STOCKPORT THEMATIC SAFEGUARDING AUDLT REVIEW

Reviewer: Anna Berry

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1) Introduction

1.1. In October 2023, Stockport Safeguarding Adults Board considered three Safeguarding Adults Review referrals regarding women who had died at the Priory Hospital Cheadle Royal. Whilst each individual case has some distinct differences, there were wider systemic thematic areas that were identified. A decision was made to carry out a thematic Safeguarding Adults Review to consider those areas. This thematic Safeguarding Adults Review was commissioned in April 2024.

1.2. The themes/ key lines of enquiry being considered are:

- The interrelationship between placing/commissioning teams, provider and local agencies (home area and host area)
- Care and treatment for people with Emotionally Unstable Personality Disorder [1], also known as "Complex Emotional Needs" , and Autistic Spectrum Disorder [2]
- Sufficiency of appropriate admissions/beds
- Harm and deterioration caused by delayed discharge and repatriation
- Oversight of risk
- Safeguarding responses
- The use of advocacy and listening to the person and their family.

1.3. This review recognises the alternative term of "Complex Emotional Needs" which can be used in place of Emotionally Unstable Personality Disorder. For the purpose of this review, the term Emotionally Unstable Personality Disorder will be used for consistency and in view of the classification in the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases and Related Health Problems.

1.4. This Safeguarding Adults Review is commissioned by the Stockport Safeguarding Adults Board because the Priory Hospital Cheadle Royal is geographically located in that area. The Safeguarding Adults Review has also required the cooperation of another three Safeguarding Adult Boards due to the areas that the three people originate from.

1.5. This process is fully cognisant of multiple parallel processes relating to the lives of each of these women and will aim not to repeat those but will reference them in due course.

[1] EUPD is a disorder of mood and how a person interacts with others. It is the most commonly recognised personality disorder (Personality disorders - NHS)

[2] Autism spectrum disorder is a neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave (Autism Spectrum Disorder - National Institute of Mental Health (NIMH))

2) The people being considered:

- **L aged 22** ended her life by ligature and the inquest concluded that this was misadventure with L not intending to end her life.

- **B aged 26** died from suicide contributed to by neglect.

- **A aged 20** ended her life by ligature and the conclusion of the inquest was misadventure.

3) What is a Safeguarding Adults Review?

3.1. A Safeguarding Adults Board has a statutory duty to arrange a Safeguarding Adults Review where:

(a) An adult with care and support needs has died and the Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect, or an adult is still alive, and the Safeguarding Adults Board knows or suspects that they have experienced serious abuse or neglect, and

(b) There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

3.2. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future. The purpose is not to apportion blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

3.3. There are clear review objectives which have been addressed to achieve these aims. Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what happened), an analysis and findings (what went wrong and what went right) and the recommendations to improve services and to reduce the risk of repeat circumstances.

3.4. The review process included a panel consisting of a cross section of strategic safeguarding leads and clinical representation and safeguarding leads from health and social care providers. The panel included representation from each of the three "home" Safeguarding Adults Boards to focus on themes, patterns and factors together with facilitation of family discussions where possible. The

Independent Reviewer has conducted research by analysing the information provided, culminating in an overview report for the Stockport Safeguarding Adults Board.

3.5. The review will cover the period from when the three people were placed at Priory Hospital Cheadle Royal to time of their deaths.

3.6. This review considers the circumstances of three individual people each with their own needs and challenges. It is not the intention of this review to compromise the voice of these three unique and individual people. It is noted that individually, each case has been carefully considered within other investigative and legal processes. Therefore, the purpose of this review is to capture the thematic challenges that these cases highlight for the mental health system as a whole.

3.7. A Safeguarding Adults Review can make local recommendations and, in this case, may also that extend beyond the local area and impact national policy or practice. While Safeguarding Adults Reviews are primarily focused on local learning and improvement, they can also identify issues that warrant national attention.

4) Thematic Areas:

4.1. The overarching theme within this thematic review is the impact of out of area mental health admissions on the safety and wellbeing of mental health patients. Specifically, when considering the individuals within this review, the harm caused to them when they were in a prolonged admissions some distance from their home. This harm included distress and anxiety, but also physical and psychological harms including death by suicide.

4.2. The review also captures specific issues such as the availability of appropriate care environments to meet the needs of individuals with a diagnosis of Emotionally Unstable Personality Disorder, the particular needs of a person with Autistic Spectrum Disorder, the "step down" provision and broadly the clinical accountability and timing of oversight of individual patients.

4.3. Within this report, the term step down is included on occasion to reflect the terminology used intermittently in each case by the agencies involved. The term is used to refer to the identified clinical need to reduce the restriction or intensity of treatment, following a period of more intensive care. Ultimately the transition to a different environment to support the person in their journey towards recovery. For these three cases, the type of "stepdown" provision varied, but the term refers overall to the identified need for a different therapeutic environment.

In summary, a care and treatment pathway that supports the individual's complex needs in the appropriate care environment.

4.4. The mechanisms for multiagency conversations and approaches, escalations as well as the strategic interrelationship between organisations both "home" and "host" areas will be explored. This will include risk formulation, oversight and awareness of safeguarding activity and matters for escalation.

4.5. Most importantly the review will keep central the question of how well the wishes and preferences of patients, family and carers influence the decisions about delivery of care.

4.6. The review will outline a number of parallel processes and investigations that have already taken place in respect of the three people we are considering in this review. Additionally, the review will be cognisant of national activity and developments that directly align to the matters we are exploring.

5) About the people

5.1. We will start the process by considering the people central to this Safeguarding Adults Review. This will be followed by a collective thematic summary. The following accounts are intended to provide a broad understanding of L, B and A's journeys; thematic analysis will be provided later in the report.

About L:

L lived in Wiltshire until the age of 10 when her family moved to Bournemouth. She is reported within the Priory Hospital Cheadle Royal serious incident report to have had a difficult time in high school but despite this she achieved good General Certificate of Secondary Education grades and went onto college to study A-Levels. The family suffered a significant loss during L's childhood when her brother died; the impact of which may have caused trauma later in her life. L's parents are separated; she has a younger brother and is described as being very close to her mother.

L was admitted to Pankhurst Ward at Priory Hospital Cheadle Royal as an inpatient detained under Section 3 of the Mental Health Act 1983[3] on 23rd July 2021 and died on 24th February 2022. The reason for L's admission to a Psychiatric Intensive Care Unit was escalating self-harm, increased distress, and suicidal thoughts. Her primary and secondary diagnoses were Emotionally Unstable Personality Disorder and Autistic Spectrum Disorder respectively. L was diagnosed with Autistic Spectrum Disorder following a privately arranged assessment (by family) during her time at Priory Hospital Cheadle Royal and not prior to her admission.

L frequently talked about aspirations for her future, her desire to return to her studies, her family and her dog. She is recorded to have insight into her frustrations and distress which manifested into self-harming as a coping mechanism. Her level of distress at times was described as "*debilitating*" and the environment of Pankhurst ward was noted to be particularly over stimulating for her. There were particular strategies for communication in place as L could become selectively mute when she was experiencing stress. L's family

[3] Section 3 of the Mental Health Act (1983) is an admission for treatment. This section allows for the detention of an individual in hospital for treatment (initially up to 6 months, with potential for extensions) to address their mental health needs.

visited often, despite the distance (approximately 245 miles) and she spoke on the phone with them daily. She is described to have cherished the time she spent with them on leave, visits and outings.

Ls first contact with mental health services was in October 2017 at the age of 16 when she presented with increasing anxiety and was displaying Obsessive Compulsive Disorder behaviours.[4] Between October 2018 and January 2021, she was admitted to several National Health Service mental health services. She spent periods of time as an informal patient as well as detained under both section 2 and section 3 of the Mental Health Act 1983. During this time, L was diagnosed with Emotionally Unstable Personality Disorder, her diagnosis of Autistic Spectrum Disorder came later. During her inpatient admissions, L engaged in numerous self-harm incidents to include head banging, cutting, ligating, walking into traffic and was at risk of ingesting such as swallowing non-consumable items such as batteries. In January 2021, L was transferred to Priory Hospital Pelham Woods (renamed Priory Hospital Dorking in February 2021) which is a locked female rehabilitation and recovery service. Subsequently she was transferred to Priory Hospital Cheadle Royal due to increased risk of self-harm.

Pankhurst ward is a is a 10-bed female Psychiatric Intensive Care Unit. The multi-disciplinary team on the ward comprises a Consultant Psychiatrist, a Specialty Doctor, a Principal Forensic Psychologist, an Occupational Therapist, qualified nurses and healthcare assistants. Care and treatment is provided to patients with varying diagnoses, often personality disorders, severe depression or psychosis. L's bed was "spot purchased" and funded by Dorset Health Care University National Health Service Foundation Trust. Her relocation to Cheadle was due to bed availability within a female Psychiatric Intensive Care Unit service.

During the time that L was on Pankhurst ward she had weekly multi-disciplinary team meetings that her care coordinator sometimes attended as well as an Independent Mental Health Advocate[5]. The multi-disciplinary team meetings were the main form of communication between her care coordinator and commissioner of her admission (Dorset Healthcare University Hospitals Trust), and her provider (Priory Hospital Cheadle Royal). She had four care plans that were reviewed at varying intervals; Keeping Safe, Keeping Well, Keeping Connected, Keeping Healthy, and she had risk assessments that were updated weekly. These risk assessments demonstrate that her level of risk fluctuated throughout her admission. Risks that were assessed included self-harm, absconsion[6], suicide, self-neglect, violence and inappropriate sexual behaviour.

[4] Obsessive compulsive disorder is a mental health condition where a person has obsessive thoughts and compulsive behaviours (Overview - Obsessive compulsive disorder (OCD) - NHS)

[5] Independent Mental Health Advocacy was introduced in April 2009 as part of changes made to the Mental Health Act 1983 (as amended in 2007). An Independent Mental Health Advocate is a qualified and experienced Advocate who supports people to understand their care and treatment and works to ensure that people's rights under the Mental Health Act are upheld.

[6] The word absconsion is used to refer to patient leaving a mental health unit without permission is a concern due to the potential risk to the person or potentially to others.

