Bedford Borough and Central Bedfordshire Safeguarding Adults Board

Safeguarding Adults Review Case A (2017)

Overview Report

Concerning the death of Miss A on 28th July 2016

Independent Author

Pete Morgan BA, MA, MA & CQSW

Contents

1. Introduction

1.1 This Safeguarding Adults Review (SAR) has been conducted as a statutory review under Section 44 of the Care Act 2014 and in line with the Multi-Agency Safeguarding Adults Policy and Procedures and with the Bedford Borough and Central Bedfordshire Safeguarding Adults Board's (the Board) SAR Framework (SARF) – see Appendix A

1.2 For the purposes of this review report and in order to protect the identities of those involved the subject will be known as Miss A.

1.3 It is easy for Safeguarding Adults Reviews and Overview Reports to focus on events and the involvement and actions of a number of agencies; it is important that this Safeguarding Adults Review and this Report recognise that, at its centre, is a human being and her family, who should both be treated with respect and their human rights protected.

1.4 Miss A was born on the 9th April 1981 in London and was 35 years old at the time of her death.

1.5 Miss A was single and is survived by her mother and father and an older sister.

1.6 At the time of her death, Miss A was a resident at Pathway House; although registered separately from the inpatient facilities in the Milton Park Therapeutic Campus in Wyboston, Bedford it was also owned by Brookdale Care and was seen as a stage in a progression pathway from the in-patient facilities. Miss A had been placed there by the Sussex Partnership NHS Foundation Trust (SPFT) on the 29th December 2015 as a voluntary patient on the Ashwood and Elstow 1 Units, both locked wards, before transferring to Pathway House, a registered care home within the Campus on the 17th February 2016.

1.7 Miss A was diagnosed with 'borderline hyperactivity' at the age of four; at primary school, she struggled to read and found it hard to form friendships. At the age of seven, she was diagnosed with Dyslexia and, at the age of eight, transferred to a specialist school, where she began to read within a term. At the age of ten, she returned to mainstream education at her old school. She attended an all-girls secondary school where she was academically successful but became isolated and ill through the increasing impact of her Anorexia.

1.8 Miss A, despite appearing unhappy and becoming obsessive about her weight and socially isolated, completed both her GCSEs and A levels. She completed a Foundation course at Wimbledon Art College but was too unwell to take up a place at university as she had planned. After several hospital admissions, Miss A subsequently completed, with a Distinction, a part-time creative writing course at Birkbeck College, London. This enabled her, at the age of 26, to read English at the University of Sussex.

1.9 Miss A had had contact with mental health services from the age of twelve. In the years before she went to University she was in Eating Disorder Units, first at St George's Hospital, Tooting and then the Maudsley Hospital from 2000 to 2005 for

treatment of Anorexia Nervosa; in 2002 Miss A was compulsorily detained under s3 of the Mental Health Act 1983 (the MHA) after a suicide attempt. She was further assessed under the MHA in 2012 and 2014 but was not detained on either occasion. She was described as presenting with symptoms of Generalised Anxiety Disorder, Obsessive Compulsive Disorder, Anorexia/Bulimia and personality difficulties that meet the diagnostic criteria for Borderline Personality Disorder. In 2014, Miss A was diagnosed with High Functioning Autism Spectrum Disorder, though Miss A disputed this, as she had most diagnoses.

1.10 Prior to her admission to the Milton Park Therapeutic Campus, Miss A was living in a residential hostel in Brighton, and was described as living a chaotic lifestyle involving the misuse of alcohol, illicit drugs and inappropriate sexual liaisons and abusive relationships with men. She was not cooperating with support services offered to her and a referral was made for a placement in a specialist locked rehabilitation facility, resulting in her placement at the Milton Park Therapeutic Campus as an informal patient, initially on two locked wards before she transferred to Pathway House, a residential home.

1.11 Miss A could be articulate and clear about her wishes and would often push any boundaries that might be imposed upon her. She could understand the need to change her behaviour and life-style, but was unable to make those changes. Despite increasing risks being identified about her behaviour, including one probable suicide attempt, Miss A remained a voluntary resident at Pathway House. She was offered an informal admission to the Elstow 1 Ward, a locked unit on the Milton Park Therapeutic Campus, but declined it. An application was made made for an assessment under the MHA in March 2016 and a further three during June and July 2016, though none were actually carried out and at no time was Miss A made the subject of a detention order. There was also a fourth application in the latter period, but this was subsequently withdrawn at her parents' request in case it jeopardised a possible new placement.

