thought age appropriate. They gave the example of her deciding to move out of home and start work, against their advice as they felt this might be detrimental to her. Over time, caring for her, they have a clear understanding of her needs and can gauge when she is in a disassociated state as her facial expressions change, but accept that to recognise this, people must know April very well.

1.2. April was first referred to Hampshire County Council’s social care team aged 15 and remains ordinarily resident in Hampshire for the purposes of health and social care support.[1] At that time, she began exhibiting behavioural problems. She later spoke of a difficult childhood, characterised by a difficult relationship with her parents, bullying at school and social isolation.[2] April developed an eating disorder and depression when she was 24 and began self-harming around this time, shortly after she became known to Frimley Health services for multiple deliberate self-harm events. Aged 25, she was admitted to hospital and shortly after diagnosed with Emotionally Unstable Personality Disorder [‘EUPD’], she continued to exhibit behaviours associated with Anorexia Nervosa. Over the following 3 years, April required medical support due to self-harming behaviours and was subsequently detained for treatment under the Mental Health Act 1983 in Berkshire. During that period, her parents report, her mental health deteriorated significantly. Her parents reported that she was isolated for 6 weeks where she would be curled up in the corner of an unfurnished room. They believed her presentations were linked to the environment in the hospital and lack of autism awareness about sensory overload. They felt staff didn’t explain the care plan or why she was left without furniture, sometimes without clothes (which they later realised might have been to reduce risks of tying ligatures). Eventually, out of desperation, they reported they agreed she could be discharged to her parent’s care (as her nearest relative) but explained they were offered no follow up support and felt there was no real plan for her recovery. After only a week, April was again detained under s.3 of the Mental Health Act 1983 [‘MHA’] and has remained for over 5 years at Farnham Road Hospital [‘FRH’] which is part of Surrey and Borders Partnership NHS Trust [‘SaBP’]. FRH is an acute and psychiatric intensive care unit [‘PICU’] inpatient mental health hospital.

1.3. April continues to report visual hallucinations, restricts her calorific intake, refuses medication (fearing this will impact on her weight) and is currently malnourished and selectively mute. She communicates through emails or via typing into her iPad. Initially this impeded professionals engaging her in psychological interventions. When in distress, she exhibits self-injurious behaviours including overdoses, tying ligatures, cutting, and gouging existing wounds and head-banging. She required emergency medical treatment on 70 occasions during the first 4 years of her in-patient detention. She has also required other physical health interventions to prevent her death, this has included exploratory surgery to recover foreign items swallowed by April whilst under 1:1 supervision and nasogastric tube [‘NG’] feeding whilst under restraint as a consequence of severe malnourishment. FRH staff raised concerns to relevant Integrated Care Boards [‘ICB’], social care departments and NHS England that they are unable to safely meet

[1] It is agreed Hampshire County Council is the relevant local authority responsible for completing social care assessments under Part 1 Care Act 2014, alongside Frimley ICB (as the relevant Integrated Care Board) for aftercare support under s117 Mental Health Act 1983. Surrey County Council are involved as they are the local authority with responsibilities under s42 Care Act. In addition, Surrey, and Heartlands ICB are involved as Host commissioner being the ICB where Farnham Road Hospital is situated.
[2] Detailed within the Social circumstances’ reports submitted to the First Tier Mental Health Tribunals.

her range of needs. The hospital does not have rehabilitation support within the hospital, and it is not commissioned to provide long term physical health intervention, especially NG feeding for prolonged periods of time. The environment is also not tailored to support people with Autism and sensory processing difficulties.

1.4. Many of the incidents also resulted in safeguarding concerns being raised for investigation by Surrey County Council ['SCC'] in line with duties under s42 Care Act 2014. Between 2020 -2023 there were 38 separate s42 enquiries completed. In July 2022 a safeguarding enquiry recommended FRH undertake a Serious Incident Investigation. This was completed on the in June 2023 in respect of 5 incidents and shared with this review. In September 2022 a further safeguarding enquiry concluded she had suffered neglect whilst an in-patient setting and recommended Surrey Safeguarding Adults Board ['SSAB'] complete a Safeguarding Adults Review. SSAB agreed the case met the s44 criteria due to the serious impact the lack of suitable therapeutic care has had on her wellbeing. Following this, SSAB liaised with Hampshire SAB as April remains ordinarily resident there. In January 2023 Hampshire SAB agreed to support the review but declined to jointly commission the report. As such, recommendations are for SSAB to progress. However, given the purpose of a SAR, it is anticipated this will be achieved across geographical boundaries in a spirit of cooperation.

1.5. Safeguarding Circle LLP were commissioned to complete this review in January 2023, but recommended the review be paused to allow an application to the Court of Protection to determine key issues relevant to this review. This was agreed by Panel in June 2023. In November 2023 the review panel were advised the Court of Protection had granted an order but advised the content of that order remain legally privileged, so this has not been shared. This application was made under the ***Re X*** procedure. April's parents were informed about the application, but neither they nor April received separate legal advice. Her parents are aware of the terms of that order.

1.6. It is a testament to her courage, her family's strength and to the coordinated efforts of key professionals now involved that April is, tentatively, making progress in her recovery and is currently on planned leave (under s17 of the Mental Health Act 1983 ['MHA']) as part of a gradual transition to support safe discharge and the provision of tailored support in the community. This is supported by her parents, who remain fully involved in her daily care and take part in weekly meetings with her clinical team and commissioners from Hampshire and Isle of Wight Integrated Care Board ['HIOW ICB'][3], NHS England, SaBP and Royal Surrey County Hospital ['RSCH']. The aspiration of the reviewers, April's parents and all the professionals involved in this review is for April's experiences to act as a catalyst for necessary change. It is imperative that lessons are learnt so that other woman who (because of trauma and/or neurodiversity developed conditions which make it difficult for them to keep themselves safe, receive trauma-informed), personalised care where reasonable adjustments for neurodiverse patients is understood to be a legal right.

1.7. April's self-injurious behaviours remain of a nature, unpredictability, and severity that, means for the foreseeable future she will require 2:1 care to stay safe. Her hope is that, with the appropriate therapeutic care in an environment adapted to her sensory needs, she can recover. She has also indicated, through her treating clinicians and parents, she does not wish for another patient to experience trauma through prolonged compulsory treatment in an institutional setting.

[3] Frimley ICB would normally be responsible for commissioning April's care because she was resident in that area when admitted to FRH, but they have outsourced this responsibility to HIOW ICB under a separate agreement.

2. Scope of Review

2.1. This review[4] will focus on how April's experiences can support multi-agency learning to explore the specific circumstances of this case to get an up-to-date and accurate appreciation of the challenges and constraints faced by April, her family and staff working with her. Most crucially, we wish to better understand how adaptations made by key members of her treating team since 2020 has enabled professionals to focus on recovery, rather than risk. The panel, family and professionals involved in this review were clear that April's experiences should inspire systematic change, highlighting necessary improvements that should strengthen the system for other people who find themselves in similar circumstances to April and offer a 'blueprint' to professionals providing treatment.

2.2. The review covers the period from October 2018 when she was admitted to Farnham Road Hospital until August 2022. The review will consider:

- Are there particular risks associated with meeting co-occurring conditions such as Autism, Personality Disorders and eating disorders, if so, what can be done locally and what should be done nationally to address those risks?
- What, if any, are the barriers to meeting April's complex needs?
- Did FRH hospital managers comply with their duties to refer April's case to the First Tier Mental Health Tribunal and was the matter referred to the Court of Protection in a timely way?
- Were aspects of her care impacted by malignant alienation and, if so, what steps were taken by hospital managers within the mental health in-patient unit and the acute hospital trust to address this? Were these sufficient to address future risk?
- How did partners work to address the systematic safeguarding concerns identified; was the s42 and NHS patient safety incident reporting decision making robust? Were escalation processes adequate? Was April or parents appropriately involved in those processes?
- Did partners (particularly SaBP, ICB and Care Quality Commission ['CQC']) meet expectations regarding oversight of safe care and treatment?
- Were any concerns regarding an unsuitable placement escalated/shared with Hampshire commissioners, the Tribunal or SSAB so that action could be taken to reduce risk for April?
- Given duties owed by Hampshire County Council and safeguarding duties (owed by SSAB partners), were local cross boundary working policies applied and are these fit for purpose?
- How do partners work together to safeguard an adult at risk detained within in-patient settings where the responsibility for care management sits with another local authority and ICB?

Involvement of April, her family and professionals involved with her care.

2.3. We drew heavily from information provided by partner agencies, to support discussions with April's family and the SAR Panel. SSAB, working with her treating clinicians, notified April of the review and she indicated that whilst she does not feel well enough at the current time to actively take part, she wanted her parents to speak with the reviewer. We have met with her parents and incorporated their views within the report. We are so grateful to them for their contributions and for providing the report with a clearer picture of who April is, what matters to her and how best to support her recovery. The reviewer and SSAB partners remain committed to supporting April's involvement and have met with her family to discuss the findings.

[4] The review has used a hybrid methodology, adapting the Social Care Institute for Excellence Learning Together methodology with tools from the SCIE SAR in Rapid Time methodology. The learning produced through this SAR concerns 'systems findings'. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to proactively safeguard, within and between agencies.

2.4. In December 2023 senior managers and practitioners from RCSH and SaBP involved in April's care took part of focus groups to consider what had enabled her to move towards recovery and identify lessons to apply more widely. HIOW ICB and HSAB are represented on the SAR panel and have indicated they will provide assurance to HSAB. To facilitate this the reviewer has set out questions for HSAB and their partner agencies.

3. Legal frameworks to support therapeutic recovery.

3.1. Underpinning the legal powers and statutory provisions to address complex presentations are statutory safeguarding duties (s42 Care Act) owed across relevant partners and an enduring duty to continue to assess[5] where there was ongoing risks of abuse or neglect. Multi-agency responses to risk should be shaped by the 'making safeguarding personal' approach. This requires practitioners to work with the adult at risk to better understand how to reduce the risk of abuse in a way that is meaningful to them. Whilst these duties are not meant to substitute care management responsibilities, repeated concerns of inadequate or unsafe care could give rise to concerns of professional misconduct (including ill-treatment or wilful neglect[6]) and / or organisational neglect.

3.2. Felton et al. research[7] reflects issues raised by April's experiences, questions if the focus, particularly within Mental Health Act, of responsibilities to address '*risk of harm to self or others also serves to more readily justify interventions that may restrict enjoyable activities or remove choice from patients, while intensive risk-monitoring can perpetuate stigma and isolation*' felt by adults with poor mental health. They advised that risk assessment tools, which largely judge people against a 'norm', fails to promote safety and recovery in the long term. This research warns that cocooning patients in a 'risk-free environment' does not support the person to develop skills in safer decision-making. Concerns voiced by FRH professionals, April, and her parents, also resonant given their views that the hospital environment was not risk free but exacerbated her self-injurious behaviours as it triggered sensory overload.

3.3. Felton advocates for a 'recovery concept' model but warns '*therapeutic risk-taking may be inhibited by organisational, professional, and social constraints… Organisational processes that are committed to supporting rather than blaming professionals and to facilitating learning in the context of adverse events are essential. These are important features of developing a culture that is able to tolerate uncertainty, that values the patient's role in decision-making and that shares responsibility with the patient …* When promoting autonomous decision-making and facilitating choices, people with mental illness should not be considered solely in terms of the dangers they present: recognising the full range of threats to their safety, alongside their strengths, successes, and protective factors, can overturn their perceived identity as creators of risk.' This recovery concept also requires practitioners to ensure family/friends perspective on risk and safety are heard. Of fundamental importance to this model is to create safe places for professionals to hold uncertainty. This approach is also advocated within Guidance from the Royal College of Psychiatrists (2016), Department of Health[8] (2007) and Implementing Recovery through Organisational Change.[9] It upholds well established legal principles expected to be applied in all cases and particularly where, as in April's case, positive or negative treatment decisions have a direct bearing on the person's human rights.

3.4. The starting point must always be (as stated by Lady Hale in ***P v Cheshire West*** [2014] UKSC 19) that '*it is axiomatic that people with disabilities, both mental and physical, have the same*

[5] S11(2) Care Act 2015
[6] Which potentially carry criminal liability under s127 MHA or s20 of the Criminal Justice and Courts Act 2015
[7] Felton, A., Wright, N., & Stacey, G. (2017). Therapeutic risk-taking: A justifiable choice. *BJPsych Advances,23*(2), 81-88. doi:10.1192/apt.bp.115.015701
[8] Department of Health (2007) Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services. Department of Health.
[9]Boardman, G, Roberts, G (2014) Risk, Safety and Recovery: A Briefing. Centre for Mental Health and Mental Health Network, NHS Confederation

human rights as the rest of the human race. It may be that those rights have sometimes to be limited or restricted because of their disabilities…This flows inexorably from the universal character of human rights, founded on the inherent dignity of all human beings, and is confirmed in the United Nations Convention on the Rights of Persons with Disabilities." Such foundations should be fully considered by practitioners, care and treatment review panels and the Courts when considering the legal justification for any care or treatment plan. Currently the Mental Health Act 1983 enables someone who presents as seriously mentally unwell to be lawfully deprived of their liberty for treatment, but the Mental Health Act 1983 Code of Practice[10] reinforces that when making any decision in relation to care, support of treatment under the Act, clinicians must apply five guiding principles, including using the least restrictive option that maximises independence, empowerment, respect, and dignity. In addition, the procedural safeguards set out within the MHA to protect against disproportionate detention, (including the 'nearest relative'[11] role, support from an Independent Mental Health Advocate ['IMHA'][12], powers for patients or their nearest relatives to ask for review[13] before the Mental Health Tribunal and hospital managers duties[14] to refer cases to MHT) must be upheld. NHS England ['NHSE'], as part of their commitment to transform care for people with autism and learning disabilities, introduced Care and Treatment Reviews[15] in August 2015.