Discussions are recorded after two months of admission regarding the requirement for a "step down" rehabilitation service to meet L's needs. It was identified at a Care Programme Approach[7] meeting on 2nd September 2021 that her home treating team (in Dorset) were considering options for her. It is identified by National Health Service Dorset that there was some ambiguity about the type of provision that was needed to meet Ls needs hence why various different options were explored to include more local Psychiatric Intensive Care Unit, acute wards, community placement and rehabilitation units. As time passed, L's frustrations are recorded to have increased as she struggled to understand the reasons for delay. National Health Service Dorset reflect that this may have been related to uncertainty about the most appropriate type of provision L needed and therefore how a move to a more appropriate care environment could be initiated. She spoke openly about how the delay in transfer was a cause for her frustrations and a reason for her self-harming. In November 2021 a private psychiatric assessment was arranged by L's family and resulted in an Autistic Spectrum Disorder diagnosis. This action was taken due to the reported long National Health Service waiting lists. There was some initial challenge between the private provider and her Priory Consultant in terms of Emotionally Unstable Personality Disorder diagnosis, however her lead Consultant concluded that she had both Emotionally Unstable Personality Disorder and Autistic Spectrum Disorder but described the Autistic Spectrum Disorder as the more "challenging" of the two diagnoses.

During January and February 2022 there had been no solution identified in terms of L's admission/move to a more appropriate care environment and she is recorded to have been "*frustrated, upset, tearful and angry*" because she had been on Pankhurst ward longer than she had expected and she wanted to return home. There was an increase in self-harming incidents, on one occasion requiring surgery to remove 6 pens that L had ingested. A safeguarding concern was referred locally to Stockport Adult Social Care and investigated by Priory Hospital Cheadle Royal (in accordance with the requirements under S42 of The Care Act "*local authorities must make enquiries or cause others to do so").* It was then considered at the Stockport "Harms Level Panel"[8].
A care treatment review and planning meeting[9] was held on 13th January and identified that it was no longer appropriate for L to remain in a Psychiatric Intensive Care Unit admission and that she needed a bed within a rehabilitation service and specifically identified that

[7] The term Care Programme Approach describes the approach currently used in mental healthcare to assess, plan, review and coordinate the range of treatment, care and support needed for people in contact with mental health services who have complex care needs

[8] The aim of the "Harms Level Panel" was to review all "level 3" investigation reports to ensure that providers have carried out a suitable investigation (proportionate to the incident and focused around the person's desired outcome). The levels and panel were articulated with the "Stockport Safeguarding Adults Service: Framework for Partnership Working in responding to Safeguarding Adults Concerns: Harm Levels Guidance for Provider Services: Single Agency or Multi-agency response". This has been superseded by the "Causing Others to Make Enquiries Process".

[9] Care Treatment Reviews are for people who have been admitted to a mental health hospital or for people who are at risk of admission. It is a meeting undertaken by commissioners to ensure that people are only admitted to hospital when absolutely necessary, for the minimum amount of time possible and to check that a persons care and treatment is meeting their needs (NHSE)

she needed to be cared for by people specifically trained to work with people with Autistic Spectrum Disorder. National Health Service Dorset reflect that the aforementioned challenge about the Autistic Spectrum Disorder diagnosis during her time at Priory Hospital Cheadle Royal may have contributed to some uncertainty about the most appropriate care pathway/environment that would best meet L's needs.

A Care Programme Approach discharge meeting was held on 20th January including L and her family, and a number of actions and assessments were agreed to be facilitated for discharge. These included a Care Act Assessment by a Local Authority Social Worker, development of a comprehensive discharge plan and risk assessment by her care coordinator, and specific assessments (Activities of daily living, sensory profile, model of human occupation tool and Speech and Language Therapy assessment). The care coordinator was continuing to look for most appropriate care pathway/environment.

During a multi-disciplinary team ward round held on Thursday 3 February 2022, L presented a letter that she had written. The letter said that that she had thoughts of suicide due to being in hospital but reiterated that she did not want to die but wanted to be closer to her family home. The multi-disciplinary team recorded that she was frustrated that discussions about her transfer to a rehabilitation service began in September 2021, yet there had been no progress. Towards the end of the meeting, L became distressed, was crying and repeating that she did not want to remain in hospital. Her family also requested for her to be moved closer to home. In February 2022, discussions took place to explore the option of moving L to another Psychiatric Intensive Care Unit but closer to home in view of the increasing level of self-harming. Her consultant reiterated that an acute bed[10] should be reconsidered as this would be less restrictive and may result in a decrease in frustrations and incidents.

On 24th February 2022 during the weekly multi-disciplinary team meeting L was told that her home treating team and the Dorset Clinical Commissioning Group [11] were still trying to find a suitable alternative provision. L requested for her observation level to be reduced and this was declined, she also requested for her escorted leave to be reinstated and was agreed. Following the multi-disciplinary team meeting L became increasingly agitated as the day went on stating "*I'm sick of being here, I just want to go home*". L was found at 22:01 in her ensuite bathroom with her body weight suspended by an item of clothing that she had looped over the corner of the door. L was transferred to hospital where treatment was subsequently withdrawn, and she died on 26th February.

[10] An acute bed for adults of working age (18–65) for males or females. Patients may be informal or subject to the Mental Health Act. Acute inpatient wards provide care with intensive medical and nursing support for patients in periods of acute psychiatric illness (NHE "Hospital bed types" 2024).

[11] Explanations will be provided later within the report about the NHS landscape

The coroner ruled that L ended her life by ligature concluding that this was "*misadventure with L not intending to end her life*". A Prevention of Future Death Report was issued by the Coroner and sent to Dorset Healthcare University National Health Service Foundation Trust and Department of Health and Social Care and National Health Service England.	
Priory Hospital Cheadle Royal Patient Safety Incident Investigation	**Significant points for this thematic review:**
The Priory Serious Untoward Incident investigation created an action plan to address finding that sit outside of the remit of this thematic review including the emergency response, staffing levels, ligature risks (ward redesign to "safer specification" design and anti-ligature doors) and increased education about "understanding autism".	- The National Association of Psychiatric Intensive Care Units Guidance for Commissioners of Psychiatric Intensive Care Units (2016) makes clear that a patient's length of stay on a Psychiatric Intensive Care Unit should be kept to a minimum, not exceeding six to eight weeks. The emphasis is on short-term intensive treatment with regular reviews of progress. L was on Psychiatric Intensive Care Unit for 7 months. - The Delayed Discharge protocol was utilised through the later multi-disciplinary team meetings but was not effective and there is no evidence of escalation. - Multi-disciplinary team and commissioning team acknowledged that the Psychiatric Intensive Care Unit was no longer a suitable environment for L, and it was detrimental to her recovery. The delays in a move to a more appropriate care environment/repatriation were significant. - The length of stay and restrictions on the Psychiatric Intensive Care Unit were particularly detrimental for a person with a diagnosis of Autism. - L reports at multi-disciplinary team meeting to feel 'trapped' in the mental health system. - Ls family advocated for her significantly.

About B:

B was born in Cornwall. She reported that she had experienced trauma in her childhood. She has a mother, father, an older brother who had moved to Australia and a sister. B reported that she had enjoyed school and had sustained employment working with children looked after. She had a long-term male partner with whom she owned a house, and she reported being part of a good friendship group. B was very active on social media, had a Facebook and Twitter account and had an online blog with a large following. During her admission to Fern Unit, she disclosed an incident of sexual assault in her teenage years. B also made an allegation of sexual assault whilst on the unit which was referred to and investigated by Stockport Adult Social Care and Greater Manchester Police.

B's history of mental health issues goes back to her school years, and she was under her local Child and Adolescent Mental Health Services team from 2011 and treated for depression and later diagnosed with "complex trauma". From 2014 she was known to adult mental health services with increased suicidal intentions. From 2018 there were periods of informal admission to a mental health ward. In 2019 B jumped from a bridge sustaining significant physical injuries and subsequently was detained under Section 2 of the Mental Health Act (1983)[12] and then on an informal basis. The long-term physical effects of the injuries included chronic pain due to the number of fractures sustained, and bladder and bowel dysfunction. Throughout B's time on Fern unit, she expressed on a number of occasions that she was struggling to come to terms with the physical health issues she experienced. B experienced severe chronic pain and functional changes (including continence issues) due to the injury to her spinal cord. Management of her physical symptoms and impact of these injuries on her mental health formed part of her care plan.

B was admitted to Fern Unit at Priory Hospital Cheadle Royal as an inpatient detained under Section 3 of the Mental Health Act 1983 on 10th November 2021 and died on 21st March 2022. B's risks had been assessed to be too high risk to be safely managed by her locality community mental health team. It was agreed that she required specialist intervention with psychological therapy in a dedicated inpatient Unit. This resource could not be sourced locally and an out of area referral was made. B's home team have provided additional context in that she requested a specialist out of area admission. This request also had emails of support from her family as well as Devon and Cornwall Police.

Fern Unit is a 10-bed specialist unit that operates a comprehensive Dialectical Behaviour Therapy programme for the treatment of patients with a primary diagnosis of emotionally unstable personality disorder. Patients admitted to Fern Unit may also have co-morbid mental health disorders such as psychosis, substance misuse, eating disorders and complex post-traumatic stress disorder. Although it

[12] Section 2 of the Mental Health Act (1983) is an admission for assessment. This section allows for the detention of an individual in hospital for assessment (up to 28 days) to determine the nature and extent of their mental health condition.

is a locked unit, it aims to achieve the least restrictive option for patients whose risk of self-harm or suicide is very high and/or where less restrictive settings have been unable to provide the necessary treatment in a safe environment.

Fern Unit has a multi-disciplinary team in place which consists of a Consultant Psychiatrist, Unit Manager, Registered Mental Health Nurses, Registered Physical Health Nurses, Clinical Psychologist, Speciality Doctor, Therapy Assistant, Occupational Therapist, Social Worker and Healthcare Assistants. The Unit holds a weekly ward round together with regular care programme approach meetings with the purpose being to review each patient's care, treatment and progress and identify the next steps to be taken. B had four care plans that were reviewed at varying intervals; Keeping Safe, Keeping Well, Keeping Connected, Keeping Healthy, and she had risk assessments that were updated on 18 occasions during her admission. These risk assessments demonstrate that her level of risk fluctuated and increased throughout her admission.

Fern Unit is located approximately 300 miles from B's home address in Cornwall. The rationale for a referral out of area was that she required an admission which could provide specialist care and treatment and manage the long-term risk she presented with. No other provision closer to home had been found and B had requested out of area admission herself. It is important to note that B did not agree with the diagnosis of Emotionally Unstable Personality Disorder and as the admission progressed, conversations took place between her home team and Priory in terms of lack of progress, increase of risk and incidents and reluctance to engage with the therapeutic programme on the ward.