1.12 As a result of Miss A's non-cooperation with her care package at Pathway House and escalating concerns about her behaviour, it was agreed on the 19th May 2016 that her placement be extended for a further eight weeks but that an alternative placement be identified for her. She was offered 1:1 support when in the home and, if she agreed, in the community.

1.13 Miss A's family, in particular her parents, were very supportive of her throughout her life, consistently championing her best interests as they saw them and advocating on her behalf. Her family relationships were difficult. Her sister would witness Miss A's, at times, self-destructive behaviour put pressure on their parents. This, combined with Miss A's what, at times, could be very manipulative and destructive behaviour towards herself and others, would alienate her older sister from Miss A. She both resented but also wished to emulate her older sister's seemingly 'successful and fulfilling' personal and professional lives.

1.14 Miss A could also be lively, funny, articulate and full of life. The artwork and creative writing she produced was very impressive and is an indication of what she might have achieved. The tension between the creative and the self-destructive in her life is clear to see and needs to be remembered as this Report is read.

1.15 At the time of her death, Miss A had agreed to an informal admission to a different placement and was awaiting a decision as to its funding.

1.16 A Safeguarding Adults Concern was raised by the Milton Park Therapeutic Campus on the 28th July 2016; the decision was made on the 29th July 2016 to initiate a s42 Enquiry under the Care Act 2014 on the grounds of alleged Self-Neglect, though the section of the Safeguarding Adults Concern form to describe the type of alleged abuse, maltreatment or neglect was not completed nor would it appear that was questioned on the form's receipt. This was undertaken by the East London NHS Foundation Trust on behalf of Bedford Borough Council and it was decided on the 25th November 2016 to integrate it into this Review.

1.17 The East London NHS Foundation Trust formally requested a Serious Adult Review (SAR) on the 16th November 2016 using the agreed form – see Appendix B. The Trust is responsible for the provision of the Approved Mental Health Professional Service for Bedford Borough and Central Bedfordshire. The Safeguarding Adult Review Subgroup (Subgroup) considered the request at its meeting on the 9th January 2017 and decided the criteria for a SAR had been met and initiated the Bedford Borough and Central Bedfordshire Safeguarding Adults Board's SAR Framework (the SARF).

1.18 In accordance with the SARF, a Safeguarding Adult Review Panel (the Panel) was convened, an Independent Author commissioned and Independent Management Reviews (IMRs) and Chronologies requested from the relevant agencies.

1.19 This Report was authored on behalf of the Board by Mr Pete Morgan, an Independent Consultant.

1.20 The administration and management of the Safeguarding Adults Review Procedure has been carried out by Ms Vivien Reynolds, Team Manager, the Safeguarding of Vulnerable Adults Team, Bedford Borough Council, supported by Ms Natasha Smith, Bedford Borough and Central Bedfordshire Safeguarding Adults Board Support Worker.

1.21 This Review was commissioned under s44 of the Care Act 2014; its commissioning will be reported in the Board's Annual Report for 2016/17 and its findings and their implementation will be reported in the Annual Report for 2017/18 as required by the Act.

1.22 The timetable set out in the original Terms of Reference for the Review had to be adjusted due to difficulties in arranging meetings of the Panel to undertake the Review and draft this Report and of the Board to consider and ratify the Report, the Executive Report and the Action Plan.

1.23 The Report was ratified by the Board at a specially convened meeting held on the 28th March 2018.

2. Bedford Borough and Central Bedfordshire Adults Board Safeguarding Adult Review Protocol

2.1 The Bedford Borough and Central Bedfordshire Safeguarding Adults Boards Safeguarding Adult Review Framework (the SARF), agreed in October 2016, established the Purpose of a SAR and the Criteria for SARs across Bedfordshire – see Appendix A

2.2 The SARF also established the Procedure for making a referral for a SAR and the Procedure for undertaking a SAR as well as its Governance structure and the Timescale within which it should be completed

2.3 The above Procedures were correctly implemented.

3. Independent Overview Report

3.1 The SARF requires the Independent Chair of the Board and the Panel to decide whether an independent author is required and the level of independence. If so the Board will appoint an independent author.