3.5. If detained for treatment, s63 MHA permits medical treatment for the mental disorder (other than those forms of treatment detailed within s57-58A). This is usually interpreted to include ancillary forms of treatment,[16] but does not extend to treatment for a physical disorder entirely unconnected with the pre-existing disorder. Nor does this power extend to compelling another clinician to provide treatment if they do not believe it is in the patient's interests. In this instance, the relevant clinicians would need to consider if the patient could give capacitated consent or, if the person lacks capacity, if it is necessary and proportionate to provide care in the person's best interests as defined by s4 Mental Capacity Act 2005. In addition, s4B MCA authorises clinicians to deprive a patient of their liberty to give life sustaining treatment "…*while a decision as respects any relevant issue is sought from the court*" (s4B(1)). This is not intended to facilitate ongoing or repeated treatment over a lengthy period against the patient's express wishes if s63 MHA does not apply. In such circumstances, including if there is disagreement, an application should be made to the Court of Protection for authorisation to provide ongoing treatment.

3.6. Clinicians responsible for providing care and treatment are expected to actively consider and apply the correct legal framework as part of their duty of care. Decisions to provide treatment which will likely impede on a patient's rights protected by way of article 3 (the prohibition against torture, inhuman and degrading treatment) and article 5 (the right to liberty) in order to comply with proactive legal duties to protect life (under article 2) may require judicial oversight. Of relevance in this case is the judgment of Mostyn J in *Nottinghamshire Healthcare NHS Trust v RC* [2014] EWCOP 1317 where he said:

"In my judgment where the approved clinician makes a decision not to impose treatment under section 63, and where the consequences of that decision may prove to be life-threatening, then the NHS trust in question would be well advised, as it has here, to apply to the High Court for declaratory relief. The hearing will necessarily involve a 'full merits review' of the initial decision. It would be truly bizarre if such a full merits review were held where a positive decision was

[10]Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF
[11] Nearest relatives (as defined by s26 MHA) have certain rights and responsibilities for patients cared for under powers within MHA. They act as important safeguards for patients under the MHA.
[12] in line with duties detailed in s130A MHA
[13] Section 66 MHA
[14] Section 68 MHA
[15] The current guidance and policy is available at: https://www.england.nhs.uk/learning-disabilities/care/ctr/. Under this guidance, the CTR should bring together those responsible for commissioning and providing services with independent clinical opinion and the lived experience of people with learning disabilities, autism, or both. NHS providers (in this instance- SaBP) are required to make arrangements for the reviews, implement recommendations arising from the reviews and must also submit data to NHSE so that they are able to monitor whether care and treatment of patients is reviewed in line with national guidance.
[16] Following the judgment in *B v Croydon Health Authority* [1995] a All E.R 683

made under section 63, but not where there was a negative one, especially where one considers that the negative decision may have far more momentous consequences (i.e. death) than the positive one."

3.7. To facilitate swift, safe rehabilitation into community-based care, a person who has been detained under s3 MHA can be made subject of a community treatment order (CTO) under s17A MHA by their responsible clinician if they require medical treatment for their health or safety or the protection of others, which can be provided in the community. If an AMHP agrees that the person meets the criteria for a CTO they will make a recommendation. CTOs are subject to conditions that the person must meet with their responsible clinician when required and may also include conditions to live at a specific address, attend appointments for treatment, as long as these are necessary for medical treatment or safety reasons and the person can reasonably comply with the conditions. The person can be recalled to hospital if they breach mandatory conditions, and their responsible clinician assesses that this is necessary. If the Responsible Clinician (or an AMHP) does not believe a CTO is the appropriate[17] it may be appropriate to consider powers to place a patient under the Guardianship of the local authority or a person, willing and approved by the local authority to act as guardian [s7 MHA]. This gives the guardian power to require the patient to reside at a specified place, attend a specified place for treatment, occupation or education and require access to any registered medical practitioner or other person so specified [s8 MHA].

3.8. Where, as in April's case, on discharge a person is likely to require constant supervision such that they will be deprived of their liberty as defined by the Supreme Court in ***P v Cheshire West*** [2014] this must be authorised through the Court of Protection [s4A Mental Capacity Act 2005]. In addition, s.117 of the MHA places an enforceable duty on the ICB and local authority to provide aftercare services to meet needs arising from or related to the individual's mental disorder, to treat and prevent a deterioration in their mental disorder and reduce the risk of the individual being returned to hospital. The ultimate aim is to maintain patients in the community with as few restrictions as are necessary. The duty to provide s117 aftercare services is triggered on discharge from hospital[18] including when a CTO or guardianship is in place. Discharge planning should begin as soon as the person is detained under MHA. If the Responsible Clinician is considering discharge, they should consider whether the person's aftercare needs have been identified and that the appropriate aftercare services necessary to meet their needs have been secured before they are discharged. Aftercare should be kept under review to ensure this continues to meet the person's needs and will only end if both the ICB and local authority are satisfied that the person no longer needs this. The individual must be fully involved in any decision-making process with regards to the ending of aftercare, including if appropriate, consultation with their carers and advocate.[19]

3.9. Where a person has co-occurring physical health needs which cannot be treated under MHA powers, legal duties to meet these needs (under s3 NHS Act 2006) persist. Where needs are of a nature, intensity, unpredictability, or frequency that specialist/nursing care is required beyond what is ancillary and incidental to social care support the adult may be eligible for NHS Continuing Healthcare. Eligibility for such provision is determined following multi-agency assessments which, if care is providing in the community, will usually include social care outcomes[20] to ensure continued focus on the wider wellbeing of the person.

[17] The power to make a CTO is restricted on grounds set out within s17A(4) MHA.
[18] Where the patient has been detained under sections 3, 37, 45A, 47 or 48 of the MHA.
[19] Supreme Court judgement in *R (oao Worcestershire Council Council) v Secretary of State for Health* [2022] available at: https://www.supremecourt.uk/cases/uksc-2022-0022.html confirmed aftercare support cannot be withdrawn simply because someone has been discharged from specialist mental health services or after an arbitrary period. If aftercare is withdrawn, services can be reinstated if it becomes obvious that was premature or if the person is re-admitted to hospital under s3MHA.
[20] Assessed under s9 of the Care Act, according to the specified outcomes detailed within s2 Care and Support (Eligibility Criteria) Regulations 2014

4. Analysis of Agencies' Actions

KLOE 1: Addressing complex needs compassionately.

Are there particular risks associated with meeting co-occurring conditions such as Autism, Personal Disorders and eating disorders, if so, what can be done locally and what should be done nationally to address those risks?

4.1. The risks associated with poorer outcomes for people with Autism, personality disorders and eating disorders are well understood, prompting Parliament to enact legislation and ministers to issue guidance to improve equality of opportunity. In 2002 the UK Government/ Department of Health introduced bills to 'break the cycle of rejection' and prevent Personality Disorder being a diagnosis of exclusion (DoH, 2002). This led to the introduction of national personality disorder development programmes. Similarly, responses to the Winterbourne View scandal led to a national programme to transform care delivered to people with learning disabilities moving away from out of area in-patient admissions to reduce the risk of abuse. NICE has provided guidance on the assessment, treatment, monitoring, and inpatient care for people with eating disorders[21] a key tenet of this is to involve the person and their family in psychoeducation about the disorder and treatment plan. There is also an expectation of multi-disciplinary coordination between services.

4.2. Despite these initiatives, there is still recognised structural stigma faced by patients with long-term conditions linked to trauma and neurodiversity.[22] As in April's case, teams working with people with personality disorders sometimes find themselves feeling "stuck" in clinical dilemmas and uncertain about how best to proceed. This can manifest itself as extreme ambivalence from the clinical team towards the service user, who then is at risk of malignant alienation. According to research[23] this is more common during inpatient admissions, as service users can present with an intense and confusing paradox of emotions: feeling contained by being in a supportive environment and not wanting to be discharged, whilst simultaneously feeling claustrophobic and agitated about the restrictive environment on the ward and expressing a wish to leave and harm themselves. This can lead to an escalating spiral of threats, acts of self-harm and violence, with the mental distress within the service user becoming translated into anxiety within the care system. To overcome this, NICE have developed quality standards[24] and advise the use of structured clinical assessment. To comply with NICE expectations, clinicians should prioritise psychological therapies and group-based cognitive and behavioural therapies. Patient should be involved in choosing the duration and intensity of any interventions. Importantly, NICE advise patients are prescribed antipsychotic or sedative medication only for short-term crisis management or treatment of comorbid conditions. To enhance therapeutic interventions there needs to be a focus within care plans on the continuity of care between inpatient and community settings, that incorporate aspirations for the person's long-term education and employment goals.

4.3. The diagnostic criterion for personality disorders recognises patients will experience cognitive distortions, defining these as '*enduring disturbance characterised by problems in functioning of aspects of the self (e.g., identity, self-worth, accuracy of self-view, self-direction), and/or interpersonal dysfunction (e.g., ability to develop and maintain close and mutually satisfying relationships, ability to understand others' perspectives and to manage conflict in relationships)*.[25] Patients with EUPD can present with cognitive distortions which present as '*a pattern of unstable and intense interpersonal relationships characterised by alternating between*

[21] Available at: https://www.nice.org.uk/guidance/ng69

[22] Klein, P., Fairweather, A.K. & Lawn, S. Structural stigma, and its impact on healthcare for borderline personality disorder: a scoping review. *Int J Ment Health Syst* 16, 48 (2022). https://doi.org/10.1186/s13033-022-00558-3. In addition, the Royal College of Psychiatry (2018) supported research completed by Cartonas (et al 2018) suggestive of negative attitudes of clinical staff towards patients with diagnosis of personality disorder.

[23] Watts, D., & Morgan, H. G. (1994). Malignant alienation: Dangers for patients who are hard to like. *The British Journal of Psychiatry, 164,* 11–15. https://doi.org/10.1192/bjp.164.1.11

[24] Published in 2015 and available at: https://www.nice.org.uk/guidance/qs88

[25] ICD for Mortality and Morbidity Statistics (1/2003) available at: https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/941859884

extremes of idealisation and devaluation.' [DSM5] These disturbances often affect their perceptions and behaviours towards clinicians providing treatment or therapy. This is called 'transference' and presents an important factor to monitor for those treating and supporting a patient's recovery to provide against intentional or unintentional abuse as '*excessively positive and negative transference can block or slow down the therapeutic process, especially if it is not recognised and processed."*[26] Clinicians can equally experience countertransference, adversely impacting on the therapeutic relationship. NICE advocate, therefore, for tailored, skilled clinical supervision and reflective practice to address the significant challenges staff face when positively supporting people with personality disorders. This is a key components of safe, effective care.

4.4. The DHSC's rapid review into Mental Health in-patient data[27], completed in July 2023, highlights the very real systemic issues in providing quality in-patient care and the impact that this has on safety of patients. This reports that 77% of the NHS trusts with 'acute wards for adults of working age and psychiatric intensive care units' had a 'requires improvement' or 'inadequate' safe rating. SaBP was rated good at their most recent inspection in 2020, the report commented that '*generally, staff completed comprehensive risk assessments and managed risks well. Physical and mental health needs were assessed and monitored, and care plans were holistic, and recovery orientated. Staff followed good practice with respect to safeguarding… Staff across all the services we inspected were kind, compassionate, supportive, and respected the dignity of patients.'* But it also noted *'health-care assistants based at the health-based places of safety were not receiving supervision regularly with only 49% being completed… Although local managers held a record of staff supervisions, there was no trust-level assurance that all staff had received supervision*.' It also required improvement to the provision of care to patients with a learning disability and autism and advised the Trust should '*ensure its rehabilitation and recovery philosophy is effectively integrated into how patients' recovery goals are described and recorded in its care planning system*' and '*use a recognised outcome measure for patients that can demonstrate patient's overall recovery progress during their admission*.' [28]

4.5. SaBP reported numerous barriers to accessing specialist eating disorder support as those services are commissioned so the Adult Eating Disorder consultant only provided consultative support to her treating ward-based team and could not provide patient facing support. Initially, this was limited to attending one meeting in 2021 where the treating team were advised that her eating disorder was related to mood, so did not present as a typical eating disorder. SaBP's Chief nurse and ICB's Medical Director of the Adult Eating Disorder ['AED'] team attended the weekly ward rounds for April from 2022. SaBP reported they also sought to recruit a dietician who could support the therapeutic team within FRH but were unable to fill this post. There is also evidence of RSCH staff, particularly those with expertise in nutrition and NG feeding, provided frequent reviews of her nutritional needs (completing 27 reviews) and providing significant training and supervisory support to staff within FRH undertaking NG feeding.