Reported with the care records in November 2021 it is noted that B talked about feeling homesick. On social media, she detailed that she missed her partner when posting about their anniversary and posted that she was unable to return home for Christmas or have a visit for her birthday due to a Covid outbreak on the ward. At the start of her admission B talked on social media about having mixed emotions but identified that she going to *'grab the opportunity with both hands'.*

In December 2021 B's Section 3 was renewed for another 6 months and in addition to her regular ward multi-disciplinary team meetings, there was also regular dialogue between the ward and her home team about the suitability of her admission and exploration of a move back to Cornwall. The risk levels, the increasing number of incidents and concerns about the level of engagement and success of the therapeutic programme for B were all discussed regularly in the weeks following. Generally, it was agreed that Dialectical Behaviour Therapy was the treatment of choice for her diagnosis of Emotionally Unstable Personality Disorder, but B was deteriorating as the admission went on. On 8th March 2022 B's Clinical Reviewing Officer from Cornwall visited , and noted the increased risks- daily ligaturing, increased attempts to abscond, poor/little engagement with the Dialectical Behaviour Therapy session and recorded that the

Responsible Clinician identified that Fern Unit was no longer a suitable treatment option for B as she had no "life goals" and continued to voice wishes to complete suicide. Therefore, at the ward multi-disciplinary team meeting on 11th March 2022 it was agreed to review B's risk and engagement on the ward and make a decision about the most appropriate place for B to receive treatment. There was liaison between the Clinical Reviewing Officer, Cornwall Partnership National Health Service Foundation Trust and Priory Hospital Cheadle Royal continually over the next week with contingency plans for alternative provision being explored. On 18th March 2022 the Clinical Reviewing Officer reviewed Bs care plan and arranged an urgent meeting with Cornwall Partnership National Health Service Foundation Trust to further consider contingency planning. A review meeting with Clinical Reviewing Officer, Cornwall Partnership National Health Service Foundation Trust and Priory Hospital Cheadle Royal was arranged for 23rd March 2022.

B voiced on number of occasions her intention to end her life, notably the incidents increased during the two months before her death. There were 41 significant incidents recorded, these include ligature incidents, absconsions, ingestion of batteries and other methods of self-harm. There was also an allegation of sexual assault made which was referred to Stockport Adult Social Care and Greater Manchester Police. B was supported by the team at Priory Hospital Cheadle Royal to share the information with her family and the home team were informed. B's overall risk was recorded to have increased, and this was reflected in the one-to-one observations that she received leading up to and at the time of her death. Her risk is recorded to increase during the admission and a number of factors may have exacerbated this such as the impact of her physical health, the safeguarding concern from a reported sexual assault, relationship breakdown with her partner, her lack of acceptance about her diagnosis and thus the inconsistent engagement with her recommended treatment.

Part of B's care plan and risk assessment included arrangements for the receiving and opening of parcels which meant that she was not allowed to open any parcels herself. B received frequent and large amounts of post/parcels due to her online blog and social media activity. On 21st March 2022 B received a parcel which seemed to contain a container that B said was "protein powder", which she was able to tip into a glass of water and subsequently ingested an amount of the powder. Despite lifesaving attempts, B died a little over two hours later in hospital.

Relevant for this thematic review is the engagement between the Priory team and the home team., in particular the timely communication of increasing levels of risk, emerging view that the admission could no longer meet her treatment requirements and management of those risks. Risks were communicated to the commissioner as not being managed on 18th March 2022 and review was scheduled for 23rd March 2022 to make plans for repatriations back to Cornwall.

The coroner ruled that that B died from "*suicide contributed to by neglect".*	
Priory Hospital Cheadle Royal Patient Safety Incident Investigation	**Significant points for this thematic review:**
The Priory Serious Untoward Incident investigation created an action plan to address findings that sit outside of the remit of this thematic review. There were a number of areas of learning and recommendations including ensuring a full awareness of patient history, documentation standards, clear information sharing and communication relating to care plan and risk assessments, ensuring that all relevant information is documented and shared within the multi-disciplinary team, the checking of emergency equipment and review of the policy and procedures for management of incoming post.	- Whilst the therapeutic environment of Fern Unit was the correct treatment for B's diagnosis, it was not working effectively for her due the number of complex issues (including physical health issues). - A requirement to strengthen safeguarding oversight. - The distance from home may have been a contributory factor but the extent to which this contributed to B's presentation is unknown. - The involvement of family in care and treatment is limited albeit B identified difficult relationships.

About A:
A was born and raised in Birmingham in a family of six children. A's family is of Somali heritage. A was described by the ward staff as a bright individual and had future plans to attend university and study to become a nurse or paramedic. She enjoyed art, especially watercolour painting and was interested in fashion.

A was admitted to Pankhurst ward at Priory Hospital Cheadle Royal as an inpatient detained under Section 3 of the Mental Health Act 1983 on 2 August 2022. Forward Thinking Birmingham as part of Birmingham Women's and Children's National Health Service Trust were the commissioners of A's admission which was a "spot-purchased" bed. Birmingham Women's and Children's National Health Service Trust is commissioned by the Birmingham and Solihull Integrated Care Board to provide mental health services for the Birmingham population under the age of 25. The reason for A's admission to a Psychiatric Intensive Care Unit was escalating self-harm and poor engagement with treatment. Her primary diagnosis was Emotionally Unstable Personality Disorder, and her secondary diagnosis was Post Traumatic Stress Disorder and disordered eating.

Pankhurst ward is a 10-bed female Psychiatric Intensive Care Unit. The multi-disciplinary team on the ward comprises a Consultant Psychiatrist, a Specialty Doctor, a Principal Forensic Psychologist, an Occupational Therapist, qualified nurses and healthcare assistants. Care and treatment is provided to patients with varying diagnoses, often personality disorders, severe depression or psychosis.

During the thirteen months that A was on Pankhurst ward she had weekly multi-disciplinary team meetings that her Forward Thinking Birmingham care coordinators sometimes attended. The multi-disciplinary team meetings were the main form of communication between her care coordinator and commissioner of her admission (Forward Thinking Birmingham), and her provider (Priory Hospital Cheadle Royal). There is evidence that A attended a high number of multi-disciplinary team meetings and was always encouraged to do so. She had four care plans that were reviewed at varying intervals; Keeping Safe, Keeping Well, Keeping Connected, Keeping Healthy, and she had risk assessments that were updated weekly. These risk assessments demonstrate that her level of risk fluctuated throughout her admission. Risks that were assessed included self-harm, suicide, self-neglect, absconsion, physical health and use of internet/social media.

In late August 2022 the multi-disciplinary team identified that A was ready to return to her previous provision and discussions commenced to start planning this move. The rationale for this was to continue to support recovery and encourage A to keep herself safe whilst using least restrictive measures. Throughout the next two months there was limited discussion about how this was progressing. In November 2022 Forward Thinking Birmingham commenced assessment for options for onward provision. A is recorded to be increasingly frustrated on Pankhurst Ward.

In December 2022 the multi-disciplinary team raised with Forward Thinking Birmingham that her time on Pankhurst should not be prolonged and in the first two months of 2023 two provision was explored with one accepting A subject to funding agreement. In May

2023 it was reported to the multi-disciplinary team that funding had not been agreed due to the onward provider being rated as "inadequate" by the Care Quality Commission. Multi-disciplinary team meetings record a concern that A was "stuck", this recording is reflected in the Priory Hospital Cheadle Royal patient serious untoward incident report. Mid-May shows a significant increase in self-harm incidents and A was assessed to lack capacity to make decisions about her care and treatment. Multiple provision options at this time were explored and assessed they could not meet A's needs.

From July 2023 the multi-disciplinary team meetings record a difference of opinion as follows: the multi-disciplinary team expressed that an admission providing Dialectical Behaviour Therapy would be the best option, however Forward Thinking Birmingham continued to explore other Psychiatric Intensive Care Unit and acute wards. The recommended option at multi-disciplinary team meetings was Fern Ward which is a rehabilitation and personality disorder service offering Dialectical Behaviour Therapy. A was accepted to Fern Ward at the end of August 2023 pending a "home commissioner" funding decision. The funding process was not concluded at the time of her death. The processes regarding her home funding decision making processes are identified within the coroner's inquest. There was an overall deterioration in A's mental health during this prolonged admission and although she received some psychological input, it was limited due to her being in Psychiatric Intensive Care Unit. Therefore, by July and August she was not applying the coping mechanisms she had learned in earlier psychological sessions. A was noted to be looking forward to the move to Fern Ward. Over the next few weeks there were increased incidents of self-harm and A was described to be withdrawn, evasive and anxious.

A was found in her en-suite bathroom at approximately 15:30 hours on 15 September 2023 with a ligature tied around her neck. The ligature was not suspended. Ward staff and emergency responders attended, and they were followed by paramedics. Emergency treatment was administered without success and A was pronounced deceased at 16:26 hours.

The coroner ruled that A ended her life by ligature concluding that that this was "*misadventure*". A Prevention of Future Death Report was issued by the coroner and sent to the Department of Health and Social Care and National Health Service England.

Priory Hospital Cheadle Royal Patient Safety Incident Investigation	**Significant points for this thematic review:**

The Priory Serious Untoward Incident investigation created an action plan to address findings that sit outside of the remit of this thematic review to include themes around observations, induction processes for bank/agency staff, emergency response and mitigating risks (room searches/prohibited items).	- The National Association of Psychiatric Intensive Care Units Guidance for Commissioners of Psychiatric Intensive Care Unit 's (2016) makes clear that a patient's length of stay on a Psychiatric Intensive Care Unit should be kept to a minimum, not exceeding six to eight weeks. The emphasis is on short-term intensive treatment with regular reviews of progress. A was on Psychiatric Intensive Care Unit for 13 months - The Delayed Discharge protocol was utilised through the later multi-disciplinary team meetings but was not effective due to a funding decision delaying the move. - The multi-disciplinary team highlighted that A was "*stuck on Psychiatric Intensive Care Unit"* and that it was detrimental to her recovery. There was a disconnect between the clinical team at the Priory and the commissioning team.