3.2 The Independent Chair of the Board and the Panel having decided an independent author was required, the Board sought expressions of interest in the role through the National Local Safeguarding Adult Board Chairs' Network and appointed Mr Pete Morgan as the Independent Author.

3.3 Mr Pete Morgan has been the Independent Chair of the Worcestershire and Hertfordshire Safeguarding Adults Boards, having retired as the Head of Service – Safeguarding Adults with Birmingham City Council. In the above roles, he has commissioned Serious Case Reviews as well as participated in them and their ratification by the relevant Safeguarding Adults Board. He has chaired and co-authored a Domestic Homicide Review for the Safer Wolverhampton Partnership, a Serious Case Review for the Walsall Safeguarding Adults Partnership Board and is currently a member of an Independent Joint Serious Case Review Team for Newcastle Safeguarding Children and Adults Boards and is authoring SAR Overview Reports for two other SABs. He was a member of the Department of Health's Safeguarding Adults Advisory Group and is the Chair of the Board of Trustees, the Practitioner Alliance for Safeguarding Adults and the Independent Chair of the Safeguarding Panel for Advance, a charity providing accommodation and support to adults with care and support needs.

3.4 He had had no involvement directly or indirectly with any member of the family concerned in this Review or the commissioning, delivery or management of any of the services that they either received or were eligible for prior to being commissioned to write this Report.

3.5 He had had no involvement directly or indirectly with any of the agencies submitting evidence to this Report.

3.6 The Panel recognised that the majority of the events detailed in the chronology developed from the IMRs related to the care and support package provided to Miss A by a range of agencies. These were considered not to be directly related to the principle questions that needed to be addressed by the Review, namely, was Miss A's death predictable and therefore preventable.

3.7 It was therefore agreed that the sequence of events would be considered and analysed using Key Practice Episodes, enabling the Review to be focused and pertinent.

4. Media Strategy

4.1 Media contact concerning the review was the responsibility of the Independent Chair of the Bedford Borough and Central Bedfordshire Safeguarding Adults Board in consultation with the Safeguarding Adult Review Panel Chair and the Independent Overview Report Author. Overall management was directed through the Bedford Borough Council's Communications Team.

5. Liaison with the Coroner and the Police

5.1 The death of Miss A is the subject of a Coroner's Inquest; the first Pre-Inquest Hearing was held on the 8th December 2016 and the second on the 14th March 2017. It was planned to hold the Inquest in November 2017, but at the time this Report was written, it had been postponed until later in 2018.

5.2 The Coroner was informed of the commissioning and progress of this Review.

5.3 The Police were represented on the Panel.

6. Legal Advice

6.1 Legal advice was available, as and when appropriate, from the Bedford Borough Council's Legal & Democratic Services to ensure the review process and final Overview Report maintained a commitment to safeguard the anonymity of Miss A and her family and complied with current legislation.

7. The Safeguarding Adults Review Panel

7.1 The Safeguarding Adults Review Panel (the Panel) is responsible for ensuring:

- the Review is completed in a timely manner
- the Overview Report is factually accurate and based on evidence gathered during the process

7.2 The Panel comprised individuals across a range of statutory, independent and voluntary sector agencies as below:

7.3 The Panel comprised:

Independent Chair	BBCBSAB and SAR Subgroup
Director, Adult Social Care	Bedford Borough Council
Chief Officer	Bedford Borough Council
Adult Safeguarding Team Manager	Bedford Borough Council
Principal Social Worker, Head of Quality Improvement and Safeguarding Adult Social Care	Central Bedfordshire Council
Assistant Director	Central Bedfordshire Council
Chief Inspector, Public Protection	Bedfordshire Police
Assistant Director of Nursing and Quality	Bedfordshire Clinical Commissioning Group
Quality and Service Director	Tracscare
Deputy Manager, Milton Park Tracscare	Tracscare
Service Manager, Brighton & Hove	Sussex Partnership NHS Foundation Trust
Director, Bedfordshire Mental Health and Wellbeing Service	East London Foundation NHS Trust
Safeguarding Practitioner	East London Foundation NHS Trust

7.4 The Panel met on: 19th July 2017, 1st November 2017 and 20th December 2017

7.5 The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommend appropriate actions to ensure that better outcomes for adults with care and support needs in similar circumstances are more likely to occur as a result of this Review having been undertaken.