4.6. Since 2022 responsibility for oversight of patient safety sits with the System Quality Groups ['SQG'] of Integrated Care Systems who are required to '*focused on engagement and intelligence- sharing for improvement, the discussions, and decisions from SQGs will feed into the designated assurance functions of both the ICB and local authorities; shaping assurance around relevant matters (e.g. safeguarding, pathways). SQGs will also escalate any risks or concerns to the ICB, local authority assurance and regional NHS England and NHS*

[26] Prasko J, Ociskova M, Vanek J, Burkauskas J, Slepecky M, Bite I, Krone I, Sollar T, Juskiene A. Managing Transference and Countertransference in Cognitive Behavioral Supervision: Theoretical Framework and Clinical Application. Psychol Res Behav Manag. 2022 Aug 11;15:2129-2155. doi: 10.2147/PRBM.S369294. PMID: 35990755; PMCID: PMC9384966.
[27] Available at: https://www.gov.uk/government/publications/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations#ministerial-foreword
[28] CQC Inspection report dated 01.05.20 available at: https://api.cqc.org.uk/public/v1/reports/5e9d7e4a-36cb-4a33-b5fb-279112aa0a74?20210113111538

Improvement teams where response and support is required.'[29] In December 2022 the Local Government Association published a report on the early impact of NHS integrated care systems and ICBs on SABs. The report commented the development of ICBs afforded an opportunity to identify systematically patterns of safeguarding concerns that had been noted by more than one SAB regarding organisational abuse. However, this recognised a missed opportunity to set out the overlap between safeguarding and patient safety within the new Patient Safety Incident Response Framework. It advised it may fall to the SQG to put in place additional policies and procedures to fill this gap.

System finding: Nationally, the challenges of providing quality, trauma-informed care to individuals with co-occurring conditions, particularly in respect of personality disorders, eating disorders and autism are well documented. National guidance, including NICE clinical quality standards, already exist to support practitioners and clinicians apply good practice but April's experiences and CQC's most recent inspection of SaBP suggest these are not firmly embedded into practice across relevant partners.

What, if any, are the barriers to meeting April's complex needs?

4.7. April's needs are unequivocally complex. She has a range of conditions each of which are recognised to present significant challenges to long-term recovery and immediate risk in respect of accidental serious injury/ death or suicidality. As noted above, there were concerns throughout 2018-19 that ward staff lacked the appropriate skills, knowledge, and access to specialist support to fully understand the complexity of April's presentations.

4.8. In 2019 her treating team described April as having '*many inconclusive diagnoses such as* Emotionally Unstable Personality Disorder ['EUPD'],[30]*, Autistic Spectrum Disorder ['ASD'], Bulimia nervosa, Anxious avoidant personality, and Schizotypal personality disorder for many years ...[her clinical team also considered] the diagnosis of schizoaffective disorder. The nature of the disorder is severe and an enduring illness i.e., long-term, recurrent, and fluctuant and the degree is that she is very chaotic in her behaviour, labile in mood, guarded, withdrawn, experiencing command hallucinations, impaired judgement, and limited insight, and has fluctuating capacity. There is ongoing risk of fire setting, and this poses a serious risk to others and herself. She has ongoing history of repeated serious self-harm and currently awaiting a forensic assessment*.'[31] The forensic assessment was requested by a specialist team based within another (out of area) mental health trust and remains outstanding at the time of writing this report. This case note provides a clear example of a focus, as described by Felton, on risk. There is little within the clinical notes throughout that period detailing the steps taken to support April to understand her different conditions or assist her to find ways to process the information she needed to retain to assist her to engage with care planning.

4.9. Staff focus was, especially during 2018-21, primarily on keeping her alive cognisant that the risks of her self-injurious behaviours were so extreme that even with 1:1 monitoring within an inpatient setting, this could not be assured. Despite NICE guidance, April's responsible clinician and treating team (in FRH or RSCH) did not have access to eating disorder expertise until she was admitted to RSCH in November 2019.[32] Regular, reliable provision with expertise in autism was not made available until 2022.

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[29] National Quality Board's guidance on system quality groups published by NHSE in 2022 and available at: https://www.england.nhs.uk/wp-content/uploads/2022/01/B0894-nqb-guidance-on-system-quality-groups.pdf

[30] EUPD or 'Emotionally unstable personality disorder, sometimes also known as borderline personality disorder. It is worth noting that since April 2022 the International Classification of Diseases no longer distinguishes the previous separate types of personality disorder, (Available at: https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/941859884) but defines it as a single condition, classified by severity. Personality disorder is '*characterised by problems in functioning of aspects of the self (e.g., identity, self-worth, accuracy of self-view, self-direction), and/or interpersonal dysfunction (e.g., ability to develop and maintain close and mutually satisfying relationships, ability to understand others' perspectives and to manage conflict in relationships) that have persisted over an extended period of time (e.g., 2 years or more).*'

[31] Taken from the medical report prepared for the First Tier Mental Health Review Tribunal in 2019.

[32] April's first presentation to RSCH with concerns regarding nutrition concerns was in September 2019, prior to that each attendance at RSCH was to treat wounds.

4.10. There is evidence, throughout the care records and reported by frontline staff, senior managers, and panel members that throughout 2018-21 that FRH was not designed to provide the complexity of care required to assist April vocalise her recovery goals. For example, staff also reported, as part of the Serious Incident ['SI'] investigation, practical difficulties in conducting observations as '*due to her sensory needs, there can be no bright lights, the lights are always on the lowest setting, the curtain is always closed and if the heating is on it can be hot or alternatively cold if it is not. During interviews with staff, they describe how 'April' can be selective in terms of engagement, sometimes choosing not to communicate at all and how difficult it is to keep observation on her. They cite the environment as being very difficult due to it being so dark and the temperature of the room. 'April' is very observant and will look for opportunities to secrete items on herself or self-harm when staff are not paying attention to her.*'[33]

4.11. Another issue to meeting her need highlighted within the SI report was her preferred method of communication. April, aware of some Trust and ICB staff's email accounts, often used email to alert staff to an incident, agency staff sleeping during 1:1 observations or if she requires additional medication. One staff from B Ward, explained how April would send them emails at varying times of the day meaning they felt compelled to check their work email when they were off, just in case they missed something or if April had self-harmed and nobody else was aware. This caused considerable stress and was a factor in their decision to leaving B Ward. Following feedback at the Care Review Panel, the Trust set up a new email inbox so April can send emails and staff on duty can pick up any concerns she has or when she requires additional medication.

4.12. The SI report and her parents identified the use of agency staff to provide 1:1 (and then 2:1 observations) of April also undermined the safe delivery of care. The report noted that often agency staff may not have sufficient training to understand the specific care April required. An example of this was that the staff observing her in January 2023 (when she was able to have large numbers of non-prescription painkillers delivered by Deliveroo and overdosed), had not received training on searching techniques. The SI report author reports that now all agency staff have searching training and all staff working on the ward are aware of the SaBP's searching policy. In addition, the ward manager has developed a crib sheet which is a briefing guide to working with April. This highlights the key things to be aware of, how to engage with April and the escalation process should an incident or concern occur.

4.13. Case notes and reports to the First-Tier tribunal rarely reflected input from wider practitioners involved in her care, including those who took part in the High Intensity User Group discussions within RSCH. These meetings started in January 2019 and included RSCH's safeguarding lead, their In-reach GP, SaBP's psychiatric liaison team with input, when necessary, from Surrey police, A&E consultants, and community mental health teams. It does not appear that FRH staff took part in these meetings, but there is evidence of separate joint care planning meetings taking place outside this multi-agency forum with FRH. A summary of involvement (submitted by RSCH) notes concerns regarding quality of care within FRH were tasked to be followed up either by the in-reach GP (if the issue was physical health needs) or by the SaBP's psychiatric liaison lead (if linked to her mental health conditions). It is not clear from any of the case notes or reports submitted for this review, how those issues were resolved between the practitioners. As noted elsewhere in this report, there is clear evidence of escalation of concerns that the care plan was not addressing April's needs safely, including inclusion in March 2021 of the RSCH's medical director and very high intensity project lead into the HIUG meeting. It is understood that, outside of this review process, RSCH and SaBP medical directors will meet to discuss learning from this case. They also reported the Trust had created a new role (head of mental health nursing) to liaise directly between SaBP at bi-weekly MDT meetings and confirmed the specialist autism position as a substantive post.

[33] Taken from s13 SI report.

4.14. In discussion with the reviewer, April's parents commented that for the first three years of her admission it felt like nothing happened. They spoke of having to fight for everything. This improved when she moved to B ward, and they wished to commend two practitioners in particular (LW and GP) for their persistence in seeking to build a good relationship with April. They explained, from this time, they were involved in her care and asked about what they felt she might need. They were able to explain how best to engage with April. They understood the challenges of caring for April, especially if the ward was heavily dependent on agency staff as, all too often, people with little knowledge of her would assume (because she was non-verbal and withdrawn) that she lacked capacity to understand. So, people would talk about her, and the challenges of caring for her, in front of her. It made April feel like a commodity. They accept she can be quite paranoid, but explained this is part of her condition so, for her to feel comfortable with staff and therefore develop a therapeutic relationship, she appreciates people making eye contact with her, explaining what they are doing and why and if they use her name. These things help to build a rapport and, they felt, LW and GP understood this and '*fought for her*'. They also commented her current GP and responsible clinician (Dr L) appear very experienced, patient focused and appear to look more holistically at April's needs, working well with her. They commented that Dr L '*always had a plan B*' and this gave them confidence.

4.15. Practitioners and, separately, her parents explained that the most challenging aspects of meet April's needs was her resistance to accepting the diagnosis of ASD. The most significant change in recent months has been her recognition and subsequent insight into ASD. The advanced clinical practitioner ['ACP'] explained the steps she has taken over the last few years to assist April understand her ASD diagnosis. As the ACP role is not commissioned to be patient facing, normally they provide guidance to ward-based staff on how to adjust practice to build a therapeutic relationship. Initially the ACP got involved in attending weekly ward meetings and supporting the matron, reporting it took over 6 weeks before she could establish a means to communicate with April directly.

4.16. Alongside the ACP's involvement, and in response to continued self-injurious behaviours thorough 2021-22, additional support of 12 hours of dedicated in-reach autism carers was funded by Frimley ICB. This enabled FRH ward staff to move from crisis intervention and provide nursing care, through feeding and clinical observations. The specialist autism in-reach team were required to work 12-hour shifts but during breaks permanent staff from the ward agreed provide cover. Again, this reduced reliance on agency staff so that April had consistency of care. The SI report confirmed the team were a small group of people to whom April could build relationships and who were able to specifically meet her needs related to her Autism. They also received an induction into SaBP's policies, including searching, restraint and safeguarding polices. However, the team reported that remaining focused and vigilant for more than one hour was made more difficult due to the non-stimulating environment (resulting in numerous examples of staff falling asleep, providing an opportunity for her to self-harm). As noted above, these were subject to safeguarding investigations and consequently care plans were strengthened so one worker remained with April in her room and an additional person stayed outside to support both April and the person undertaking the 1-1 observation. In addition, the lead clinical nurse was expected under the care plan to review the observation logs in the morning and challenge any noncompliance. SaBP reported to this review they would have expected non-compliance to be raised by staff within the weekly reviews or ward rounds which were overseen by a Consultant and GP. April's room was also subject to daily searching. Staff reported '*whilst initially she did not like it, she now feels a sense of reassurance that staff are paying close attention to her welfare and safety*.'[34] Arguably this runs contrary to a recovery-based model. Everyone involved in the focus group concurred that providing the bespoke support needed to maintain April's safety was exceptionally difficult within a ward where attention was divided across 14 patients, all of whom had their own high level of needs. The onward monitoring arrangements by senior Trust leaders for oversight of concerns raised or

[34] Taken from p14 SI investigation.

non-compliance within ward rounds remains unclear. Consideration should be given, following the SI report and this review, by Trust directors to clarify escalation and monitoring arrangements.