5.2. Collective thematic overview:

L Aged 20 at time of death in February 2022	**B** Aged 26 at time of death in March 2022
Originating/ commissioning local area: **DORSET**	Originating/ commissioning local area: **CORNWALL AND THE ISLES OF SCILLY**
Primary Diagnoses: **Emotionally Unstable Personality Disorder and Autistic Spectrum Disorder**	Primary Diagnoses: **Emotionally Unstable Personality Disorder and Post Traumatic Stress Disorder**
Mental Health Act status at time of death: **Section 3**	Mental Health Act status at time of death: **Section 3**
Inquest Conclusion: L ended her life by ligature and the inquest concluded that this was *"misadventure with L not intending to end her life".* A Prevention of Future Death Report was issued by the Coroner.	**Inquest Conclusion:** The inquest concluded that B died from "*suicide contributed to by neglect"*
Thematic factors to explore: - Admitted into a bed away from area of home. - Delayed discharged/repatriation, length of stay was 7 months, she was ready for a move to a more appropriate care environment much earlier. - Absence / insufficiency of an appropriate care environment provision compounded by lack of clarity on what the care and treatment pathway should be-clear formulation of need and risk. - System approaches to Emotionally Unstable Personality Disorder and Autistic Spectrum Disorder. - Interface between home team, provider and local Integrated Care Board. - Impact of the views of the person and their family and use of advocacy. - Harm and deterioration caused by delayed discharge. - Escalation and multi-agency working. - Risk formulation and patient safety - Consideration of statutory safeguarding duties.	**Thematic factors to explore:** - Admitted into a bed away from area of home - Delayed communication of increasing risk. - Interface between home team, provider and local Integrated Care Board - Harm and deterioration caused by length of stay. - Escalation and multi-agency working - Risk formulation and patient safety - Consideration of statutory safeguarding duties
Single factors: Autistic Spectrum Disorder	**Single factors:** Safeguarding incident involving an allegation of sexual assault.

A Aged 20 at time of death in September 2023
Originating/ commissioning local area: **BIRMINGHAM**
Primary Diagnoses: **Emotionally Unstable Personality Disorder, Post Traumatic Stress Disorder, Eating Disorder**
Mental Health Act status at time of death: **Section 3**
Inquest Conclusion: A ended her life by ligature and the inquest concluded that this was *"misadventure".* A Prevention of Future Death Report was issued by the Coroner.
Thematic factors to explore: - Admitted into a bed away from area of home. - Delayed discharged/repatriation- length of stay was 13 months, she was ready for a move to a more appropriate care environment after 4 weeks. - Absence / insufficiency of an appropriate care environment. - System approaches to Emotionally Unstable Personality Disorder. - Interface between home team, provider and local Integrated Care Board. - Harm and deterioration caused by delayed discharge. - Escalation and multi-agency working. - Risk formulation and patient safety. - Consideration of statutory safeguarding duties.
Single factors: Funding delays

6) Parallel Processes

6.1. A number of other processes may take place alongside a Safeguarding Adults Review and have not delayed the process of the review. To note a Safeguarding Adults Review is not an inquiry into how an adult has died, this is for the coroner to investigate. It is also not a criminal investigation, that is for the police to determine. Lastly it is not a complaint, disciplinary or single agency investigation, where necessary, that is for individual agencies to manage. It is however helpful to be cited on parallel processes which, where relevant may be referenced throughout this report. In all of these cases there are several processes that have taken place.

6.2. The coronial inquest into each case has already taken place and concluded. For reference, inquests are legal inquiries into the cause and circumstances of a death, and are limited, fact-finding inquiries[i].

6.3. In two of the cases the coroner sent a Prevention of Future Deaths report.[ii]. The Prevention of Future Deaths reports applied to the cases of A and L. Under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 Act, and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, where an investigation gives rise to concern that future deaths will occur, and the investigating coroner is of the opinion that action should be taken to reduce the risk of death, the coroner *"must"* make a report to the person the s/he believes may have the power to take such action.

6.4. In L and A's case, the Prevention of Future Deaths reports were sent to the Secretary of State for Health (Department of Health and Social Care) and to the Chief Executive of National Health Service England. In L's case, a second Prevention of Future Deaths report was sent to Dorset Healthcare University National Health Service Foundation Trust.

6.5. The Prevention of Future Deaths reports in L and A's case highlighted.

- Underfunding for local mental health beds. (L and A)
- An over-reliance by the National Health Service on independent providers for mental health beds. (L and A)
- A delay in identifying a care and treatment pathway that supports the individual's complex needs in a more appropriate care environment, closer to home (L and A).
- A national scarcity of specialist personality disorder rehabilitation units (A)

- Untimely commissioning/funding arrangements for specialist provision that may not be fit for purpose (A).
- Inadequate and insufficient communication between Dorset Healthcare National Health Service Trust, The Priory and relevant parties (L).

6.6. In B's case the inquest concluded that the cause of death was suicide contributed to by neglect. The inquest records the subsequent measures adopted by Priory Hospital Cheadle Royal were dealt with satisfactorily to mitigate against future risk. There was not a Prevention of Future Deaths report made in respect of B.

6.7. For reference, incidents that occur within the National Health Service were investigated at the time of L and B's cases in accordance with the National Health Service Serious Incident Framework (2015).[13] This has now been replaced by the new Patient Safety Incident Response Framework (2022).

6.8. Dorset Healthcare University National Health Service Foundation Trust undertook such a review resulting in an action plan in January 2023, this was revisited with a Quality Assurance Check in November 2024 following receipt of the Prevention of Future Deaths report. Action planning included implementation of a complex case panel review process, appointment of an out of area coordinator, review of the out of Area Standard Operating Procedure, review of the Acute Inpatient Operational Policy and assurance review processes against all these areas for development.

6.9. National Health Service Cornwall and Isles of Scilly Integrated Care Board (formally known as Kernow Clinical Commissioning Group) undertook a review of all people placed out of county, subsequently the processes for assurance when commissioning out of area were reviewed alongside the working practices and communication methods with Cornwall Partnership National Health Service Foundation Trust. Additionally, the escalation process was strengthened and specific training and awareness relating to online access in secure settings was implemented.

6.10. There were no reviews undertaken by organisations within Birmingham in respect of A.

6.11. For reference, incidents that occur within the Priory Group are investigated under their Patient Safety Incident Response Policy (2023-26) and all three

[13] serious-incidnt-framwrk-upd.pdf (england.nhs.uk)

Patient Safety Incident Investigation reports were shared for the purpose of this review. For each case there were a number of findings, recommendations and associated action plans and these were referenced and scrutinised within the inquest processes. Additionally, and in respect of the collective learning, they have reviewed and implemented a standard operating procedure for delayed discharge and repatriation of out of area patients.

6.12. The Care Quality Commission is the independent regulator of health and social care in England and carry out regular checks on health and social care services. These inspections are called "comprehensive inspections", and they are undertaken to make sure services are providing care that is safe, caring, effective, responsive to people's needs and well-led.[iii]

6.13. The latest Care Quality Commission inspections outcomes for the three "home" provider mental health trusts related to these cases, and Priory Hospital Cheadle Royal are summarised as follows:

- **Cornwall Partnership National Health Service Foundation Trust** inspected in 2022 -overall rating is "requires improvement"
- **Forward Thinking Birmingham** (as part of Birmingham Women and Children's National Health Service Foundation Trust) inspected in 2024- overall rating "requires improvement"
- **Dorset Healthcare National Health Service University Hospital Trust** inspected in 2019- overall rating is "outstanding"
- **Priory Hospital Cheadle Royal** inspected in 2024- overall rating is "requires improvement"

7) The national position

7.1. It is important to be cognisant of the level of national attention to the thematic issues this review is exploring. In addition to the parallel processes articulated above, there are significant national developments, Inquiries and reviews that are relevant to the themes we are investigating and these have been considered, discussed with the Safeguarding Adult Review panel and outlined in Appendix 1.

8) Summary of findings for analysis:

8.1. We have examined the circumstances of each case, the parallel processes that have already happened and the most recent national activity relating to the themes in this review. Let us now bring back to this report to the set of themes that the circumstances of L, B, and A have raised.

8.2. Firstly, it is acknowledged that there are layers of complexity and learning at different levels (national, regional, local, interface across structures).

- **NATIONAL POSITION**- new Mental Health Bill, multiple new strategies and guidance documents, investigations and Inquiries, acknowledgement of national shortage of beds. The national position includes the use of over 60 different independent providers of mental health inpatient services.
- **REGIONAL POSITION-** variance and shortage of specialist provision in each region, oversight of the response to national drivers and challenges.
- **LOCAL POSITION**- shortage of specialist provision, challenges in identifying care and treatment pathways to support the individual's complex needs in the appropriate care environment, over reliance on out of area and independent providers, differences in commissioning arrangements and processes, variance in the interface across geographical boundaries, differences in how funding decisions are made, host and home arrangements.
- **PLACE BASED**- variance in local arrangements, resources, oversight, quality assurance, common understanding of risk and spheres of responsibility, connectivity and role of local Safeguarding Adults Board.
- **PROVIDER**- in these cases a provider working with over 42 commissioning organisations, managing harm/risk exacerbated by delayed transfers, escalation and application of process, progressing action plans relating to the finding of each individual case, connectivity to local Safeguarding Adults Board.

- **OVERALL-** In the timeframe of this review, there were:

  Three National Health Service regions (Northwest Region, Midlands, Southwest)
  Four Integrated Care Boards (National Health Service Greater Manchester Integrated Care Board, National Health Service Cornwall and Isles of Scilly Integrated Care Board, National Health Service Dorset Integrated Care Board, National Health Service Birmingham and Solihull Integrated Care Board)

Three home provider/commissioner organisations (Cornwall Partnership National Health Service Foundation Trust, Forward Thinking Birmingham /Birmingham Women and Children's National Health Service Foundation Trust, and Dorset Health Care University National Health Service Foundation Trust)
One independent provider (Priory Hospital Cheadle Royal)
Four local authorities (Stockport, Birmingham, Cornwall, Dorset).

8.3. There are findings against the following areas that will be summarised:

- Emotionally Unstable Personality Disorder and provision of services
- Autistic Spectrum Disorder and provision of services
- Out of area admissions
- The robustness of the system to provide patient safety and quality oversight from the commissioners
- Delayed transfers of care
- Safeguarding response
- Person, family/carer voice and advocacy

8.4. Recommendations will be made against the thematic areas of learning.

9) Points for analysis:

9.1. Emotionally Unstable Personality Disorder and provision of services

9.1.1. Emotionally Unstable Personality Disorder is a mental disorder characterised by affective instability, interpersonal problems, and chronic suicidality, which is associated with reduced functioning, poor quality of life, and lower life expectancy[iv]. The suicide rate is fifty times that of the general population and one in ten people with a diagnosis of Emotionally Unstable Personality Disorder will die by suicide[v]. The National Institute for Health and Care Excellence guidelines for Emotionally Unstable Personality Disorder only recommend considering acute psychiatric admissions for the management of crises and on a short-term basis, in recognition of unintended adverse effects of admission[vi].