8. The Safeguarding Adults Review's Terms of Reference

8.1 The meeting of the Panel, held on the 19th July 2017 agreed draft Terms of Reference for the Review.

8.2 At each Panel meeting the Terms of Reference were reviewed and revised as agreed appropriate.

8.3 The finalised Terms of Reference are to be found in Appendix C

9. The Scope of the Safeguarding Adults Review

9.1 The scope of the SAR was set as the period from the 29th December 2015 until the 28th July 2016.

9.2 The following agencies were asked to submit the evidence below to the SAR:

- East London NHS Foundation Trust – s42 Safeguarding Enquiry Report re Miss A dated 13th January 2017 – see Appendix F
- East London NHS Foundation Trust Serious Incident Report dated 8th February 2017 see Appendix D
- the Independent Review Report of the AMHP Service dated January 2017 - see Appendix E
- Milton Park, Tracscare – an Independent Management Review including a Serious Incident Review re Miss A dated 24th August 2016
- Sussex Partnership NHS Trust – Serious Incident Report re Miss A dated 31 March 2017 – see Appendix G
- Bedfordshire Police – a chronology

9.3 Where they submitted completed reports, agencies were required to make recommendations within their evidence as to how their own performance and that of partner agencies could be improved. These were accepted and adopted by the agencies concerned. The recommendations are supported by the Independent Author.

9.4 The evidence submitted was of a mixed standard, reflecting the experience and expertise of their authors, their agencies of origin and the brief they were given to work to. The submissions were considered at the Panel meetings held on the 19th July 2017 and 1st November 2017; they were amended or clarified as necessary in the light of any comments.

9.5 A full and comprehensive review of the agencies' involvement and the lessons to be learnt was achieved.

9.6 Additional evidence was requested and provided as the Panel considered it appropriate and necessary.

10. Family liaison and involvement

10.1 Miss A's parents were informed of and fully involved in both the s42 Enquiries that were initiated with regard to her. They were also invited to contribute to this SAR; they met with the Independent Author at the beginning of his involvement on the 10th April 2017 in order for him to introduce himself and to explain the SAR process and how it would interface with the Coroner's Inquest.

10.2 The Independent Author also offered to meet with C, Miss A's sister, and they met on the 22nd August 2017.

10.3 Miss A's family were kept regularly up-dated with the progress and process of this SAR and were able to comment upon the Overview Report in draft form. These comments were, where appropriate, incorporated into the final version of the Overview

Report; where the Independent Author did not support their comments, this disagreement was also acknowledged within the Overview Report.

10.4 Miss A's family had the opportunity to read and discuss the final version of the Overview Report with the Independent Author before it was submitted to the Board.

10.5 Miss A's parents were invited to and attended the Board meeting held on the 28th March 2018.

11. The Context of Miss A's Placement at Milton Park

11.1 Although this Review is focused on the period that Miss A was placed at Milton Park, it is important to remember that she was admitted to the placement at the end of a turbulent period in what had been, at times, a somewhat troubled life and to understand the events of the period of this Review in this context.

11.2 Miss A had been known to adult mental health services in Sussex since 2008 when she was a university student in Brighton. She suffered from complex mental health difficulties, with diagnoses of Autism, Obsessive Compulsive Disorder, Anorexia Nervosa and Emotionally Unstable Personality Disorder; these made her vulnerable to self-harm, sexual exploitation and substance misuse. These difficulties were a major factor in her going to university somewhat later than her contemporaries.

11.3 Miss A was also intelligent and highly articulate, strengths that may well have masked the impact of her mental health difficulties and autism, providing a veneer of understanding and independence that professionals working to support her may have found hard to accommodate.

11.4 Throughout her life, Miss A was supported by a very caring family who were, particularly her parents, actively involved with service providers and advocating on her behalf.

11.5 Immediately prior to her placement at Milton Park, Miss A was living in Brighton in a placement with 24 hour staffing to manage varying levels of risk in social issues including emotional health and well-being and healthy weight and nutrition. This placement was meant to only be a temporary one but lasted 15 months, during which period she continued to struggle with eating and alcohol misuse. In May 2014, five months before this placement commenced, Miss A was formally diagnosed as High Functioning Autistic Spectrum.