4.17. The ACP took what other practitioners involved in the focus group described as a 'pragmatic and persistent approach' to build trust with April on her terms, understanding that the therapeutic trust needed to be developed over time. The ACP explained this was made possible by her own line manager's flexibility to enable her to dedicate more time than had been commissioned for this task. It was also strengthened as she could break down (for April) stereotypes or misperceptions of Autism and how this presents. She pointed to people with public profiles (such as Chris Packham) who have openly talked about the positive benefits of autism to enable April to consider looking more widely into characteristics. Thereafter, understanding that she would need time to process information, the ACP provided relevant resources (via YouTube videos) that could support April to understand how her experiences and presentations met the diagnosis criteria and, more importantly, how understanding this might help her to access psychological therapies to help her employ positive techniques to reduce internal distress when she is experiencing sensory overload moving away from self-injurious behaviours. The impact of the ACP had is best expressed by others involved in the focus group who explained '*once we had this 'resource' everything else moved forward*'. All, including the ACP acknowledged though that April is still at the very early stages of her autism journey. For many though, this changed the whole approach from one that had prioritised keeping her alive, whilst trying to find a more specialist provider to whom they could refer, to thinking about how they could adapt the usual hospital offer to a shared care model that bought in external wrap around support, including working with her family to enable recovery (and therefore discharge into the community) planning to begin.

4.18. SaBP's SI report concluded (p17) that by June 2023 '*The B Ward leadership team should be commended for their outstanding efforts. [April] has very complex and challenging needs, hence why thirty hospital and community placements would not accept a referral due to risk. Considering such difficult circumstances, they provide excellent care for her.'* As noted above, recommendations from RSCH's consultants and offers of shared care planning were not always prioritised within FRH resulting in numerous admissions when April's health deteriorated to a critical condition. As detailed below (4.31-4.34), by 2021 this resulted in professional conflict regarding whether continued treatment or emergency interventions to sustain life was in her best interest. Regrettably, that professional disagreement resulted in further safeguarding concerns (alleging organisational or discriminatory abuse) which could have been avoided had this been properly escalated to the Court of Protection.

4.19. More recently, April has undoubtedly been assisted to engage more positively with her treatment plan, but consideration should be given particularly now she is moving into the community, to putting in place clear immediate plans to respond if she absconds. Without clear plans in place and careful monitoring, April remains at foreseeable risk of serious harm or death. Those clear plans will need to comply with good practice re notifications to relevant safeguarding partners[35] and ensure her parents are alerted at the earliest opportunity so they can assist, if possible, with efforts to locate her, especially given the implementation of 'Right Care; Right Person' policy.

4.20. Plans should also clarify how her treating team (including whilst receiving ancillary treatment in RSCH) have access to specialist support from SaBP to ensure her care plan complied with NICE clinical guidelines for treating personality disorders. To avoid a repeat of professional conflict or gaps in her current treatment plan, urgent consideration should be given to how this is managed currently, whilst in the in-patient setting, and how training on personality disorders

[35] Whilst the Herbert Protocol is intended to support police and agencies quickly find an elderly adult with dementia if they go missing, this form could be adapted to better support April if she absconds. More information is available at: https://www.surreysab.org.uk/wp-content/uploads/2020/10/The-Herbert-Protocol-poster.pdf

will be provided to carers supporting her whilst on s17 leave and, following her discharge, as part of her s117 MHA aftercare plan.

4.21. Consideration will also be needed to how carers and her treating team monitor her nutrition and other physical health issues arising from serious self-injurious behaviours.

4.22. In addition, the wider systematic issues identified in her case regarding the lack of suitable resource to prevent admission and overreliance on medication to treat patients with personality and behavioural disorders has not been addressed. April's case identified the severe lack of resource, both at a local and national level to address the needs of those with severe and enduring co-occurring conditions. There were long periods of time when, despite interventions by high level regional leads it was not possible to secure alternative safe, effective treatment. Nor were FRH and RSCH staff supported (until 2022) to 'buy-in' external resources to address identified her needs. This resulted in breaches of April's human rights with insufficient regard had at every level of each relevant organisation to securing lawful judicial oversight for declarations that the proposed treatment plan was in her best interest.

System finding: Following the decision by SSAB to initiate a safeguarding adults review into April's care and the decision by SaBP to undertake a SI review, there does now appear to be progress into her discharge planning. However, poor access to specialist input re eating disorders, ASD and personality disorders meant that staff within FRH felt unsupported and operating beyond their expertise. Actions to address concerns raised within CTR, at the Mental Health Tribunal and by the team around April were not taken by hospital managers or HIOW ICB (responsible for oversight of her care and commissioning discharge in a timely manner). Whilst there is evidence that numerous attempts were made to identify alternative hospital placements, there is insufficient explanation for why, having approached numerous resources and placement all of whom confirmed they were unable to support April based on her risk profile, the responsible ICB did not act sooner to commission bespoke care within an environment better placed to safely meet her needs. SaBP appeared to have fewer mechanisms than might have been available to them (if they were working with their local ICB-Surrey Heartlands ICB), to liaise and secure agreement for effective discharge planning in a timely manner.

Did hospital managers comply with their duties to complete CTRs, refer April's case to the First Tier Mental Health Tribunal and was the matter referred to the Court of Protection in a timely way?

4.23. April's case was considered by the First Tier Mental Health Review Tribunal ['MHRT'] following a referral by hospital managers in May 2019. This was consistent with their legal duties to submit an application under s66 MHA. There remains, however, unexplained delaying in referring her case for a Care and Treatment Review prior to 2021. SaBP's CQC inspection report in 2020 comments on support provided to front line clinical staff by the proactive Mental Health Act administration team to ensure staff understand and discharge their roles and responsibilities under the MHA and MCA. This report also reported '*patients could access specialist independent mental health advocates and mental capacity advocates. There was information displayed within each service on how to contact an advocacy service*.'[36] The importance of access to advocacy and other essential procedural safeguards to protect against inadvertent, possibly well-meaning but ultimately unnecessary or disproportionate compulsory admissions under the MHA is set out in section 3 above. It is particularly important for this to be rigorous for adults with a learning disability or autism who can only be subject to the powers under the MHA if associated, as it was in April's case, with abnormally aggressive behaviour or seriously irresponsible conduct. Since 2022 SaBP state they have arranged for ward staff supporting patients with Autism to receive weekly sessions with their lead Nurse from the ASD team, the SaBP's learning disability and autism team also link directly with wards to provide support and arrange CTR panels. In addition, Oliver McGowan training is now mandatory for staff. *(Please see attached statement from HIOW ICB)*

[36] Ibid, p6

4.24. Throughout the review period all mental capacity assessment reports concluded that April at all times lacked capacity with regards to her treatment regime.[37] However, reports to the Mental Health First Tier Tribunal report April had capacity to understand her rights to attend and have legal representation for those meetings, but that she declined to exercise those rights throughout 2019-22. She was legally represented at the tribunal on two occasions, but again declined to attend herself. It was also noted on the in 2021 that she had refused consent for her nearest relative to attend or be informed of the hearing.

4.25. It is asserted within case notes that she always declined an advocacy service and was assessed to have capacity to make that decision. Practitioners reported within the focus groups, this was particularly true if she didn't receive from the advocate the answers she wanted. FRH and RSCH staff explained within the focus groups that they placed weight on her wishes, even if incapacitated, in the hope that this would enable a therapeutic relationship. In addition, practical difficulties in securing independent advocacy within RSCH in a timely way or finding advocates suitable skilled to work with someone selectively mute and with April's complex needs meant insufficient regard was given to the public law obligation (to ensure a fair hearing, protected under article 6 ECHR). Presently, SaBP report they advertise advocacy services by way of a poster at each service, but hospital manager should reflect if this is sufficient to meet their duties, particularly for patients who (due to neurodiversity or existing mental health conditions) have difficulties in engaging. Likewise, though her parents remained involved in her care, visiting daily to bring her food, or supporting her recovery by providing access to her pets, there are examples of them being excluded from care planning discussions and not notified, in line with legal duties, of their rights to attend tribunals. Her father performed his functions as 'nearest relative' with her best interests in mind. Their exclusion from decision making was justified in one medical report to the Tribunal as '*although she finds her family supportive, she was reluctant to involve them in her care*'.[38]

4.26. Throughout the review period, April remained resistant to treatment interventions, and it was universally agreed she lacked capacity to weigh up her behaviours to severely restrict her nutritional intake resulting in potentially life-threatening deterioration in her physical health. Similarly clinical staff agreed that, to protect her life, she required admissions to the RSCH and administration of IV fluids and NG feeding under restraint provided by SaBP staff, both of which she frequently opposed. Medical, nursing, and social circumstance reports consistently note April remained non-compliant with all aspects of her treatment. She had received ECT treatment in 2018 and again between November 2019- January 2020 and from March 2020. She was tried on number of antipsychotics including Clozapine with medical staff noting some improvement, but (as with the slight improvements after ECT) that this was difficult to sustain due to noncompliance. She remained selectively mute and would not engage with psychological therapeutic input when this was offered in April 2020.

4.27. Throughout the review period her clinical team continued to report to the Tribunal further decline in her mental health, stating in their report of March 2020 the '*team here in ward is desperately trying to keep her alive and minimise the risks*.' They recommended continued detention as if she were to become '*an informal patient it would be highly likely that April would self-discharge from the ward. She would then be likely to decline her depot and refuse intervention by the community teams. This would put her at serious risk of severe and rapid decline in mental state, increasing the risk of self-harm and even death (intentional or accidentally)*.'

4.28. By January 2021, the Tribunal also voiced concerns that '*FRH is not the right environment as April's treatment requiring a specialist ASD placement.*' The Tribunal noted that MCA powers had been considered by deemed not appropriate and so authorised the continued detention,

[37] The review has had sight of capacity assessments completed on the 06.11.18, 12.05.21, 15.09.21, 08.12.21, and February 2023.
[38] Taken from the Medical Report to the Tribunal dated 11.03.20

whilst expressing a hope to see the ASD placement '*become a reality in the very near future*.' As noted above, CTR reports accepted that April continued to require compulsory admission, but also concluded FRH was not an appropriate placement.

4.29. SaBP staff taking part in focus groups confirmed that, throughout the review period, they provided care (albeit sometimes within RSCH's acute hospital wards) under MHA powers because they felt her physical health needs were ancillary to her mental health condition. They spoke of taking legal advice and considering steps to limit restrictive practices to the minimum, for example by using soft cuffs. They felt that the clinical notes perhaps did not convey sufficiently that her best interests were at the heart of their decision making. They understood her self-injurious behaviours, though extremely challenging, were as a result of her mental health conditions. Where they could, they acted in a way that respected her wishes, but also sought to reach consensus across her clinical teams in RSCH and FRH. They spoke of the challenges of treating complex co-occurring conditions without a full understanding of how her autism and personality disorder might impact on her decision making. Whilst they welcomed basic awareness on autism introduced through the Health and Care Act 2022 (named after Oliver McGowan) much more specialist support was required to implement appropriately adaptative invasive and lengthy treatment plans such that April required to address her eating disorder.

4.30. RSCH staff raised frustrations that, as April did not have specialist eating disorder input within FRH, their input was repetitive and limited to treating the symptoms rather than addressing the underlying cause. Certainly, the steps and advice given during her in-patients stays within RSCH and the support provided to train SaBP staff within FRH did not appear to address long-term needs or prevent her physical health deteriorating. This resulted in a conflict of professional opinion when, she required a critical care admission in late April 2021. At this time, because the frequent NG feeding interventions were causing her serious distress and unlikely to prevent her death, (which by this time was expected to occur within weeks due to severe malnutrition associated with her anorexia), they took the view it would be in her best interests to provide palliative care rather than continue invasive NG feeding procedures. Some practitioners (from FRH and completing s42 enquiries) queried if this indicated discriminatory behaviour. This led to the first overt conflict of professional opinion, with staff from FRH proposing instead RSCH continue to provide medical treatment. Professionals were aware that her parents still believed staff should pro-actively treat so were advised they would need to obtain legal authorisation from the Court of Protection to withhold care and treatment. This was not progressed when interventions meant her physical health recovered. In March 2022 SaBP clinicians on ward B were advised they could use powers under s63MHA to restrain and treat April's wounds, confirming this would be similar to their legal powers to provide NG feeding. In response to additional queries arising in this review, SaBP confirmed their legal team sought external counsel's opinion which also confirmed that ultimately it was for clinicians to reach a view on whether treatment was appropriate under s63 MHA. In June 2022 Frimley ICB's Director of Safeguarding confirmed, as part of this review, they had sought external legal support to apply to the Court of Protection but a lack of clarity about the agreed treatment plan[39] meant this was further delayed until October 2023. The safeguarding enquiry report in September 2022 the s42 enquiry officer criticised this impasse, commenting '*there are undoubtedly significant clinical and complex ethical issues including April's experience of trauma. It is likely however that a degree of judicial oversight at some point between March and late April may have improved the transparency of decision-making in terms of April's best interests*.'[40]

4.31. There are clear lessons that can be drawn from this case and similar cases involving the lack of suitable Tier 4 CAMHS resource to support children reported within case law, including consideration within one judgment that a guardian should consider initiating a judicial review of

[39] SaBP reported they received contradictory advice in August 2022 that it was not necessary to apply to the Court of Protection
[40] Taken from the s42 enquiry report.

the decision to detain under s3 MHA.[41] SSAB and HSAB partners should also note *SF v Avon and Wiltshire Mental Health Partnership* [2023] where the Upper Tribunal upheld the first tier Judge's decision to adjourn because the treatment proposed was not appropriate medical treatment within the meaning of s72MHA. Within her judgment UTJ Church identified:

"Appropriate medical treatment' can only mean treatment that is appropriate to the relevant patient's particular needs. While it is accepted that to satisfy the requirement in section 72(1)(b)(iia) the treatment available need not be the best or the most comprehensive treatment that could be provided, but it cannot be the case that treatment that is wholly inadequate for a patient's needs can satisfy that test." [p50]

4.32. It appears on the face of the case notes April's Responsible Clinician (acting under duties imposed by the MHA) sought to impose a positive obligation on RSCH clinicians to treat the symptoms or manifestations (malnutrition) of her mental illness (anorexia nervosa) under powers conveyed by s4B Mental Capacity Act 2005 rather than under s63MHA powers, however they have subsequently confirmed they believed s63MHA provided legal authority to treat even within the physical health ward. Whilst SaBP staff may have concluded such treatment could be authorised under s63MHA and that this could be permitted to take place within RSCH's facilities under s17(3) MHA, we do not believe those powers could compel RSCH professionals to provide treatment they had concluded was not in her best interests. The issue of whether powers under s63MHA may fall away in such circumstances was not discussed. This created important procedural difficulties in respect of judicial oversight and practical barriers to safe care which inevitably led to professional conflict leading to allegations of organisational abuse (by FRH staff) and discriminatory practice by RSCH staff (reported on 18.08.23) which did not adequately take into consideration the context (namely a lack of alternative placement options and sufficient specialist staffing resource) placing practitioners from both RSCH and FRH in an unenviable position, increasing the risk April would experience malignant alienation.