9.1.2. Two of the profiles are that of women with a diagnosis of Emotionally Unstable Personality Disorder who required a bed in time of crisis and were placed in the Psychiatric Intensive Care Unit at Priory Hospital Cheadle Royal, this was intended to be a short-term admission and due to lack of availability locally ended up a distance away from home. However, both people remained on the Psychiatric Intensive Care Unit for a long period of

time with a deteriorating clinical presentation due to the length of stay in this restrictive area. In both profiles the level of self-harming was recorded to be increasing, and the multi-disciplinary team identified early on that they needed to be in a less restrictive and more therapeutic specialist environment.

9.1.3. Several forms of therapy have proven to be effective for Emotionally Unstable Personality Disorder with Dialectical Behaviour Therapy being the most common intervention often in conjunction with psychiatric medication. The Dialectical Behaviour Therapy model of care is based on recovery. The focus is to empower and skill the patients to adapt, manage and plan their own lives in a safe and effective way, promoting independence, realistic goal setting and autonomy and providing the necessary generalisation of Dialectical Behaviour Therapy skills to their daily lives. Based on the core principles of the Dialectical Behaviour Therapy approach, the aim is to discharge patients to live a happier and more independent life within the community.

9.1.4. Therefore, for patients diagnosed with Emotionally Unstable Personality Disorder it is essential to use the least restrictive environment. If, like L and A a short-term crisis admission is clinically required, it should be for the shortest period of time possible, with a timely move to an appropriate care and treatment pathway/environment when clinically indicated. This of course should balance complex risk assessment, care planning and within the least restrictive environments. In L's case a further consideration may be about how Dialectical Behaviour Therapy can be adapted where both Emotionally Unstable Personality Disorder and Autistic Spectrum Disorder manifest in clinical presentation.

9.1.5. In B's case it was good practice in the first instance to utilise Fern unit who provided Dialectical Behaviour Therapy, but her risk was increasingly demonstrated as being extremely high and there were fluctuations in her assessed suicidal ideation. B is recorded to have doubted her diagnosis and was not engaging with interventions. It is relevant to note here that B had requested an out of area bed, additionally from a clinical perspective, it was expected that she would find it difficult to engage initially.

9.1.6. Cornwall and Isles of Scilly Integrated Care Board report that they (and the clinical home team) became aware of the full extent of the increasing risk 5 days prior to her death. When this was communicated, together with feedback that the unit could no longer meet her treatment needs, a review was planned with a repatriation plan to transfer B to an acute mental

health ward which would be expected to be within 2-4 weeks. There is indication of learning in terms of oversight from the home teams, multi-way communication, clear and open discussions about levels of risk and a shared, consistent understanding of what is "high risk".

9.1.7. In A's case the trajectory of delay in seeking the right provision had come before and during her time at Priory Hospital Cheadle Royal. The need for specialist intervention was acknowledged but there was a lack of timeliness in sourcing and agreeing the right place for her to be admitted. This created a significant delay and although a bed was identified within a unit in Priory Hospital Cheadle Royal, this was delayed due to her local funding processes. This was not resolved at the time of her death.

9.1.8. Each area was cognisant of the themes highlighted within individual clinical presentations in each case, including complex emotion needs, Emotionally Unstable Personality Disorder, history of trauma and autism. Cornwall and Isles of Scilly Integrated Care Board outlined how this awareness has informed local work to include their Community Mental Health Programme and Mental Health Strategy. Cornwall and Isles of Scilly Integrated Care Board highlighted that complex mental health need requires services to work together to jointly assess need and to work across service boundaries to support individual recovery safely and ideally in the community. Additionally, that inpatient care is not optimal for recovery, and in fact can cause harm and therefore there is a commitment to avoid inappropriate in-patient admission, as well as improving the community Mental Health, Learning Disability and Autism pathway, and discharging individuals in inpatient settings as soon as possible.

Finding 1

There was a challenge in each case in identifying the most appropriate therapeutic provision to meet the complex needs of each individual in this review, and the reasons this were multi-faceted. This may also have been exacerbated by the geographical distance between home and placement, with the person being somewhat out of sight due to the less frequent face to face oversight from "home" teams. Mitigations against delays are dependent on effective relationships between provider and home teams, and robust escalation points where delays and challenges are identified. In these cases, the mitigating actions were not effective, contributed to by a national challenge in terms of local provision, and an absence of national guidance relating to appropriate environments for complex risk patients who require a less restrictive care environment.

9.2. Autistic Spectrum Disorder and provision of services

9.2.1. The second national analysis of Safeguarding Adults Reviews (2019-2023) identified the significance of Autistic Spectrum Disorder/Attention Deficit Hyperactivity Disorder waiting times and a lack of clarity on how to support people with Autistic Spectrum Disorder who have complex needs. It also identified the insufficiency of mental health risk assessment in terms of focus on Autistic Spectrum Disorder and highlighted the links between suicide prevention and autism. This review highlights a case of a person who was assessed and diagnosed in the midst of a crisis thus adding to her vulnerability and risk.

9.2.2. L was diagnosed with Autistic Spectrum Disorder during her time at Priory Hospital Cheadle Royal, this was a private assessment arranged by her family. Many acute mental health patients have neurodevelopmental conditions and may benefit from early testing when they are in contact with community and acute mental health settings. Early assessment makes sure people are placed on the right pathway and may reduce admissions to acute mental health settings and the need for out of area admission. L's consultant identified that autism was the more challenging of her diagnoses. This meant that L had a specific vulnerability that raised her risk, and her new diagnosis should have created additional oversight of the sufficiency and length of time of her admission.

9.2.3. There is limited evidence that her new diagnosis changed the way that her case was considered or increased the urgency to get her to a different environment. There is feedback from her home team that the Autistic Spectrum Disorder diagnosis during her time at Priory Hospital Cheadle Royal may have contributed to some uncertainty about the most appropriate care and treatment pathway/environment to best meet L's needs

9.2.4. The new Mental Health Bill makes specific provision for people with autism and learning disability in term of placing a limit of 28 days for which they can be detained unless they have a co-occurring mental health condition. It is difficult to conclude in retrospect what this might have meant for L, but it may have escalated the concerns about the length of time that she remained in a Psychiatric Intensive Care Unit unnecessarily.

Finding 2

Whilst only one of the people in review was diagnosed with Autistic Spectrum Disorder and this diagnosis was in the latter stage of the timeframe, it highlights that added complexity contributed to further transfer delays in L's case. This in turn highlighted a lack of availability of suitable local provision to meet her needs.

9.3. Out of area admissions

9.3.1. The NICE guideline and gold standard for Emotionally Unstable Personality Disorder recommends psychological therapies for managing and treating the disorder, with a strong emphasis on therapies like dialectical behaviour therapy (DBT). Because of the variety of symptoms and variation in needs, flexible approaches that are responsive to the needs of each person are important. This involves structured, long-term treatment plans, developed collaboratively with the person. The guideline also specifies the need for a comprehensive care plan, including risk management and social care needs.[14]. However, access to the most appropriate gold standard treatment may not always be available in a person's local/geographical area of living.

9.3.2. An 'out of area admission' for acute mental health in-patient care happens when a person with assessed acute mental health needs who requires adult mental health acute inpatient care, is admitted to a unit that does not form part of the usual local network of services.

9.3.3. The Health Services Safety Investigations Body investigation report identified that harm can be caused by out of areas admissions including dying by suicide, misadventure, physical, psychological, distress and anxiety and we can apply those findings directly to all three of the women in this case and their families. This harm was due to the prolonged out of area admission and/or delayed discharge and transfer of care, and the impact of being far away from their normal support network. Identified in the agency information is evidence of significant anger, frustration and loss of trust in the mental health system as a result of their experiences.

9.3.4. Where mental health inpatient services are commissioned by Integrated Care Boards/ National Health Service providers on their behalf and spot purchased, this can lead to care for people in a single location originating

[14] https://www.nice.org.uk/guidance/qs88

from multiple and dispersed geographical areas. We know that in the case of Priory Hospital Cheadle Royal, whilst their beds are contracted to the National Health Service regionally (Northwest of England), beds are also spot purchased by a range of commissioning organisations. The inquest into L identified that Priory Hospital Cheadle Royal deals with 42 National Health Service commissioning organisations. By inference Priory Hospital Cheadle Royal is regularly working with a range of arrangements from different geographical areas.

9.3.5. It could be said that out of area admissions are an indicator of a whole mental health system under pressure, not simply the result of too few acute mental health beds. A lack of focus on prevention, high levels of delayed discharges, increasing pressures in community care, lack of crisis response, and a rise in Mental Health Act use can all increase the pressure on bed capacity, which can in turn lead to reliance on out of area beds. This creates significant risk, patient safety issues and safeguarding concerns in turn.

9.3.6. To note, there is distinction between Psychiatric Intensive Care Units and Acute Mental Health Units and there may be differences in terms of clinical oversight processes from a national perspective. In terms of application of learning since the cases included in this Safeguarding Adults Review there have been changes in terms of home team oversight. Dorset Health Care University National Health Service Foundation Trust now have an out of area care coordinator. Cornwall and Isles of Scilly Integrated Care Board have developed a targeted repatriation team for all out of area Psychiatric Intensive Care Unit and acute admissions. From the Priory Hospital Cheadle Royal perspective, it is noted that a new standard operating procedure for delayed discharge has been implemented.

9.3.7. National Health Service organisations can improve patient safety by maintaining clinical and welfare oversight and responsibility for patients being treated in an out of area mental health bed. This can ensure harm is minimised and that patients are returned to their sending hospital/area as soon as possible. The review has also considered the themes of length of stay and system oversight locally and through the relationships with home and host commissioner (in its widest sense), and some inconsistency has been identified.

9.3.8. It was generally acknowledged throughout the course of this review that where possible the home areas would avoid out of area admissions and

only admit people into "out of area" beds when 'local' options are exhausted and following a full clinical review. This does also link back to the points made earlier in terms of complex clinical need, availability of specialist provision, least restrictive practice, length of stay and provision of care and treatment pathways to support an individual's complex needs in the most appropriate care environment.

Finding 3

It is acknowledged by this review and via national learning that out of area and prolonged inpatient stays can cause deterioration and harm. In two of the cases considered, delayed inpatient stays in restrictive environments contributed to deterioration and increased risk and there was a lack of availability of options for the most appropriate care in their local areas. In L's case there are multiple references to the sense of desperation felt at the length of stay and the distance from family. This finding was included in the Coroner's Prevention of Future Deaths reports and is acknowledged as a national challenge and not unique to the cases considered in this review.

9.4. The robustness of the system to provide patient safety and quality oversight from the commissioners

9.4.1. In this case there were three women who tragically died as inpatients in mental health settings, and this review highlights that that enhanced systems oversight was needed but lacking.