11.6 On the 19th August 2015, Miss A was assessed as needing a placement in "a specialist unit for (adults) with complex needs on the autism spectrum that has the facility to deprive her of (her) liberty subject to a risk and capacity assessment and that could engage (her) in positive creative activity with 24 hour monitoring and staff support."

11.7 On the 18th September 2015, the specialist funding panel identified two possible placements; these were discussed with Miss A by her Care Coordinator on the 24th September 2015, when she "expressed concerns about remaining in her current placement but also concerns about (the) possible move."

11.8 On the 23rd September 2015, Miss A was referred to Milton Park, requesting an "assessment of a 34 year old female with diagnosis of ASD, Eating Disorder and OCD. Currently in hostel in Brighton but requires locked rehab facility. Eating disorder is severe. Would require DOLS as she is informal. Long history of Mental Health issues"

11.9 On the 16th October 2015, Miss A requested an appointment with her Consultant Psychiatrist as she had not received an update on the progress of the process of finding her a new placement; on the 19th October, her key worker at Shore House, high support accommodation reported (she) was "in decline mentally and drinking alcohol to excess" with the result a Care Programme Approach (CPA) review was arranged for the 30th October 2015 which Miss A failed to attend.

11.10 On the 5th November 2015, Miss A was seen by the General Manager from Milton Park as part of the assessment/admission process; prior to the assessment, she had expressed concerns about the potential loss of freedom this might entail and, while her human rights were pointed out to her, so were the powers available under the Mental Capacity Act 2005 (MCA) if she were assessed as lacking the capacity to make any specific decision. There was some discussion between Care Coordinator and staff from Milton Park as to the appropriateness of the MCA and the Deprivation of Liberty Safeguards, but no assessment was made of Miss A's mental capacity.

11.11 In the assessment meeting, Miss A's anxieties about the placement were reduced when the working practices there were explained to her and she agreed to visit the facility.

11.12 On the 12th November 2015, Miss A visited Milton Park with Care Coordinator, where they were joined by Miss A's parents. Miss A smelt of alcohol during the visit, fell asleep on the journey there, said she felt ill and didn't eat any of the food that was available to her. Milton Park's records state that they were shown around Ashwood (a locked ward) as well the residential care home, Pathway House. It was explained that the best pathway would be through Ashwood as this would provide an inpatient assessment and more therapeutic intervention. Miss A's parents' records are different: 'We were allowed to look briefly into Ashwood and were quickly taken away as there was an incident going on with a lot of shouting. We actually saw the small Elstow 1 ward and then spent most of our time in Pathway House.'

11.13 Although this could have happened earlier, Miss A asked that she was not admitted to Milton Park until after Christmas as she wished to spend it with her parents; it was therefore agreed that she be admitted on the 29th December 2015.

11.14 On the 28th December 2015, Miss A's father contacted the Mental Health Rapid Response Service, Brighton & Hove. (SPFT), in the morning and at night to express concerns about the admission to Milton Park arranged for the following day: Miss A was buying alcohol and subsequently became drunk and angry, saying she did not

want to either go to Milton Park nor return to Brighton but wanted “to sleep on the streets.”

11.15 On the 29th December 2015, the Duty Worker from the Assessment and Treatment Service, Brighton and Hove, contacted Miss A’s father who said things “were not brilliant but calmer”, but a phone conversation was needed with Miss A to persuade her to go to Milton Park. In the event, Miss A was taken by her parents in their car, but twice got out of the car in heavy traffic and had to be persuaded to get back in and eventually arrived at Milton Park intoxicated and angry.

12. Sequence of events – 29th December 2015 – 28th July 2016

NB Prior to this Safeguarding Adults Review being commissioned the East London NHS Foundation Trust (ELFT) had:

- completed a s42 Enquiry into the action on the part of the Bedfordshire AMHP Service in responding to the requests for assessment of Miss A under the Mental Health Act 1983. The conclusion of that Enquiry was that the allegation of neglect was upheld. Recommendations were made that included the review of the Bedfordshire AMHP Service
- commenced a further s42 Enquiry was initiated by the Bedford Borough Council, delegated to the ELFT to carry out, to consider the treatment of Miss A by Pathway House and an allegation that they had planned to evict Miss A without adequate support and safeguards. This Enquiry was integrated into this Review and not therefore formally completed. The information that had been gathered for both Enquiries was made available to the Independent Author
- completed a Serious Incident Review that limited its scope to the contact between Miss A ‘or others acting on her behalf with ELFT services, largely the North Bedfordshire AMHP Service’

ELFT also commissioned an Independent Review of the Luton and Bedfordshire AMHP Service in January 2017, the findings and recommendations of which are in Appendix E.