4.33. As noted by Mostyn J above, a positive or negative decision to treat April under s63 MHA even if this required restraint and compulsion should have received a full merits review either via the Court of Protection or the High Court's inherent jurisdiction because the two treating teams were not in agreement about the proposed care plan. This would have provided much needed clarity from all those responsible for delivering her treatment plan (including IV supplements within RSCH) of the impact that compulsory treatment would have in respect of further trauma, particularly in light of her ASD diagnosis and EUPD. Putting all available options before the court to objectively determine her best interests would have enabled all relevant parties, including April (via the official solicitor if necessary), her parents, the two hospitals and responsible ICBs to carefully balance her seemingly conflicting rights with wider public law duties owed under MHA and, thereafter, determine if it was lawful to compel her to continue to receive treatment, even if (as in the case of *RD v A Midlands Trust* [2021] [42]) to remove the element of compulsion may result in deterioration and possible death of a patient who lacks requisite mental capacity. Parties to these proceedings might want to take note of the warning given by John McKendrick KC in *NHS Foundation Trust v KL* [2023] that '*no public body tasked with caring for vulnerable people should compromise their charges' welfare through a lack of cooperation*' following delays issuing those proceedings due to a dispute regarding the bringing of proceedings.

4.34. All those involved in this review, including panel members, lacked clarity about how cases such as this should progress to the Court of Protection/High Court for adjudication or a 'full merits review'. Some practitioners explained they had believed, incorrectly, the Court of Protection only had jurisdiction to determine disputes regarding withdrawal of medical treatment. Others explained it was used to authorise surgery for individuals who lacked capacity to consent or to

[41] *Lancashire County Council v X* [2023] EWHC 2667 (Fam)
[42] Available at: https://www.bailii.org/ew/cases/EWCOP/2021/35.html

authorise discharge to the community when this would require continual supervision, or elements of compulsory care and the person lacked capacity to consent to the care plan. Many found it helpful to reframe the Court's role to assist with the balancing of conflicting rights within treatment plans and to ensure parties responsible for commissioning care were actively engaged with relevant bodies providing the care to adapt usual offers where this was necessary to effect safe, therapeutic interventions.

4.35. Currently, there is too little guidance or policy to support senior leaders and hospital managers in both SaBP and RSCH to understand their own legal obligations in respect to public law and human right obligations and complexities regarding omissions or gaps in service provision. This is made more complicated when (as in April's case) the complexity of her care and treatment needs means she is moved whilst in crisis across geographical boundaries. As noted above, April's co-occurring conditions and current presentations make it likely that she will continue to experience risks associated with self-injurious behaviours including those associated with poor nutrition. Currently, there is no provision to continue restraint and compulsory treatment for her eating disorder under s63 MHA. HIOW ICB has confirmed this aspect of her care was not part of the care plan within the ***Re X*** application to the Court of Protection. As such, it appears the obligations set out by Mostyn J in ***Nottinghamshire Healthcare NHS Trust v RC*** [2014] for a full merits review remain unaddressed in this case. This is a matter for HIOW and (as partners in the s117 aftercare plan) Hampshire County Council, but HSAB may wish to seek assurance that non-compliance will not, as it has done previously, result in further organisational or discriminatory safeguarding concerns.

4.36. In January 2023 a Parliamentary Joint Committee published their report on proposals to reform of the MHA. Of relevance to this review was evidence exploring the impact of proposed amendments to exclude a person with a learning disability or autism from compulsory admission under s3 MHA. The committee welcomed the proposal but weighted this heavily as likely to be counterproductive and unlikely to result in a reduction of long-term institutional based treatment[43] unless and until there was significant investment in alternative community-based resources. They accepted expert testimony that '*people with autism and/or learning disabilities are more likely to have co-occurring mental health conditions than the general population, so disaggregating the symptoms of a psychiatric disorder from presentations of autism is complicated, especially if, [as for April] the hospital lacks specialist skills and training in learning disabilities and autism. This includes having the communication skills and the skills to make the necessary reasonable adjustments to well established therapies to make them available to people with learning disabilities and autistic people… [Also, because] the "inaccessible and distressing conditions" that people with learning disabilities or autistic people experience in inpatient settings "often lead to expressions of trauma which are wrongly interpreted as their having a mental health condition". This may lead to a mental health diagnosis where there is none, especially in environments where there is little understanding of learning disabilities and autism. … 28 days is not long enough to accurately assess the complex inter-relationship of biological, psychological, and social factors in a patient's condition, as well as the effect of in inpatient environment. We also heard that assessing someone with complex needs requires a "very multidisciplinary approach" that is difficult to coordinate in that time frame, as it involves not only the psychiatrist, but psychologists, speech and language therapists, occupational therapists, and nurses. Discharge planning is also particularly challenging as it requires coordination with the relevant bodies and would need to begin soon after admission when care needs are not yet established*.'[44] This resonates with April's case as, even after compulsory admissions amounting to over 7 years, professionals are only at the early stages of understanding the intersectionality of her conditions to formulate a longer-term recovery care and treatment plan.

[43] With specific fears raised that this might result in unintended consequences that people could be held under powers within MCA which offers less procedural safeguards or, worse still, their behaviours referred for action by criminal justice agencies resulting in detention under part III MHA.
[44] Parliamentary Copyright House of Commons 2023, available at: https://committees.parliament.uk/publications/33599/documents/182904/default/

4.37. The committee also made recommendations to strengthen the duty for responsible commissioners and appropriate ICB so that rather than a requirement they 'have regard to' recommendations from CTR panels any local authority or ICB must follow the recommendations or, alternatively, provide a good reason for not following any recommendation. Such changes if introduced nationally would assist local accountability, however, HSAB and SSAB may wish to explore whether local protocols with ICBs, local authorities and NHS England (who retain responsibility for monitoring adherence) could improve consistency and the timeliness of action planning. April's case highlights that this requires a systemwide reform without which the mechanisms to prevent against arbitrary detentions fail.

4.38. For April, the absence of any alternative community-based or specialist inpatient placement and lack of pro-active engagement from the relevant ICBs and local authority to seek alternative treatment (including by introducing external support for over 3 years) meant both the CTR panel and Tribunal felt compelled to accede to continued detention under the MHA despite understanding that the environment was detrimental to her wellbeing as the alternative, allowing the compulsory powers to fall away due to the absence of sufficient therapeutic benefit to justify continued detention, would likely result serious harm or death.

System finding: Failures to consider obligations to ensure April's voice[45] was properly represented via her nearest relative and/or advocacy resulted in insufficient regard to the long-term impact of continued compulsory detention with little therapeutic benefit. It also directly prevented her parents (until 2021) being involved in care planning. April and her parents have routinely been provided with insufficient information by SaBP. In addition, her parents have had little practical support to help them to undertake their role as carers and in the case of her father, as her nearest relative. They remain, as far as the reviewer is aware, without adequate support currently to fully understand their role within the most recent application to the Court of Protection or without an assessment of their needs as carers.

Furthermore, the long delay in seeking judicial oversight of the treatment plans placed additional pressure on treating clinicians in both RSCH and FRH as they lacked legal oversight and guidance on the safe parameters of their decision making regarding her treatment. Hampshire County Council and HIOW CCG (now ICB) responsible for commissioning her care appeared to have no mechanism to proactively engage and monitor April's continued detention under the MHA or ensure she benefited from the legal obligations to appoint independent advocates suitably expertise to enable her voice to be heard.

KLOE 2: Overcoming unconscious bias and malignant alienation.

Were aspects of her care impacted by malignant alienation and, if so, what steps were taken by hospital managers within the mental health in-patient unit and the acute hospital trust to address this? Were these sufficient to address future risk?

4.39. The term 'malignant alienation' describes a process common before suicide of psychiatric in-patients, which is "*characterised by a progressive deterioration in their relationship with others, including loss of sympathy and support from members of staff, who tended to construe these patients' behaviour as provocative, unreasonable, or overdependent.*".[46]

4.40. The complexity for staff working to treat April's multifarious presentations have already been acknowledged. Her parents have also articulated how misperceptions of her abilities and cognition (based on her diagnosis and selective mutism) continue to undermine her trust in

[45] Obligations to ensure patients voice form part of treatment and safeguarding decision making are underpinned by the legal obligations detailed within section 3 of this report and enshrined in the Making Safeguarding personal principles set out within chapter 14 of the Care and Support Guidance.
[46] Watts, D., & Morgan, H. G. (1994). Malignant alienation: Dangers for patients who are hard to like. *The British Journal of Psychiatry, 164,* 11–15. https://doi.org/10.1192/bjp.164.1.11

those providing supervision, care, and treatment. Throughout the review period concerns were raised both by staff working directly with April, practitioners responsible for investigating safeguarding concerns and April herself that the therapeutic relationship was progressively deteriorating. For example:

a) Former and current nursing staff on B Ward have highlighted that when agency and/or bank staff have come to work a shift on the ward they have refused to conduct observation on her or have any engagement with her. They have an awareness of previous incidents involving April and are either concerned that something will happen, and they may be held responsible, or she may attack them.[47]
b) RSCH reported 'self-neglect' as the type of concern giving rise to her admission to RSCH in a critical condition in April 2021. This prompted HIOW ICB caseworker to raise a subsequent safeguarding concern concerned that SaBP failed to recognise this as potential willful neglect or ill-treatment by their staff or alternatively organisational neglect. That subsequent safeguarding enquiry did not receive input from Surrey police despite the possibility of a criminal offence.
c) In April 2022 ward staff reported it was '*also really difficult when there are a number of open allegations against staff, staff are now scared to be on 1:1 with her, and also impact on them supporting her, it is traumatising for them too. (There are currently six open safeguarding concerns re: 'April' and staffing)*'
d) In February 2023 April reported that a member of staff told her "If *I really want to die then I should wait till I leave hospital and do it properly*".
e) In August 2023 practitioners reported *"there are several issues raised above involving multiple clinicians from RSCH that have in our view unnecessarily put-up barriers for 'April' to receive treatment which could have led to catastrophic consequences however, we would specifically want to raise concern for a consultant gastroenterologist who seems to have clear negative views towards 'April'. She has been significantly involved in discussions about 'April' treatment options and continues to express views that 'April' should be receiving palliative care and that she is not prepared to conduct any exploratory tests..." April has at risk of being denied medical treatment for her physical health. However, SaBP acted swiftly and appropriately to address this issue with the medical directors for SaBP and the RSCH. I am pleased that the RSCH have taken this seriously and appointed a new consultant in gastroenterology who would be in charge of April's care should she need an admission in the future. There are ongoing issues with April being an inpatient at FRH, regular multi agency meetings are taking place to ensure her safety and to continue with the progress of her discharge*.
f) Her parents reported to this review being told by ED staff that treating her was a 'waste of time' and that this was said in front of her. Conversely, they wished to commend Frimley ED staff for the polite, respectful manner they speak with April. They spoke of the impact that one consultant had by explaining to April what steps they would take, because of their duty of care, if she were to abscond from hospital and how that helped her, even in distress, feel valued.[48]

4.41. In 2022 CQC published a report detailing their work to prevent the development of closed cultures within providers of care. This guidance[49] sets out indicators of closed cultures and the potential impact of closed cultures on human rights and equality. In addition, in September 2022 NICE published an update to its Self-harm guidelines[50] which states: *"Do not use aversive treatment, punitive approaches or criminal justice approaches such as community protection notices, criminal behaviour orders or prosecution for high service use as an intervention for frequent self-harm episodes."* NICE states that this amounts to malpractice. In March 2023,

[47] Taken from p14 SI report.
[48] RSCH were only made aware of these concerns through this review and have therefore not had an opportunity to investigate those allegations through their patient safety framework.
[49] Available at: https://www.cqc.org.uk/guidance-providers/all-services/how-cqc-identifies-responds-closed-cultures
[50] Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE

NHS England published its position on serenity integrated mentoring and similar models[51] which had previously been advocated as a possible treatment plan for personality disorders, explicitly stating that this should not be used, and that three key elements should be eradicated from mental health services. Firstly, avoiding the involvement of police in delivery of therapeutic interventions in planned, non-emergency community mental health care. Secondly, that the NICE guidance against use of sanctions, withholding care or other punitive approaches must be followed. Thirdly prohibiting discriminatory practices and attitudes towards patients who express self-harm behaviours, suicidality and/or those who are deemed 'high intensity users', including the labelling of patients by professionals as 'manipulative' and 'attention seeking'.