9.4.2. Therefore, we know there were red flags and concerns about each person due to increased risk, safeguarding incidents, delayed discharge and new diagnoses (not exhaustive). We also know that the system as a whole did not function to flush out these issues and respond to them in a timely way.

9.4.3. Quality assurance responsibilities in this case were captured through direct communications through the spot purchasing arrangements in each case, through multi-disciplinary team meetings, care programme approach meetings, care treatment review meeting (L) and telephone and email communications. The review has not been presented with evidence of formal contracts or quality assurance arrangements between the home commissioner and the host commissioner (which was a Clinical Commissioning Group) at the time of admission for L, B and the Integrated Care Board at the time of admission for A).

9.4.4. As a point of observation, the reviewer received differing explanations of the arrangements in these cases. Therefore, overall, the representation and understanding of the contractual (or non-contractual) oversight was not consistent for the purpose of this review.

9.4.5. There was no legal duty placed on hosting commissioners of acute mental health provision at the time of these incidents. To note, there are National Institute for Health and Care Excellence quality standards for high dependency services and National Health Service guidance for acute Out of Area admissions. There is also guidance for hosting authorities of Learning Disability and Autism provision.[vii] This is relevant to L who to note, was diagnosed with Autistic Spectrum Disorder during her time at Priory Hospital Cheadle Royal and not before.

9.4.6. It may be simpler to break down the quality assurance responsibilities and patient oversight and responsibilities between the key partners in this review. Depending on the exact circumstances of each admission, "home" teams are tasked with managing the relationship, supported by corporate contracting and commissioning teams within their organisations.

9.4.7. It is important to note that the landscape has changed since the deaths of B and L and what were then Clinical Commissioning Groups, transformed into wider Integrated Care Boards in July 2022[15]. In L's case, the care coordination and the commissioning of provision came from the local National Health Service Trusts on behalf of the Integrated Care Board/Clinical Commissioning Group. In B's case, admission was commissioned by the Integrated Care Board/Clinical Commissioning Group and care coordination was led by local National Health Service Trust with external commissioner (clinical reviewer) oversight. In A's case her admission was commissioned by the local National Health Service Trust on behalf of the Integrated Care Board. Some of the standard factors that should be explored prior to admission are:

- Quality of the provider – Care Quality Commission reports and previous intelligence
- Listening to patients, family/carers and advocates to ensure needs are understood and met at admission.
- Ensure treatment goals are appropriate, is the provision suitable?

15 Integrated care boards are NHS organisations responsible for planning health services for their local population.

- Due diligence for admission such as reviewing the provider, and review policies and procedures as part of the contract.
- Arrangements for case reporting back to home commissioner with a regular reporting schedule
- Information sharing agreements.
- Regular site visits and arrangements to attend and coordinate appropriate clinical review forums such as multi-disciplinary team and care programme approach meetings.
- Discharge planning from point of admission.
- Notification of any incidents and resulting actions e.g. Safeguarding referral

9.4.8. Explored in this review is the complex interrelationship between "host" and "home" and "provider" and "wider system" and the absence of a formal arrangements to ensure safe and robust processes.

9.4.9. It is useful to consider current and emerging practice to define roles and responsibilities. Pilot guidance produced by the Midlands regional mental Health Quality Oversight Group sets out the "enhanced" responsibilities of a host Integrated care Board for the quality oversight and monitoring of specialist non-secure mental health inpatient National Health Service and independent provision in their geographical areas.

9.4.10. This guidance is entitled "Mental Health Host and Home Integrated Care Board guidance" and makes clear the expectations of the role of the home Integrated Care Board for the oversight of the care of the people that are placed in a mental health unit outside of the Integrated Care Board geography where the person is usually resident. It is underpinned by the aforementioned National Health Service - Learning Disability and Autism Host Commissioner Guidance.

9.4.11. Fundamental to the implementation of the guidance is the requirement to involve and listen to the voices of people, families and carers and independent advocates in the oversight of the quality of care and safety of people. Specifically in L's case we know that her parents tirelessly advocated for her and represented her distress, their worries and concerns about her delayed discharge but this did not influence or escalate risk when it should have done.

9.4.12. In B's case it is acknowledged that she had requested an admission in an area away from her home and this was supported by her family. There is also evidence that Cornwall and Isles of Scilly Integrated Care Board undertook

reviews prior to and during her admission to consistently hear her voice in terms of her provision.

9.4.13. There are also a number of national guidance documents that require analysis and thought when improving oversight methodology to include:

- National Guidance on Quality Risk Response and Escalation[viii]
- State of care 2022/2023- Care Quality Commission[ix]
- Getting It Right the First Time national report for mental health rehabilitation (2022)[x]
- National Health Service Commissioning framework for mental health inpatient services (2023)[xi]
- National Health Service Acute inpatient mental health care for adults and older adults (2024)[xii]
- National Health Service commissioner guidance for adult mental health rehabilitation service (2024)[xiii]

9.4.14. The integrated guidance developed by Midlands sets out a clear expectation that the detailed description of the role of the home Integrated Care Board will make sure that the host Integrated Care Board has at hand the intelligence needed to identify early warning signs of quality and safety issues. In this thematic review there were early and later warning signs present:

- Length of stay
- Effectiveness of the delayed discharge protocol
- Effectiveness of escalation
- Diagnostic discrepancy
- Lack of influence of the voice of person, family, advocate in changing the situation
- An increase in serious incidents (some were reported within Priory Hospital Cheadle Royal Datix incident reporting system, and some were reported to Stockport Adult Social Care as safeguarding incidents)
- Allegation of sexual assault
- Timeliness of actions from multi-disciplinary team recommendations

9.4.15. In consideration of the above, the review finds that the approaches to commissioning, patient safety, quality and safeguarding oversight did not work to create a coherent "systems" approach. A robust approach maintaining oversight of concerns, risks and discharge issues would have given the Priory Hospital Cheadle Royal the opportunity to ask the host Integrated Care Board for advice and support about such matters. As it was,

the lines of communication between the home commissioner, the host commissioner and the provider were not opened up.

9.4.16. There is insufficient evidence of a formal process or agreement between the home commissioners and the host commissioner for these cases. This meant that when concerns started to escalate, there wasn't an effective communication process in place. Home commissioners were only aware of the concerns with their own cases, whereas host commissioners may have had a wider "helicopter" view if the system was connecting in a different and systematic way to capture serious incidents, safeguarding concerns, and delays in transfer of care.

Finding 4

There is a wide variance in terms of arrangements nationally for system oversight of quality, patient safety and safeguarding. There is also variance across the organisations involved in this review. Whilst the review has found a strengthening of local systems, there is a lack of assurance that the issues present in these cases would not occur again elsewhere. In particular and illustrated through this thematic review is the scale of challenge for Stockport as the "host" area for people placed with Priory Hospital Cheadle Royal, and the sufficiency of their resource to appropriately support the provider to manage safeguarding, quality concerns and patient safety incidents. This will be a challenge for many other areas nationally who have large amounts of people placed from outside their area. This should be acknowledged as an area requiring a national steer and guidance.

9.5. Safeguarding

9.5.1. This follows on from the previous section but specifically, we know that there were safeguarding incidents reported in respect of B when she ingested lithium batteries and when she alleged she had been sexually assaulted, for L on two occasions when she required hospital treatment to remove objects she had ingested and for A on one occasion when she self-harmed and obtained and drunk alcohol on the unit.

9.5.2. In L's case safeguarding referrals were made by a local acute hospital after she required treatment to remove ingested items, Priory Hospital Cheadle Royal investigated these incidents, and learning was actioned with the staff involved and across the service.

9.5.3. In A's case a safeguarding referral was made due to self-harm and alcohol use whilst she was under 1-1 supervision. The Local Authority report that they attempted to progress this referral and escalated this within Priory Hospital Cheadle Royal due to an absence of response.

9.5.4. In Bs case, she required acute hospital treatment after ingesting lithium batteries and this prompted a safeguarding referral which was investigated by Priory Hospital Cheadle Royal and did not require a section 42 enquiry[16]. In response to the allegation of sexual assault, a Section 42 enquiry was commenced, and Police carried out an investigation that concluded after she died. Although the home team were aware of the second incident, there is no evidence that the local agencies (Stockport) met with the home team to consider the incident or whether it may have clinically exacerbated an already deteriorating situation.

9.5.5. We know in B's case there were over 40 "significant" incidents including ligatures, ingestion and other methods of self-harm. We know that her parcels were being checked, to look for means of self-harm, as a proportionate response to her risks. There were also many more significant incidents in L's case and in A's too. A finding of the Priory Hospital Cheadle Royal Patient Safety Incident Investigations was that not all incidents were reported on their incident reporting system. This may mean that inconsistent reporting of patient safety incidents may limit identification of themes or trends or particular patient risk issues.

9.5.6. Conversely, there were other similar incidents that were not raised as safeguarding concerns, this includes incidents of significant self-harm, some requiring hospital treatment and some, where an emergency response was needed in the clinical areas. To note, there was an additional factor in that due to the geographical position of Priory Hospital Cheadle Royal, the women were taken to different acute hospitals at different times thus widening out the number of contacts and providers and resulting in an absence of consistent response.

9.5.7. This raises the question of the interrelationship between patient safety incidents, consistency of application of safeguarding thresholds and the system ability to have oversight of areas that are showing increased patterns or trends. This would internally alert the provider in the first instance, and subsequently the wider system such as the local authority

[16] A Section 42 enquiry is a process undertaken by a local authority in response to concerns about an adult at risk of abuse or neglect, as outlined in the Care Act 2014.

and Integrated Care Board to a high level of risk which may be indicated through quality and safeguarding oversight. It is acknowledged that local system arrangements may differ across geographical areas.

9.5.8. Local (Stockport) methodology to increase oversight and triangulate incidents includes review of delayed discharges, site visits, and oversight of themes and trends though "heatmaps" presented at regular relationship meetings. Additionally, if there are concerns about any provider, there are joint mechanisms within the Integrated Care Board and Local Authority for enhanced system quality oversight processes. Examples of themes and trends may include an increasing number of safeguarding incidents or patient safety incidents which may apply to an individual patient, location or set of patients prompting increased scrutiny. In turn this may lend itself to strengthened system thresholds, oversight and escalation where required.