A Serious Incident Review was also undertaken by the Sussex Partnership NHS Foundation Trust into the circumstances of Miss A’s death. It was completed on the 31st March 2017 and has been made available to the Independent Author.

This Safeguarding Adults Review will not duplicate these Reviews but will consider and incorporate their findings and recommendations, which can be found in Appendices D and E in the Conclusion. This Sequence of Events will not therefore include details of contact covered by these Reviews but will note when requests for AMHP assessments were made.

12.1 29th December 2015 – 17th February 2016

12.1.1 On the 29th December 2015, Miss A was admitted to Milton Park as arranged and was placed on the Ashwood Unit, the locked female ward, as a voluntary patient. It is normal practice at Milton Park for patients to stay on the unit they are admitted to for their twelve week assessment period. Miss A's parents deny that either they or Miss A was told this; their recollection is that they were advised by the Service Manager that she would be on the Ashwood Unit or Elstow 1 Ward for no more than two weeks for in-depth psychological assessment. They were advised that she could be admitted to Pathway House but that it would be better to be placed on the Ashwood Unit first.

12.1.2 5th January 2016 the Care Coordinator phoned Milton Park, and was advised that Miss A was settling, though the transition was difficult. Miss A stated she was very unhappy to be at Milton Park. She stated that she had not been out except for a small walk with staff. She had spoken with a psychologist yesterday and there was a meeting that day about psychological input. She was hoping to be moved to the high support house as soon as possible as she believed this would be less restrictive.

12.1.3 From the outset, however, both Miss A and her parents frequently requested that she be moved to a less restrictive environment. For example, on the 7th January 2016, albeit only ten days into the placement, Miss A's father expressed his concerns to the Care Coordinator that the placement was not going well and requested she be moved to the unlocked ward. These were concerns that the Care Coordinator also held as to the progress of the placement, despite normal practice being for a 12 week assessment period on admission to Milton Park – see 12.1 1 above.

12.1.4 A bed became available on Elstow 1, also a locked female ward on the Milton Park Campus, but a quieter one with fewer restrictions, and Miss A transferred there on the 4th January 2016, although Miss A's parents' records state that she transferred to Elstow 1 on the 1st January 2016. The Psychiatric Report to the Coroner's Court states she had been assessed and accepted by Pathway House at this time, which conflicts with 12.1.10 as advised by Tracscare.

12.1.5 On the 8th January 2016, the Care Coordinator spoke to placement staff who agreed that, with hindsight, Miss A being admitted on the 29th December 2015 had been ill-advised but that she was now settling, spending time with staff and starting to eat a little.

12.1.6 By the 15th January 2016, Miss A was recorded 'as having settled with no incidents following her initial difficult transition and that her morale had improved immensely'.

12.1.7 On the 22nd January 2016, the Care Coordinator emailed the Tracscare Service Manager to advise that she planned to visit to review the placement on the 26th February 2016 with the Quality Lead from Brighton and Hove Clinical Commissioning Group (BHCCG).

12.1.8 On the 29th January 2016, the Care Coordinator was enquiring about 'restrictive practices on ward'; Miss A was an informal patient on a locked ward . Miss A had complained that she didn't have the freedom she wished for and wanted to be in a less restrictive environment. The Care Coordinator discussed with staff that Miss A may not

be being deprived of her liberty but what was happening did constitute a restrictive practice and that involving Miss A's parents as per guidance might have gone a long way to help them understand why this was being done in her best interest. It would also have ensured it was clear which safeguards were in place and that what was happening was lawful.

12.1.9 Miss A visited her family on 30th January 2016 for a planned overnight stay but returned to Milton Park a day late, intoxicated and with traces of cannabis in her urine. She had bought half a bottle of vodka which she drank without her parents' knowledge prior to her return. Her parents advised the Care Coordinator that they felt home leave was unhelpful at this time but also advised her that Miss A was losing confidence in her placement.