4.42. It is understood that presently neither SaBP or the ICB have in place local polices to support the implementation of NICE quality standards in respect of personality disorders. SaBP have made available via the website some resources to support the development of trauma-informed approaches across the organisation as part of the Changing Futures Programme. Training is also available for staff members. SaBP reported they have also updated their Service operational Policies to include advise on the application of a trauma-informed approach and completed the NHS inpatient care standard gap analysis which identified treatments for patients with personality disorder as an area for improvement.

4.43. In consultation with the reviewer RSCH safeguarding leads spoke of the steps they were introducing to support their staff to ensure each interaction with patients enhances the person's therapeutic goals. They explained how this is central to their values and so threaded through training, clinical supervision, staff appraisals, safeguarding guidance and, on rare occasions, when necessary, disciplinary processes. They explained the assurance framework they have in place (as will SaBP) to enable monitoring of their staff's competency with respect of safeguarding practice and a proper balance of skills. However, they highlighted that April's case puts into stark awareness risks posed by agency staff for whom the NHS Trusts may have little opportunity to challenge if they see practice which runs contrary to professional standards. They spoke of times they had raised with personnel or care agencies concerns regarding the expertise or attitude of agency staff and received little or no response. They welcomed clear mechanisms locally and nationally through professional regulatory bodies (such as NMC, GMC, HCPC and SWE) to monitor more closely the expertise and continual professional development of agency staff.

System findings: April's experiences identify risks associated with malignant alienation. This will likely have negatively impacted on her ability to develop trusted therapeutic relationships and puts her at higher risk of serious self-injurious behaviours. The ICB and both Trusts have indicated an ambition to move towards trauma-informed practice, but this is in its infancy and would benefit from clearer local policy guidance for staff. The risk of associated with malignant alienation and unconscious bias should inform wider policy framework and specific training for staff across the health sector and for those tasked with completing s42 enquiries to ensure against closed organisational culture developing which often facilitate abuse and neglect.

[51] NHS England » NHS England position on serenity integrated mentoring (SIM) and similar models

KLOE 3: Patient safety and safeguarding against organisational abuse.

Did partners (particularly SABP, ICB and CQC) meet expectations regarding oversight of safe care and treatment? How did partners work to address the systematic safeguarding concerns identified; was the s42 and NHS patient safety incident reporting framework decision making robust? Were escalation processes adequate? Was April and her parents (acting as advocates) appropriately involved in those processes?

4.44. The NHS Serious Incident Framework 2013[52] details how all organisations providing NHS funded care should report, investigate, and monitor serious incidents. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. The purpose of the serious incident reporting and learning process is to demonstrate assurance of good governance and safety for the most serious incidents; facilitate the wide sharing of learning; help prevent reoccurrence; and to support health service improvement by providing guidance and recommendations to support leaders in directing resources to improve quality and safety. The Strategic Executive Information System (StEIS) is a national reporting system that ensures compliance with the wider NHS Incident Framework. The organisation where the Serious Incident occurred has overall responsibility for reporting the Serious Incident to StEIS, investigation and implementation of subsequent action plans. Lead commissioners are responsible for monitoring the management of serious incidents reported by providers of NHS funded care. The National Framework required that a serious incident notification referral is completed on StEIS within 48 hours of the incident and that a local root cause analysis or significant event type investigation should be undertaken no more than 60 working days (or 6 months for an independent investigation) from the date reported to the StEIS system.

4.45. Regulation 18 of The Care Quality Commission (Registration) Regulations 2009 requires a statutory notice to be provided to CQC where there has been an allegation of abuse. However, there is an exception to that requirement under Regulation 18(4) where the service provider is a health service body if, and to the extent that, the registered person has reported the incident to the National Patient Safety Agency (NSPA). For clarity, all patient safety incidents should be reported to the NSPA's National Reporting and Learning System, but those which have resulted in serious harm must also be reported through StEIS.

4.46. In August 2022, NHS England published a new Patient Serious Incident Response Framework (PSRIF),[53] which has replaced the Serious Incident Framework after a 12-month transition period. It removes the 'serious incident' threshold for investigation, instead requiring organisations to create a patient safety incident response plan that is jointly developed and agreed upon by a wide stakeholder group, including patient partners, front line staff, integrated care board members and Care Quality Commission inspectors. These plans are based on the organisation's local incident profile and existing improvement work, so that the resulting learning will have the most benefit for patient safety. StEIS has been replaced by the Learn from patient safety events ('LFPSE') system. The previous and current patient safety framework relies heavily on the subjective judgement of senior Trust managers to comply with patient safety and care quality obligations. April's circumstances are undoubtedly complex, but practitioners involved in this case commented this level of complexity is becoming more common place.

4.47. Throughout the entire review period treating clinicians were raising concerns they were unable to safely meet April's complex needs within the care settings. Despite those escalations and over 70 incidents when she required transfer to RSCH for emergency treatment following

[52] http://www.england.nhs.uk/ourwork/patientsafety/. In 2022 The NHS has introduced a new Patient Safety Incident Reporting Framework removing the distinction between patient safety incidents and serious incidents. However, as this was introduced after the review timeframe, this KLOE has assessed responses in line with the applicable policy at the time.
[53] NHS England » Patient Safety Incident Response Framework

serious self-injurious behaviours and a further 38 safeguarding enquiries, there appears to be a lack of recognition from SaBP strategic leadership that the prevalence of 'near misses' should trigger their responsibilities to explore if systems or current practice was contributing to physical or psychological harm or injury. Failure to do so, and report this within the StEIS system throughout 2018- 2022 meant that quality assurance mechanisms designed to provide oversight of patient safety issues also failed as neither the CCG (now ICB) or CQC would have been made aware through those processes.

4.48. Instead, SaBP ward staff and safeguarding leads referred each incident as separate, unconnected events to SCC for investigation under s42 Care Act. SSAB's local safeguarding adults' policy provides, however, for continued obligations for:

- employers [s20 procedures] where allegations are made against staff, as they frequently were in April's case,
- commissioners of services [s21.5 procedures]
- NHS trusts to complete SI investigations [s22 procedures]
- Care providers to report quality of service issues [s24 procedures]

Those duties do not appear to have been understood or applied prior to June 2022, and particularly when she was residing on A ward. This resulted in April experiencing harm on numerous occasions which may otherwise have been avoided.

4.49. During a multi-agency meeting in June 2022 a senior safeguarding lead from Frimley CCG questioned why the SI process had not been triggered in response to the numerous failures of care which had, individually, been reported by FRH staff for investigation as safeguarding concerns. The conclusion of a further safeguarding enquiry on the 15.07.22 recommended FRH complete a SI investigation. April's allocated social worker from SCC expressed concerns '*that any of the 18 Safeguarding incidences could have met the threshold for an SI to be invoked for what appears to be a systemic issue. …the issue of SaBP not raising case as an SI is another safeguarding concern in itself*.' The meeting went on to minute concerns '*over inappropriate male 1:1 supervision whilst conducting intimate personal care and reports struggling to understand how this is allowed to happen. .. 'April' would benefit from a safeguarding IMCA and is concerned that 'April' was detained in [2018] with one referred tribunal and questions where is her voice in all of this. .. 'April' requires a referral tribunal with a lawyer working in April's Best Interest as per Article 3.*'[54] Despite this, neither local authority, the ICB or SaBP[55] appointed an advocate to support April.

4.50. FRH recorded a datix report on their internal system and referred a further safeguarding concern to the local authority after a member of staff used restraint technique '*intended to cause pain'*. A fact-finding review of the incident reported the agency staff member was '*digging his fingers into April's leg and arm whilst carrying out restraint to cause pain to get April to comply. She reported that she was clearly distressed and even spoke shouting 'yes you are hurting me'. April has not spoken for over a year, so this was a clear indication of her discomfort*.'[56] This was viewed to be excessive force used by the alleged perpetrator and not in line with SaBP's violence reduction training techniques. This was subsequently reported for police investigation as an allegation of assault. April had reported this herself by email. SaBP reported to this review, ward staff had also reported concerns about the agency worker directly to the Nursing Agency and suspended the worker from taking any shifts at the hospital whilst the enquiry was ingoing, but it was not believed to warrant a referral to the NMC. They explained ward staff made attempts to debrief April with staff whom she had developed a trusted relationship. The enquiry completed on 13.09.22 found '*the care that April received on B Ward, in respect of her physical healthcare needs, prior to April 2021 comprised neglect'.* This again recommended that FRH

[54] Taken from the minutes of the meeting on the 14.06.22
[55] Each organisation could have instructed advocates, but SaBP had a legal duty under s130A MHA, HCC had a legal duty under s67 Care Act and SCC equally could have done so under s68 Care Act.
[56] Taken from further submissions made by SaBP following specific questions raised by the reviewer.

complete a SI investigation and that the matter be escalated to the SSAB. In breach of guidelines, SaBP did not instigate a Serious Incident ['SI'] investigation. The police were notified of the concerns and reported to this review they spoke to SCC's enquiry officer (a qualified social worker and AMHP) who agreed to liaise with SaBP's ward staff, April, and the police to enable the enquiry and police investigation. Police report '*attempts to engage with SaBP and gain further information about this incident this never came to fruition and highlights to me an inability for FRH and SaBP to work together, investigate internal matters, and assist police investigate complaints from patients around their care from staff at the location*.' The police officer investigating also reporting requesting support from ward staff to communicate with April but encountered 'extreme difficulty' so tried to contact April directly though her email. He received no response so '*ultimately the view we took was that this was a case of well-intentioned but rather heavy-handed behaviour by staff which was better addressed by the hospital authorities rather than the police and the case was closed*.'[57]

4.51. Whilst a high number of safeguarding concerns were reported and investigated during the later part of the review period after April's move to ward B, it is very likely she would have had similar experiences throughout her in-patient stay both in FRH and in Berkshire. FRH staff from B ward should therefore be commended for the open way in which they recognised patient safety issues as triggering safeguarding duties, notwithstanding the systematic issues detailed below in response to KLOE 3. However, the adverse impact of those serious incidents had on April's ability to trust staff, particularly agency staff, is best summed up in her words:

> "I feel sick I don't know who these men usually are let alone have them hurting me and shouting at me… it really hurt he was a big man and they literally threw me on my bed holding me down so tight it hurt so much I couldn't stop panicking and crying and they did inject me as they said it doesn't work and I wiggle of the side of the bed and ran into the corner again and stayed there until they had all gone the normal staff don't restrain me all the time they talk to me and ask if I want or need anything or just want them to sit with me but the agency staff just attack me they hate me"[58]

4.52. Since the review period SSAB has introduced a 'nursing concerns panel' chaired by the Chief Nurse Operator to explore, through multi-disciplinary approach, practice and professional concerns which includes the actions of agency and bank staff. They have also published an inter-agency escalation policy and procedure,[59] but all those involved in this review accepted more needed to be done to socialise that policy so that safeguarding and criminal investigations are not closed prematurely without statutory partners ensuring that the adult at risk's voice has been heard.