9.5.9. For clarity, not all self-harm incidents necessarily require a safeguarding response. While self-harm is always serious, not every instance would automatically result in safeguarding action and a Section 42 safeguarding enquiry under The Care Act 2014. Where there are no concerns that care plans and risk assessments have not been followed, then safeguarding under Section 42 would not necessarily be required. If the person has mental capacity and is making an informed decision to self-harm, and there is no evidence of coercion, abuse, or neglect, safeguarding may not be the appropriate route. Instead, mental health services or risk management planning might be more suitable. This means that if the self-harm is not linked to abuse, neglect, or self-neglect (as defined in safeguarding guidance), then it may fall outside the safeguarding remit and be better addressed through clinical or therapeutic support.

9.5.10. Of course, each incident is assessed individually. From a wider system perspective, whilst individual case clinical oversight from "home" commissioner may facilitate case reporting, it would not provide overall insight in terms of wider themes or trends which would usually come from quality reporting via a contract. This points toward the need to strengthen home and host commissioner arrangements.

9.5.11. We can also see in these cases there was not consistency about how they were reported, managed, how information was shared and whether the full picture was explored. In B's case the allegation proceeded to a section 42 enquiry. In A and L's case, the self-harm incidents that were raised as safeguarding concerns were investigated by Priory Hospital Cheadle Royal and one incident was discussed at the Harms Level Panel. To note, the

Harms Level Panel was a multi-agency panel that would review the provider enquiries from a quality perspective. Quality oversight is now done as part of the Causing Others to Make Enquiries Process.

9.5.12. To note, for any provider such as Priory Hospital Cheadle Royal, wherever they may be geographically, a national solution is necessary to create consistency of understanding across organisations. This is demonstrated in Stockport in consideration of the size of Priory Hospital Cheadle Royal, as there is an obvious challenge in terms of ongoing communication with all the Integrated Care Boards who may be placing people out of their home areas.

9.5.13. Priory Hospital Cheadle Royal have included actions in their serious incident investigations to strengthen patient safety and safeguarding reporting. Relationships between Stockport Safeguarding Adults Board and Priory Hospital Cheadle Royal have also been strengthened and in 2024 the Stockport Safeguarding Partnership developed a Safeguarding Risk Matrix to support decision making across the partnership about what needs to be referred into the Local Authority to be investigated under the section 42 process. This will support any provider in respect of what to report and will provide consistency. In practice this means that all section 42 Enquiries are overseen by the Local Authority and quality checked. With reference to the cases in this review, the process also ensures that the home teams are cited on any concerns and actively involved in the protection and planning moving forward.

Finding 5:

There were a high number of patients safety incidents some of which resulted in safeguarding action. The application of local safeguarding thresholds, and the methodology for safeguarding response was not consistently applied by the agencies involved. Furthermore, the home teams were not always aware of incidents and actions as they were happening.

9.6. Delayed transfers of care

9.6.1. Delays in discharge or transfers of care is identified as the most significant challenge and driver for the use of out of area admissions. The Health Services Safety Investigations Body investigation found that if discharge could be addressed "systemically" then flow would improve. All National Health Service trusts and out of area providers told the Health Services

Safety Investigations Body investigation that the most significant factor preventing timely discharge was the lack of health and social care integration and collaborative working. National Health Service England told the investigation that challenges relating to discharge had an impact on flow through the system and could create additional harm to patients, as previously mentioned in this report.

9.6.2. We know that all three women experienced harm due to the nuances and delays in accessing an appropriate provision in a timely way to respond to their levels of risk. This was clearly identified by the coroner and reflected in the Prevention of Future Deaths reports that were issued in two cases.

9.6.3. The factors evident in these cases and nationally include insufficiency in local provision and an over-reliance by the National Health Service on independent providers for mental health beds whether general acute beds, Psychiatric Intensive Care Unit beds or specialist units. Also identified in two of the inquests in this case was a "*national scarcity of specialist Personality Disorder rehabilitation units*".

9.6.4. Panel members observed that the independent healthcare sector contracted to provide National Health Service services are valued within the system. This is because they provide additional capacity, specialist care, and additional patient choice. It was also highlighted that there are established National Health Service contractual and Quality Assurance frameworks to support National Health Service provider capacity and enhance patient choice- this resonates in B's case. Central to this is quality assurance oversight and performance indicators provided through the National Health Service standard contract which are:

- Standardisation
- Clarity and Transparency
- Quality Assurance
- Financial Accountability
- Performance Management
- Risk Management
- Flexibility:

9.6.5. Cornwall and Isles of Scilly noted that whilst this is standardised, the contract allows for some local tailoring through the "particulars" section, enabling commissioners to address specific local needs. In essence, the National Health Service Standard Contract provides a robust framework for

commissioning services from independent providers, promoting quality, accountability, and efficiency within the National Health Service system. However, for independent providers who do not agree to the terms of the National Health Service standard contract, Cornwall and Isles of Scilly commission "care by exception". Again, this may vary on a national level.

9.6.6. The review has considered specific blockers:

- Ineffectiveness of the Delayed Discharge Protocol via the provider, and subsequent lack of escalation into the wider system.
- Insufficient and untimely oversight by the home teams in terms of delayed transfers of care, escalation and action.
- Delays caused by funding due to a complex arrangement for decisions for certain types of provision.

9.6.7. It is noted that action has been taken by Dorset Healthcare University National Health Service Foundation Trust to strengthen their oversight of delayed transfers of care with the appointment of a designated care co-ordinator for its out of area patients. A single point of contact will strengthen robust communication and oversight of delays and risks. This development relates to the Prevention of Future Deaths report from the Coroner in L's Case.

9.6.8. Also noted is the action taken by Cornwall and Isles of Scilly Integrated Care Board in response to B's death which included a review of any people out of the county, recommendations for oversight of Psychiatric Intensive Care Unit and acute mental health wards. Additionally, a revision of the processes to seek assurance prior to commissioning out of area, which now includes checks and balances with local social care teams and Integrated Care Board about any safeguarding concerns and intelligence such as Care Quality Commission inspection information and or incidents which may not be in the public domain. Also, improvements in communication, escalation, contingency planning and specifically training and awareness of online access in secure hospital settings with a focus on sodium nitrate.

9.6.9. The Priory Hospital Cheadle Royal shared some of the challenges it faces in dealing with a significant number of different commission organisations. There is a challenge of having a consistent approach when dealing with variance in the commissioning landscape.

9.6.10. Priory Hospital Cheadle Royal acknowledge that their application of the delayed discharge escalation was not effective in these cases and have

since reviewed their processes and implemented a protocol/standing operating procedure in respect of delayed discharge. This, if applied stringently should reduce the risks of a patient being delayed in their move to a care and treatment pathway in the most appropriate care environment repatriation. It includes a number of escalation points and action. It should be noted that this still relies on the actions of the home commissioner, of which there are multiple.

9.6.11. There is also the matter of a national shortage of local National Health Service mental health beds (acute, Psychiatric Intensive Care Unit and specialist). Mentioned earlier is the Health Services Safety Investigations Body report (2024) which found that despite the government commitment to eliminate out of area mental health admissions, the number increased in 2023 and therefore this is a national issue to resolve. The cases considered here also highlight insufficiency in the availability of robust community based residential provision that can manage complex risk in the least restrictive way.

Finding 6

Finding 3 captures this section in part. It is acknowledged that the organisations involved in this review have all applied learning and implemented new systems to mitigate against delayed transfers, but their effectiveness is likely to continue to be impacted by the low national availability of specialist provision.

9.7. Person, family/carer voice

9.7.1. Patient, family and carers wishes and preferences are required in the Mental Health Act 1983: Code of practice and are not always reflected or documented by health and care staff. This creates a frustration when people feel that they are not being listened to or that their views are important when making decisions.

9.7.2. When patients do not have the support of family or carers, or if there are differences of opinion, advocacy services are vital for a patient to be able to put forward their views for consideration in decision making.

9.7.3. The review has found variance in relationships with the families, and the role of advocacy. Evidence of frequency and the range of advocacy should be integral to quality reporting and demonstrate how effective the voices of

people, and their families are to care. It should be noted that A requested for her family not to be contacted.

9.7.4. The new Mental Health Bill (2025) seeks to strengthen the voice of patient, family and advocate in terms of decision making and specifically when an out of area admission is needed, thus causing delays in repatriation/ identification of a care and treatment pathway that supports the individual's complex needs in the most appropriate care environment.

9.7.5. There was a sense of the patients' voice, and in some cases the families in the cases presented here. The reviewer was able to capture a sense of the level of distress, dissatisfaction and desperation through the words of the people involved. However, to reiterate it didn't make a difference in terms of tangible actions to alleviate the problem at hand. Additionally, how the "voice" was expressed in other ways such as through incidents and events, was not taken into account as a significant warning sign that urgent action was needed.

Finding 7

In the cases considered there are differences in terms of what we know about the views of the people concerned. The way in which they are evidenced to express themselves, the family role and the use of advocacy was individual to each person. We do know that each person expressed concerns about the environment that they were in, which was supported in clinical recommendations. The extent to which their concerns influenced their situation was superseded by a range of system challenges described within this report. Patient voice should correlate directly with care planning, discharge planning and patient safety, meaning that issues are resolved quickly, dealt with earlier and result in fewer incidents of harm.

10) Conclusion

10.1. This review captures the tragic deaths of three women who were in mental health settings. They were all individual people with their futures ahead of them, and families that miss them, and they had challenges, issues and difficulties that they needed help to overcome. Despite the individual efforts of agencies and services to meet their needs, systemically they were failed. These failings are multifaceted, some within the local gift to overcome and others reliant on a national system change.

10.2. It is to note that the landscape is likely to be changing again in the future and thus when considering the question of whether this could happen again, ensuring the right safeguards are in place is never more important. In summary:

- There is variance nationally (reflected in the cases in this review) in the arrangements between the host and home commissioners and this creates a lack of consistency in the review frameworks. This creates challenges for providers such as Priory Hospital Cheadle Royal who work within a high number of "home" commissioning arrangements.

- The approach to safeguarding incidents should be consistently applied in terms of duty to report concerns when safeguarding concerns are raised. This should include clear local safeguarding arrangements to facilitate the connections with the "home" teams and consequently robust oversight of emerging themes either systemically or individually. It is acknowledged that the Risk Matrix and Decision-Making tool in Stockport was implemented in 2024 to facilitate consistent approaches.

- The points of escalation when there are delays in repatriation, transfer, or an identified need for an alternative care and treatment pathway in a different and more appropriate care environment should be clear in the wider system, not just in a provider protocol. This requires contingency planning in case the objectives of the admission are not met. One such example of strengthened oversight and assurance is the Cornwall and Isles of Scilly "prior approval" form.

- The voice of the person and their family should influence actions and decision making about care. This should be balanced with clinical views on risk and safety with clear processes if there are differences of opinion. Advocacy should form part of this.