12.1.10 On the 2nd February 2016, Miss A was re-assessed by the Manager of Pathway House, a registered residential home, as meeting the criteria for admission, but there were no beds available. At this stage, Miss A, was described as 'fully engaged' in 'all therapies including 1:1 sessions with a psychologist and a psychiatrist and group sessions.'

12.1.11 This was not consistent with normal practice at Milton Park – see 12.1.1 – but was considered appropriate in Miss A's case as there was an increasing likelihood of her discharging herself and it was felt better that she remained in the placement and continued to receive some therapy and retain some support.

12.1.12 On the 3rd February 2016, an Interim Care Coordinator was temporarily allocated to cover the absence due to sickness of the Care Coordinator. She phoned Milton Park to discuss restrictive practice and issues around mental capacity. The Interim Care Coordinator discussed the need for evidence to document current restrictive practice- this seems to be limited to Miss A being an informal patient on a ward which was sometimes locked – in particular the duty to document all decisions about using restrictive practices to manage challenging behaviour or resisting essential care and the requirement to include the service user and their family in any agreements to ensure consistency. There was a need to evidence how it reduced harm to Miss A or to the person implementing the actual practice.

12.1.13 Milton Park said that they carried out a capacity assessment when Miss A was admitted and she was deemed to have capacity to reside on a locked ward and has signed a form agreeing this. The Interim Care Coordinator asked for copies of the mental capacity assessment and agreement to be emailed to her. They discussed issues around her alcohol use. The Interim Care Coordinator asked for the manager to ring her back about how they are going to address these risks- she mentioned that their Applied Psychologist was looking at family sessions to work through these concerns.

12.1.14 On the 9th February 2016, the internal Multi-Disciplinary Team (MDT) Review at Milton Park noted that Miss A was engaging well with her care plan, including 1:1 psychology sessions, art therapy and various groups at the Star Centre; she was also having one hour periods of unescorted leave in the local community. She asked that she have weekend leaves at a local hotel as, during the visit to her parents, they had

argued and she had used alcohol. This was agreed, on an overnight basis, provided she complied with an agreed care plan.

12.1.15 On the 10th February 2016, the Interim Care Co-ordinator met with Miss A's parents when concerns were discussed that, in their view, the placement was not meeting its contract in terms of length of stay on the locked ward – see 12.1.1 and 12.1.3 above - and Miss A and her parents not being involved in decision-making. It was also suggested by her parents that the placement had admitted that the positive urine test for cannabis was inaccurate and their alcohol monitor was unreliable. Milton Park would not accept this suggestion.

12.1.16 On 11th February 2016 the Interim Care Coordinator and the Clinical Quality and Patient Safety Manager in BHCCG were making arrangements to carry out a joint placement and CPA review at the end of the month. This was originally arranged for the 26th February 20166, but was cancelled as she had only transferred to Pathway House a week earlier. The Interim Care Coordinator emailed the Applied Psychologist and a second Consultant Psychiatrist, not her Responsible Clinician at Milton Park with this proposal and stated that she had telephoned the previous week to speak to either the Service Manager or the Responsible Clinician for an update on Miss A's progress and to request copies of her care plans and review documents. She said she also requested copies of Miss A's consent to remain on a locked ward and a copy of the capacity assessment that had apparently been completed regarding this.

12.1.17 On the 12th February 2016, Miss A had her first overnight stay at the local Premier Inn.

12.1.18 On the 16th February 2016 the Interim Care Coordinator and Specialised Services' Commissioning Finance for Complex Care Pathways received an email from Tracsare with a new service agreement regarding Miss A moving to Pathway House sometime later that week, as she 'has made sufficient progress to move into Pathway House as per the original 8-12 week plan'.

12.1.19 When a bed became available on Pathway House, Miss A transferred there on the 17th February 2016. At this time, she was described as 'engaging, on the whole, and was an informal patient choosing to leave inpatient service.'

12.1.20 Milton Park record that, at the time of the transfer, there were concerns that Miss A would self-discharge from the placement but it was 'felt that she would continue to benefit from the therapeutic input especially her psychology sessions with which she was remaining very engaged.'