4.53. April's parents have questioned instructions for male staff to monitor April's intimate personal care. They explained that she (and they) found this extremely distressing and, whilst they understood it was to protect against self-harming behaviours, felt it a disproportionate invasion of her privacy. In August 2022 April disclosed to her trusted psychologist that prior to her admission she had experienced sexual abuse in 2015.[60] There is evidence that, in response to this allegation, ward staff made a referral to Surrey Multi-Agency Safeguarding Hub and recorded this within the internal datix system. In addition, April's parents explained her treating psychologist worked with her to empower her to share what had happened with them. They explained how, for them, this demonstrated how significant that therapeutic relationship was to April. Surrey Police, however, confirmed that, despite clear obligations within the local SSAB safeguarding adults' policy (s23 procedures) and accessible forms to facilitate the sharing of

[57] Taken from Police SoI prepared for this review.
[58] Taken from an email she sent to staff on the 09.06.22 which formed the basis of a referral by FRH under s42 Care Act for a safeguarding enquiry. This was subsequently upheld as neglect.
[59] Available at: https://www.surreysab.org.uk/wp-content/uploads/2024/01/SSAB-Inter-Agency-Escalation-Policy-V7-October-2023-FINAL.pdf
[60] At that time, she was living away from home, her employment only provided accommodation during the working week so, to avoid homelessness, she had stayed with a work colleague at weekends who required sex as payment for her accommodation.

information regarding crimes with police (available on the SSAB website), they had no record of this disclosure or any referral to the Sexual Assault Referral Centres from either SCC or SaBP. It is understood that SaBP believed further action would be led by SCC via the s42 procedure, though this may provide an opportunity to clarify how best to coordinate such sensitive disclosures, particularly where it will be important to preserve therapeutic relationships and achieve best evidence from vulnerable victims of crime. In addition, SaBP may wish to reflect that (given her experiences), having male carers monitor intimate personal care is very likely to have been re-traumatising. In 2020 CQC explored systematic issues to address sexual safety within mental health wards,[61] many of the findings of that review should resonant with SaBP senior managers. It is noted that SaBP does not, presently have policies in place for staff, patients, or visitors regarding sexual safety, though they report there are materials available on wards regarding sexual safety. SaBP also advise they have signed the NHSE sexual safety charter and are part of a sexual safety collaborative looking to commence work in February 2024. This forms part of their hospital improvement, oversight, and assurance programme. Whilst this is positive, urgent consideration should be given to putting specific policies in place to ensure that whenever 1:1 supervision is required during intimate personal care tasks this is done in consultation with the service user and according to gender preferences.

4.54. As noted above, following further safeguarding concerns, SaBP did initiate a SI investigation, within which the author commented there had been safeguarding concerns raised by both April's parents and SABP staff regarding her treatment whilst at RSCH as they perceive her needs are not fully understood, with her previously being placed on a bed in a loud and well-lit hospital corridor which caused significant distress, resulting in her banging her head against the wall. There have also been concerns raised by RSCH staff regarding the behaviour of SaBP staff. A Datix was raised in November 2022 by RSCH after a ward nurse challenged SaBP staff who were trying to stop the alarm on an IV pump that was administering feed to her. RSCH reported to the review, they were not consulted by the SI independent author but had tried to make contact during that investigation to ensure they could review any concerns raised about their services. The report doesn't appear to have been conducted in line with expectations within the 2015 framework and there remains no explanation for why the investigation focused on 5 out of 38 safeguarding concerns.

4.55. RSCH reported they now employ an autism practitioner so, during office hours, they can support April whilst she is at RSCH and make any reasonable adjustments that are needed. Her parents commented that they have not had many opportunities to speak with the Autism specialist about how to safely engage with April.

4.56. During this period FRH was subject to an improvement plan, overseen by the CCG (now ICB). ICB staff stated information on the progress of actions is sent to the regional system governance committee.[62] It was reported that both the ICB and CQC had undertaken visits and had 'raised no concerns'. However, as noted above because SaBP had not assessed the numerous near misses as requiring investigation under the patient safety framework, but solely referred these to the local authority for investigation, they may not have been aware of April's circumstances.

System finding: Despite clear articulation from treating clinicians, the CTR panel and First Tier tribunal of repeated concerns that the environment provided little therapeutic benefit for April, too little regard was had to escalating concerns in a timely manner via the correct legal or regulatory frameworks. There has been insufficient explanation as to why an IMHA was not appointed given her self-harming

[61] https://www.cqc.org.uk/publications/major-report/sexual-safety-mental-health-wards

[62] The regional and system quality governance committee is a strategic group that is part of NHS England's National Quality Board Framework to ensure all statutory quality functions are discussed across all ICBs for oversight and escalation purposes. It does not inform placements or take decision on individual patients as this is a function for the ICS. As safeguarding is a statutory function for the region, there is a Regional Safeguarding Steering Group which reports in to this committee and has an annual deep dive as well as risks escalations The membership includes CQC, GMC, NMC, and HSIB to share insights, best practice, or lessons. They do not have safeguarding responsibilities at the meeting more informing and consulting.

presentations and the universally accepted position that she lacked capacity with regard to treatment decisions.

The previous and current patient safety framework relies heavily on the subjective judgement of senior Trust managers to comply with patient safety and care quality obligations. April's circumstances are undoubtedly complex, but practitioners involved in this case commented this level of complexity is becoming more common place. Presently, there is insufficient evidence that the quality assurance policy framework or organisational support to assist treating clinicians and frontline staff escalate serious concerns is used effectively so that strategic and multi-agency involvement in shared risk and care planning results in swifter, less restrictive care and prevents further traumatising patients with co-occurring conditions.

Consistent with the s42 enquiry, this review concludes that agencies did not work as expected to ensure that April and her parents were consulted in line with expectations under NICE guidance, MCA, and MHA codes of practice.

Similarly, failures to report allegations which, if proven, would constitute a criminal offence is a breach of both national and local safeguarding policies. Those safeguarding duties form part of employees' duties under Trust policies and their own professional standards.

Finally, there is no explanation as to why only 5 of the safeguarding incidents formed the basis of the SI investigation report completed by SaBP in June 2023. Consideration should also be given to how SSAB can work with the Trust and relevant SSAB partners to secure assurance that the new PSIRF is fully socialised into quality assurance across mental and acute provider trusts in the area.

Were any concerns regarding an unsuitable placement escalated/shared with Hampshire commissioners, the Tribunal or SSAB so that action could be taken to reduce risk for April?

4.57. There is evidence that staff within FRH acted in a timely way to seek HCC's adult social care's involvement for an assessment of her social care needed. HCC's assessment, however, was limited to confirming she would be eligible for s117 MHA aftercare support at the point of her discharge. There does not appear to be in place local channels to enable more holistic support to maintain patient's social care skills whilst they are receiving in-patient treatment. HCC do not appear either to have taken a pro-active approach to supporting her parents to maintain their considerable caring role, despite duties (s10 Care Act) to do so. Both FRH and RSCH practitioners also reported significant difficulties in accessing basic support (for example Speech and language therapists) to assist they better understand April's specific communication needs.

4.58. Her treating team also articulated their concerns to relevant commissioning bodies in October 2019 (reporting they required additional support to HIOW ICB) and in December 2020 to NHS England. Initially, the escalation in 2019 resulted in specialist support from LDAP, but it is notable that it took a further year before CTR meetings were arranged. Whilst it is important to acknowledge operational pressures experienced as a result of the Covid Pandemic, this should not have prevented LDAP staff from escalating their concerns to hospital managers that these had not taken place. Once those reviews began, from April 2021, the unsuitability of the placement and current treatment plans to meet April's complex needs was clearly escalated by the CTR panel to hospital managers. Again, despite a widespread understanding of the adverse impact for April (and, as detailed below, the consequences for frontline staff) hospital managers appeared powerless, in the face of no alternative provider willing to accept a transfer of care, to progress the required action plans. *(Please see attached statement from HIOW ICB)*

4.59. As noted above, April's Responsible Clinician was transparent regarding the lack a therapeutic environment and the likely adverse impact this was having on her longer-term recovery when submitting their reports to the MHRT. Equally, as required, they were honest about the immediate risks that would present if the Tribunal took the view, she should not be subject to compulsory treatment under s3MHA. Presently, s72(b,iia) MHA requires a MHRT to direct the discharge of a patient if they are not satisfied (alongside other criteria detailed s72(b i-iii) 'appropriate medical treatment is available for him'. In April's case, the Tribunal (albeit

seemingly reluctantly) agreed the need to continue detention because no other alternative specialist care or community provision had been identified, so the immediate risk to her life was, understandably prioritised. It is notable that the MHRT could have adjourned the proceedings to direct commissioners to provide further evidence regarding appropriate medical treatment. The Court of Protection, however, could equally act as important adjudicator to protect against continued detention under MHA where there is little therapeutic benefit or, as in April's case, real concern this is unnecessarily impeaching her article 3 ECHR rights.

4.60. The failure to consider referral to the Court of Protection to seek judicial oversight of shared responsibilities between commissioners (HIOW ICB and HCC) as well as her treating clinicians resulted in significant strain for frontline clinicians and contributed to conflict between her treating teams. Within SaBP, practitioners reported (within the SI investigation) that decisions to reduce the use of agency staff (whilst important to provide consistency of care) placed '*more pressure on the permanent staff members who have cited the increased stress this causes. Ordinarily a ward will have a permanent Nurse in Charge (NIC), however due to the stress caused by being responsible for April, this is now done on a two-month rotation. The ward manager had arranged for a psychologist to speak with staff, who have experienced high levels of stress or struggling to cope. Most of those interviewed have confirmed that the stress of working with her has been a significant factor for them moving to either another ward or a role in the community. There does appear to be a high attrition rate of staff on B Ward when reviewing staff movement, although this has not been directly compared to other inpatient wards.*'[63] This also contributed to inter-agency and inter-disciplinary conflict which should have been avoided if SaBP hospital managers and the ICB as responsible commissioners had agreed to escalate the issues for adjudication to the Court of Protection.

4.61. Parties remained unclear even in June 2023 as to who would be expected to initiate proceedings to the Court of Protection to review the current and future care plans, including when she moved into the community following discharge from the inpatient unit. Because the terms of the order granted have not been disclosed to this review, it remains unclear what legal framework is expected to apply whilst she is transitioning to her community placement. For the avoidance of doubt, we remain of the view that any clinicians treating physical manifestations of her eating disorder should request confirmation that the ICB, HCC and responsible clinician have fully explored if they can authorise continued restraint and compulsory treatment under s63 MHA within her community placement.

System findings: The action taken to ensure her treating team had appropriate support from autism, eating disorder and personality disorder specialists was inadequate to provide a timely response to the ongoing substantive beaches of April's human rights. We accept all those involved in her care were motivated to try to preserve her life, but notwithstanding this, too little regard was had to the serious impact the unsuitable placement would have on her long-term prognosis. This was an avoidable harm.

Given the ongoing duties owed by Hampshire SAB partners and safeguarding duties (owed by SSAB partners), were local processes for cross boundary working applied and were these fit for purpose? How do partners work together to safeguard an adult at risk detained within in-patient settings where the responsibility for care management sits with another local authority and ICB?

4.62. There was very little reference within the case notes or reports to the Tribunal and CTR panel to cross boundary protocols. The social worker conducting the safeguarding enquiries in 2022 made reference to NHSE's host commissioner guidance, but commented on how little weight was given to those obligations and how difficult it was to effect meaningful change for April because of the national shortage of specialists working with such complex presentations. NHSE regional lead also noted how difficult it was to expediate an earlier assessment by specialists

[63] Taken from p14 SI report.

with South London and Maudsley NHS Trust for April. We believe this assessment is still outstanding at the time of writing.

System findings: Current protocols and policies are not fit for purpose. It remains of concern that, whilst April is subject to a gradual transition into community-based care, commissioners have indicated continued uncertainty about who will lead on providing oversight of her after-care support within the new setting. HCC has now provided assurance to SSAB that they understand their legal obligations regarding s117MHA continue until such a time as April no longer requires input and that they will not seek to withdraw from overseeing her care and treatment needs, following a period of stability, unless and until this is agreed after full consultation with April and her parents (as her nearest relative and carers). Equally, HIOW ICB and HCC should provide assurance that they sought advice on whether a full merits review is required regarding the lack of available legal powers to address foreseeable harms arising from her eating disorder during and after her transition into the community.

5. Conclusions and recommendations

Addressing complex needs compassionately.

5.1. System finding: Nationally, the challenges of providing quality, trauma-informed care to individuals with co-occurring conditions, particularly in respect of personality disorders, eating disorders and autism are well documented. National guidance, including NICE clinical quality standards, already exist to support practitioners and clinicians apply good practice but April's experiences and CQC's most recent inspection of SaBP suggest these are not firmly embedded into practice across relevant partners.

Recommendation 1:
SSAB to share the findings of this review to HSAB and to both Council's Health and Wellbeing Boards with a view to support work done across Surrey to support the implementation of legal duties under the Autism Act 2009.

Recommendation 2:
HIOW and Frimley ICBs should confirm to SSAB that they have mechanisms for identifying people with learning disabilities and autism at higher risk of detention and that they have, or are developing, means to maintain a 'Dynamitic support register'[64] which could include those subject to compulsory care and treatment by virtue of legal powers under both MHA and MCA.

Recommendation 3:
SaBP put in place policies for staff, patients, and visitors regarding sexual safety. This should take into account obligations under the local safeguarding policies to directly report to the police incidents which, if proven would constitute a crime. It should also explicitly highlight professional duties to cooperate with police and safeguarding investigations.

Recommendation 4:
SaBP should also update their policies regarding intimate personal care, ensuring that whenever 1:1 supervision is required during intimate personal care tasks this is done in consultation with the service user and according to gender preferences.

5.2. System finding: Following the decision by SSAB to initiate a safeguarding adults review into April's care and the decision by SaBP to undertake a SI review, there does now appear to be progress into her discharge planning. However, poor access to specialist input re eating disorders, ASD and personality disorders meant that staff within FRH felt unsupported and operating beyond their expertise. Actions to address concerns raised within CTR, at the Mental

[64] We have used the term proposed by the Select committee rather than the proposed 'risk register' for the reasons stated by the committee and because it enables the focus to be of the provision of timely, community-based provision rather than merely risk. In doing so, it should promote the recovery model advocated by Felton et al.