- Complex mental health requires services to work together to jointly assess need and work together flexibly across service boundaries to support people safely and support individual recovery. Stakeholders involved in this review articulate ongoing work to improve mental health, learning disability and autism pathways and reduce out of area admissions. One such approach and example is in Cornwall and Isles of Scilly in the introduction of an intensive assertive outreach pathway because inpatient care is not always optimal for recovery and can in some instances cause harm. For reference, phase 1 of this pathway relates to psychosis and is underway, phase 2 is due

to commence in 2026 following a scoping of need, to include complex emotional needs and neurodiversity presentation.

10.3. It is to be hoped that the deaths of L, B and A will positively influence the way the system respond to people in great need of help.

11) Summary of findings:

Summary of findings	
Emotionally Unstable Personality Disorder and provision of services	**Finding 1** There was a challenge in each case in identifying the most appropriate therapeutic provision to meet the complex needs of each individual in this review, and the reasons this were multi-faceted. This may also have been exacerbated by the geographical distance between home and placement, with the person being somewhat out of sight due to the less frequent face to face oversight from "home" teams. Mitigations against delays are dependent on effective relationships between provider and home teams, and robust escalation points where delays and challenges are identified. In these cases, the mitigating actions were not effective, contributed to by a national shortage of provision and an absence of national guidance relating to appropriate environments for complex risk patients who require a less restrictive care environment.
Autistic Spectrum Disorder and provision of services	**Finding 2** Whilst only one of the people in review was diagnosed with Autistic Spectrum Disorder and this diagnosis was in the latter stage of the timeframe, it highlights that added complexity contributed to further transfer delays in L's case. This in turn highlighted a lack of availability of suitable local provision to meet her needs.

Out of area admissions	**Finding 3** It is acknowledged by this review and via national learning that out of area and prolonged inpatient stays can cause deterioration and harm. In two of the cases considered, delayed inpatient stays in restrictive environments contributed to deterioration and increased risk and there was a lack of availability of options for the most appropriate care in their local areas. In L's case there are multiple references to the sense of desperation felt at the length of stay and the distance from family. This finding was included in the Coroner's Prevention of Future Deaths reports and is acknowledged as a national challenge and not unique to the cases considered in this review.
Patient safety and quality oversight	**Finding 4** There is a wide variance in terms of arrangements nationally for system oversight of quality, patient safety and safeguarding. There is also variance across the organisations involved in this review. Whilst the review has found a strengthening of local systems, there is a lack of assurance that the issues present in these cases would not occur again elsewhere. In particular and illustrated through this thematic review is the scale of challenge for Stockport as the "host" area for people placed with Priory Hospital Cheadle Royal, and the sufficiency of their resource to appropriately support the provider to manage safeguarding, quality concerns and patient safety incidents. This will be a challenge for many other areas nationally who have large amounts of people placed from outside their area. This should be acknowledged as an area requiring a national steer and guidance.
Safeguarding	**Finding 5:** There were a high number of patients safety incidents some of which resulted in safeguarding action. The application of thresholds, and the methodology for safeguarding response was not consistently applied

	by the agencies involved. Furthermore, the home teams were not always aware of incidents and actions as they were happening.
Delayed transfer of care	**Finding 6** Finding 3 captures this section in part. It is acknowledged that the organisations involved in this review have all applied learning and implemented new systems to mitigate against delayed transfers, but their effectiveness is likely to continue to be impacted by the availability challenges of local specialist provision.
Person, family/carer voice	**Finding 7** In the cases considered there are differences in terms of what we know about the views of the people concerned. The way in which they are evidenced to express themselves, the family role and the use of advocacy was individual to each person. We do know that each person expressed concerns about the environment that they were in, which was supported in clinical recommendations. The extent to which their concerns influenced their situation was superseded by a range of system challenges described within this report. Patient voice should correlate directly with care planning, discharge planning and patient safety, meaning that issues are resolved quickly, dealt with earlier and result in fewer incidents of harm.

12) Recommendations:

Recommendations	
Recommendation 1:	This report should be shared with each of the "home" Safeguarding Adults Boards for consideration of the recommendations, practice improvements and action planning across their own geographical areas.
Recommendation 2:	To raise awareness of the findings and learning, this report should be escalated using the national escalation protocol facilitated through the National Safeguarding Adults Board Chairs Network. In additional, Stockport and the associated Safeguarding Adults Boards should consider methods of sharing the learning through National Health Service England structures, Association of Directors of Adult Social Services, business managers networks and any other appropriately placed local, regional and national networks.
Recommendation 3:	Safeguarding Adults Boards involved in this review should be assured that all relevant local providers have effective processes to identify increasingly high-risk patient safety incidents including patterns of self-harming behaviours, to include application of thresholds for reporting of safeguarding concerns. Locally, this may be a measure of effective application of the Stockport Safeguarding Adult Partnership Risk Matrix and Decision-Making Tool.
Recommendation 4:	There is a need for host commissioner guidance for mental health which synchronises with existing processes (such as care treatment review) to be implemented and tested. The aim of this is to strengthen the quality, patient safety and safeguarding oversight of independent providers within their area, with particular reference to patients who are placed in their geographical areas from outside of that area.

	However, this report acknowledges that to achieve this is beyond the reach of any individual area involved in this review and recommends that this action should be directed on a national footprint. Regional National Health Service areas are asked to share this recommendation centrally with National Health Service.
Recommendation 5:	This review has highlighted: - A challenge about the availability of local specialist provision for people with an Emotionally Unstable Personality Disorder diagnosis and how this challenge is addressed though commissioning channels. - Acknowledging the NICE guideline and gold standard for treatment, the panel agreed that these cases highlight an absence of a nationally recognised and effective trauma informed pathway for Emotionally Unstable Personality Disorder and neurodevelopmental conditions to include length of stay, appropriateness of provision, and contribution of patient and family voice. **However, this report acknowledges that to achieve this is beyond the reach of any individual area involved in this review and recommends that this action should be directed on a national footprint. Regional National Health Service areas are asked to share this recommendation centrally with National Health Service England.**
Recommendation 6:	The review recommends the development of national guidance relating to appropriate care and treatment pathway that supports the individual's complex needs in the appropriate care environment. **However, this report acknowledges that to achieve this is beyond the reach of any individual area involved in this review and recommends that this action should be directed on a national footprint. Regional National Health Service areas are asked to share this recommendation centrally with National Health Service.**

Recommendation 7:	The review has highlighted that there may be variance in terms of the extent to which a person's voice and that of their family influences their care planning and provision. It is recommended that the Safeguarding Adults Boards involved in this review seek reassurance about the use of generic/ non-statutory advocacy services and review the extent to which patient voice is embedded into quality assurance oversight processes.

Appendix 1

Summary of the national position:

The Lampard Inquiry which is actively occurring at this time. The Lampard Inquiry is an independent statutory inquiry investigating the deaths of mental health inpatients in Essex. The terms of reference for the Inquiry include some broadly similar themes to this thematic review to broadly include:

- Patient safety and risk
- Listening to the patients and their families, and the extent to which this influences decisions about care.
- The interface between the provider and the commissioners of the provision (and other bodies)
- Autism and mental health.

The Health Services Safety Investigations Body came into operation in 2023 as an independent "arm's length body" of the Department of Health and Social Care. The role of the Health Services Safety Investigations Body is to investigate patient safety concerns across the National Health Service in England, and in independent healthcare settings where safety learning could improve National Health Service care.

In June 2023 the Secretary of State for Health and Social Care announced that the Health Services Safety Investigations Body would undertake a series of investigations focused on mental health inpatient settings. Their thirds investigation published in November 2024 explored the patient safety risks associated with inappropriate out of area admissions, including those for adult, older people and children and young people. The Health Services Safety Investigations Body describe the report to be *"intended for healthcare policy makers to help influence improvements in patient safety and therapeutic care. It is also intended for those who work in and engage with mental health inpatient settings, such as integrated care boards and local authorities".* The report draws direct parallels to the themes we are exploring and is a helpful reference point.

Very broadly the findings capture the following areas:

- Involvement of patients, family and carers and the use of advocacy services in terms of decisions about care.
- Harm caused due to the impact of out of area admissions, and being away from support networks.

- Variance of arrangements for governance, oversight, accountability and processes.
- Late assessments for neurodevelopmental conditions.

The investigation made "safety recommendations" to the Department of Health and Social Care and "safety observations" for National Health Service organisations and mental health inpatient services.

The Mental Health Bill (2025) is currently progressing through Parliament setting out planned changes to the Mental Health Bill. Key points include:

- strengthening and expanding the rights of a detained person to appeal their detention and the right for someone to represent them
- strengthening and clarifying the detention criteria to make sure people are only detained if they are a danger to themselves or others
- reforming the use of "community treatment orders"
- stopping the unnecessary detention of people with a learning disability and/or autism, by creating a 28-day limit for detention, unless they have a co-occurring mental health condition that requires hospital treatment
- introducing statutory care plans for people detained under the Mental Health Act
- changes to involve patients more in decisions about their care, including a new clinical checklist and helping patients make an advance choice document about their care
- ending the use of police cells and prisons as places of safety

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[i] Coroners | The Crown Prosecution Service (cps.gov.uk)
[ii] Revised Chief Coroner's Guidance No.5 Reports to Prevent Future Deaths[i] - Courts and Tribunals Judiciary
[iii] Care Quality Commission
[iv] Gamlin C., Varney A., Agius M. Emotionally unstable personality disorder in primary care: a thematic review and novel toolkit. Psychiatria Danubina. 2019;31(Supplement 3):282–289
[v] Björkenstam E., Björkenstam C., Holm H., Gerdin B., Ekselius L. Excess cause-specific mortality in in-patient-treated individuals with personality disorder: 25-year nationwide population-based study. The British Journal of Psychiatry. 2015;207(4):339–345
[vi] National Collaborating Centre for Mental Health. Borderline Personality Disorder: Recognition and Management. National Institute for Health and Care Excellence Clinical Guidelines website: NICE guidelines; 2009
[vii] NHS England » Learning disability and autism – host commissioner guidance
[viii] NHS England » National Guidance on Quality Risk Response and Escalation in Integrated Care Systems
[ix] State of Care 2022/23 - Care Quality Commission
[x] Mental Health – Rehabilitation - Getting It Right First Time - GIRFT
[xi] NHS England » Commissioner guidance for adult mental health rehabilitation inpatient services
[xii] NHS England » Acute inpatient mental health care for adults and older adults
[xiii] NHS England » Commissioner guidance for adult mental health rehabilitation inpatient services