Health Tribunal and by the team around April were not taken by hospital managers or Frimley ICB (responsible for oversight of her care and commissioning discharge provision) in a timely manner. Whilst there is evidence that numerous attempts were made to identify alternative hospital placements, there is insufficient explanation for why, having approached numerous resources and placement all of whom confirmed they were unable to support April based on her risk profile, the responsible ICB did not act sooner to commission bespoke care, preferably within a community setting so that her environment would be better placed to safely meet her needs. SaBP appeared to have fewer mechanisms than might have been available to them if they were working with the ICB responsible for oversight of their services (Surrey Heartlands ICB) to liaise and secure agreement for effective discharge planning in a timely manner.

5.3. Failures to consider obligations to ensure April's voice[65] was properly represented via her nearest relative and/or advocacy resulted in insufficient regard to the long-term impact of continued compulsory detention with little therapeutic benefit. It also directly prevented her parents (until 2021) being involved in care planning. April and her parents have routinely been provided with insufficient information by SaBP. In addition, her parents have had little practical support to help them to undertake their role as carers and in the case of her father, as her nearest relative. They remain, as far as the reviewer is aware, without adequate support currently to fully understand their role within the most recent application to the Court of Protection. Furthermore, the long delay in seeking judicial oversight of the treatment plans placed additional pressure on treating clinicians in both RSCH and FRH as they lacked legal oversight and guidance on the safe parameters of their decision making regarding her treatment. Hampshire CC and HIOW CCG (now ICB) [66] responsible for commissioning her care appeared to have no mechanism to proactively engage and monitor April's continued detention under the MHA or ensure she benefited from the legal obligations to appoint independent advocates suitably expertise to enable her voice to be heard.

Recommendation 5:
Hampshire Local Authority and SaBP NHS Trust review pathways for appointing advocates, including where an application to the Court of Protection or High Court is indicated under s63 Mental Health Act 1983 or Mental Capacity Act 2005 and that nearest relatives are provided with clear guidance on their role and rights to provide assistance.

Recommendation 6:
SaBP working with SCC and Frimley ICB detail what steps have been taken by commissioners and advocacy service providers to ensure suitable qualified advocates, trained in communication techniques and autism enable patients' voice to routinely be placed at the centre of CTR and Tribunal processes. This should enable a continued focus on the suitability/ appropriateness of compulsory powers within a therapeutic relationship.

Overcoming unconscious bias and malignant alienation

5.4. System findings: April's experiences identify risks associated with malignant alienation. This will likely have negatively impacted on her ability to develop trusted therapeutic relationships and put her at higher risk of serious self-injurious behaviours. The ICB and both Trusts have indicated an ambition to move towards trauma-informed practice, but this is in its infancy and would benefit from clearer local policy guidance for staff. The risks associated with malignant alienation and unconscious bias should inform wider policy framework and specific training for staff across the health sector and for those tasked with completing s42 enquiries to ensure against closed organisational culture developing which often facilitate abuse and neglect.

[65] Obligations to ensure patients voice form part of treatment and safeguarding decision making are underpinned by the legal obligations detailed within section 3 of this report and enshrined in the Making Safeguarding personal principles set out within chapter 14 of the Care and Support Guidance.
[66] Frimley ICB would normally be responsible for commissioning April's care because she was resident in that area when admitted to FRH, but they have outsourced this responsibility to HIOW ICB under a separate agreement.

Recommendation 7:
Frimley and Surrey Heartlands ICBs and social care commissioners should consider commissioning training support (possibly through SaBP) on personality disorders awareness for health and social care staff. Police should also be encouraged to attend, particularly officers who will be involved in safeguarding or sexual abuse investigations so that they can comply with their duties re Equality Act 2010 and special measures to support prosecutions.

Recommendation 8:
SSAB should write to the Chief Executive of Deliveroo highlighting how poor practice within their organisation could have resulting in serious harm or death. They should be invited to review their policies to ensure drivers are trained in the legal obligations under the Medicine and Healthcare Regulatory Agency's guidance on the sale of medicines for pain relief[67] to prevent the delivery to an NHS mental health in-patient unit of over-the-counter medication for pain relief. SSAB should also consider sharing the findings of this review with the relevant authority's trading standards.

Recommendation 9:
Prior to local implementation of the 'Right Care: Right Person' approach, Surrey Police to review their Missing from Health Care MOU and the Herbert Protocol[68] to ensure where adults who are known to abscond are at high risk of self-injury or suicide, there are appropriate agreed responses that include family members where they have indicated they are willing and able to form part of an immediate protection plan.

Recommendation 10:
Partner agencies should provide assurance to the SSAB that their safeguarding competency training frameworks should address risks associated with malignant alienation and unconscious bias. SSAB should provide multi-agency training to professionals from across the partnership to socialise pro-active use of local escalation processes and national quality assurance frameworks to enable effective challenge so that the paucity of specialist resource does not result in a loss of focus on patient safety. This, in turn, will protect positive work/ organisational cultures and reduce risks of organisational abuse concerns.

Patient safety and safeguarding against organisational abuse.

5.5. System Finding: Despite clear articulation from treating clinicians, the CTR panel and First Tier tribunal of repeated concerns that the environment provided little therapeutic benefit for April, too little regard was had to escalating concerns in a timely manner via the correct legal or regulatory frameworks. There has been insufficient explanation as to why an IMHA was not appointed given her self-harming presentations and the universally accepted position that she lacked capacity with regard to treatment decisions. The previous and current patient safety framework relies heavily on the subjective judgement of senior Trust managers to comply with patient safety and care quality obligations. April's circumstances are undoubtedly complex, but practitioners involved in this case commented this level of complexity is becoming more common place. Presently, there is insufficient evidence that the quality assurance policy framework or organisational support to assist treating clinicians and frontline staff escalate serious concerns is used effectively so that strategic and multi-agency involvement in shared risk and care planning results in swifter, less restrictive care and prevents further traumatising patients with co-occurring conditions.

5.6. System Finding: Consistent with the s42 enquiry, this review concludes that agencies did not work as expected to ensure that April and her parents were consulted in line with expectations under NICE guidance, MCA, and MHA codes of practice. Similarly, failures to report allegations which, if proven, would constitute a criminal offence is a breach of both national and local

[67] Available at: https://assets.publishing.service.gov.uk/media/6012d8a1d3bf7f05be4d1e87/Appendix_4.pdf
[68] More information about the approach Surrey police take is available at: https://www.surrey.police.uk/notices/af/herbert-protocol

safeguarding policies. Those safeguarding duties form part of employees' duties under Trust policies and their own professional standards.

5.7. System Finding: There is no explanation as to why only 5 of the safeguarding incidents formed the basis of the SI investigation report completed by SaBP in June 2023. Consideration should also be given to how SSAB can work with the Trust and relevant SSAB partners to secure assurance that the new PSIRF is fully socialised into quality assurance across mental and acute provider trusts in the area. The action taken to ensure her treating team had appropriate support from autism, eating disorder and personality disorder specialists was inadequate to provide a timely response to the ongoing substantive beaches of April's human rights. We accept all those involved in her care were motivated to try to preserve her life, but notwithstanding this, too little regard was had to the serious impact the unsuitable placement would have on her long-term prognosis. This was an avoidable harm. Current protocols and policies for inter-agency and cross area oversight are not fit for purpose. It remains of concern that, whilst April is subject to a gradual transition into community-based care, commissioners indicated continued uncertainty about who will lead on providing oversight of her after-care support within the new setting.

Recommendation 11:
The local authority, ICBs and SaBP should provide assurance to SSAB of the processes to assure they comply with legal obligations regarding s117MHA. This should include evidence that all relevant partners are aware it is not lawful to withdraw from overseeing her care and treatment needs, following a period of stability, unless and until this is agreed with the relevant local authority after full consultation with the patient and their nearest relative and carers. Equally, SaBP and ICB lead should issue guidance on when judicial oversight or a full merits review is required to address foreseeable harms arising from complex needs and/or unavoidable gaps in specialist service provision.

Recommendation 12:
SSAB to notify NHSE's national learning disability and autism team of the findings of this case, namely that a lack of suitable provision to address April's complex needs resulted in breaches of her human rights. NHSE, ICBs and SaBP hospital managers should provide assurance that they have reviewed their case lists and provide data demonstrating compliance Care and Treatment Reviews are conducted in line with practice expectations. NHSE consider escalating the findings of this case to the National NSHE national learning disability and autism team to consider whether new escalation routes within the 2023 guidance in respect of Care and Treatment Reviews are understood and applied by panel chairs to escalate concerns regarding unsafe care. Clarity should be provided about how hospital managers monitor and provide assurance (including escalating to the SSAB where this results in strategic safeguarding issues) that system issues are recognised and reported in accordance with agreed local governance arrangements.

Recommendation 13:
SSAB, working with HSAB regionally if this is more efficient, set up a working group to oversee and report on the implementation of recommendations locally or regionally from the DHSC's rapid review into data on mental health in-patient settings. That working group should engage with local PSIRF ICB leads for safeguarding related matters. Partners should confirm if multiple s42 concerns relating to an adult who is subject to compulsory admission is now captured in data and reported to the ICB by provider Trusts as part of any PSIRF dataset. ICB and SCC Adult social care to explore with the ICB PSIRF lead how data can be triangulated and regular assurance given to the SSAB.

Recommendation 14:
NHSE, all regional ICB and CQC (working with the SQG) should provide assurance to SSAB information pertinent to patient safety and commissioning responsibilities is routinely reported. The local authority should work with ICB PSIRF and safeguarding leads to ensure processes for resolving disputes during s42 enquiries utilise ICB escalation routes and are understood by everyone undertaking safeguarding enquiries. Local policy should set out the robust governance requirements so that, where concerns are raised regarding organisational abuse, the provider and ICB provide

assurance responses are in line with Host Commissioners guidance and national safeguarding policy. NHSE should also clarify how they will report to SSAB emerging concerns (e.g., persistent failure to implement actions plans) escalated via CTR panels, including for cases involving complex care in out of borough placements. Partners should provide assurance that the governance routes have been appraised for effectiveness and demonstrate that improvement work is focused on reporting concerns via those established routes and also address out of borough placements.

6. Questions for HSAB

6.1. How do HSAB partners monitor the quality of care provided to in-patients placed out of area? Does that assurance framework routinely report if care and treatment plans are recovery focused?

6.2. How is oversight of long-term out of area community placements (under s117MHA or DoLS) for adults with autism and co-occurring conditions correlated with safeguarding data at a county level? Is this governed by HSAB, the local Learning Disability Partnership Board or the Health and Wellbeing Board?

6.3. How is the use of advocacy and carer support (under MHA, MCA, and the Care Act) monitored for those placed out of area and under restrictive care for protracted periods?

6.4. Is there sufficient guidance to clinicians, senior leaders, and MHA administrators to navigate the interface between MHA and MCA legal powers to prevent professional conflict of opinion resulting in safeguarding concerns (including allegations of organisational or discriminatory abuse)?

6.5. How does HSAB and their partners support the implementation of trauma-informed care? How do partners evidence adherence to NICE quality standards for adults with complex, co-occurring conditions?

6.6. Does HIOW ICB have sufficient patient facing resource to provide therapeutic interventions and diagnosis for adults with autism and/ or personality disorders and/or eating disorders? If this is delivered (as in Surrey) via non patient facing support to ward staff, is there sufficient flexibility and capacity to enable the proactive care seen in April's case or, alternatively, a dedicated training resource for frontline clinicians and practitioners in Hampshire?

6.7. How do HSAB partners responsible for care and treatment monitor the skills of those providing frontline care for adults placed out of area?

6.8. How does HSAB and partner agencies support the safe disclosure of physical and sexual abuse (including historical abuse) to police? Does this ensure adults at risk have access to appropriate support (in line with the Victim's Code and Youth Justice and Criminal Evidence Act 1999)? Are there clear escalation processes to ensure partner agencies work cooperatively across disciplines and geographical boundaries to enable robust police investigations that are trauma-informed?

6.9. Is it intended to work regionally to support the implementation of recommendations from the DHSC rapid review into Mental Health in-patient data, the new Patient Safety Incident Reporting Framework and review the efficacy of Host Commissioner guidance? How will HSAB disseminate learning from this review?

Glossary

ACP	Advanced Clinical Practitioner
ECHR	European Convention on Human Rights
EUPD	Emotionally Unstable Personality Disorder
FRH	Farnham Road Hospital
HCC	Hampshire County Council
HIUG	High Intensity User Group
ICB	Integrated Care Board
PICU	Psychiatric Intensive Care Unit
RSCH	Royal Surrey County Hospital
SAR	Safeguarding Adult Review
SaBP	Surrey and Borders Partnership NHS Trust
SCC	Surrey County Council
SSAB	Surrey Safeguarding Adults Board