12.2 18th February – 30th March 2016

12.2.1 Miss A's parents understand that a meeting that had been arranged under the CPA for the 26th February 2016 to review Miss A's placement was cancelled as she had only transferred to Pathway House just over a week before.

12.2.2 Miss A had a hotel visit with her parents on the 28th February 2016, from which she returned intoxicated and with traces of cannabis in her urine.

12.2.3 On the 1st March 2016, Pathway House were contacted by a local pub to advise them that Miss A had been seen misusing aerosol cans.

12.2.4 On the 2nd March 2016, placement staff advised the Interim Care Coordinator that Miss A 'merits an assessment for detention under the act in view of her current presentation' and recommended an admission under s3 MHA. She advised that they would need to contact the local AMHP service.

12.2.5 The Interim Care Coordinator contacted Miss A's parents – the Nearest Relative as defined by the MHA and therefore able to oppose any application under the Act. They expressed concerns as Miss A would have a very negative reaction to being detained, having been subjected to s2 and s3 admissions under the MHA in the past due to her low weight and would rather she remained in the Bedford area so she could continue to build relationships with staff and vice versa. The Interim Care Coordinator noted that Miss A was eligible for s117 aftercare.

12.2.6 There was a disagreement between the services in Bedfordshire and Brighton and Hove, as to which should undertake the AMHP assessment. The Interim Care Coordinator confirmed with the Brighton and Hove AMHP Service the procedure and they stated that Milton Park would need to refer Miss A to their local AMHP Team and request an assessment. The Responsible Clinician was advised that the local AMHP team could then consider this and they may also wish to liaise with their colleagues in Brighton and Hove. It would be for the local AMHP and assessing team to determine whether they agreed that the grounds for an admission under s3 were met on the day.

12.2.7 Assurance was provided by Brighton and Hove City Council that section 117 aftercare responsibly would remain with them. This was followed up in writing on 3rd March. The Interim Care Coordinator made BHCCG and the Complex Care Pathways General Manager aware of the request for an assessment under the MHA and disagreement about the process. They were also made aware that if Miss A was detained this may be to Ashwood, a locked ward at Milton Park, and therefore there would be a higher cost to the placement.

12.2.8 On the 3rd March 2016, Milton Park staff formally referred Miss A for the first time to the Bedfordshire AMHP Service for an AMHP assessment under the MHA.

12.2.9 On the 4th March 2016, the Duty AMHP, an AMHP candidate, declined the referral on the basis that the primary problem was one of substance misuse rather than of Miss A's mental health.

12.2.10 On the 23rd March 2016, Miss A's parents contacted the Interim Care Coordinator asking when she was going to carry out a formal review of the placement and the CPA review. The Interim Care Coordinator stated she was waiting for confirmation of the availability of the Clinical Quality and Patient Safety Manager in BHCCG to attend with her. Miss A's father also expressed concerns at the vagueness of Milton Park's care plan for Miss A and that she was not doing much socially to build her confidence or structure her time. Milton Park's records show that they were not made aware of these concerns and were of the view that she remained engaged in her

1:1 sessions, was trying treatment options and was working well with her key worker within a clear care plan. Miss A's father is adamant that he did discuss his concerns with staff at Pathway House and that Miss A had told him that she had raised them at the MDT meeting on the 23rd March 2016 although the Review Form of the meeting does not record them.

12.2.11 On the 25th March 2016, at the MDT Review, Miss A was noted as engaging well, attending all her therapeutic sessions and seeking some voluntary work, which she eventually got in a local Care Home in St Neots. She was noted as pushing boundaries and continuing to refuse psychotropic medication.

12.2.12 Miss A's parents have recorded that, on the 25th March 2016, she booked herself into a local hotel for two nights but that she stayed away from Pathway House for four nights, becoming increasingly disturbed and frequently phoned her parents.

12.2.13 On the 29th March 2016, her parents' records state that she threatened suicide while on a footbridge and was taken to an Accident and Emergency Department by ambulance. They advise that they were spoken to by a Support Worker at Pathway House who advised them 'don't worry there is a psychiatric hospital next to A&E and they assess her'. There is no record of any assessment taking place. Pathway House's records state Miss A's mother phoned them to advise that Miss A would be attending the Accident and Emergency Department at Bedford Hospital in the hope of seeing a psychiatrist. There is not record of a Support Worker advising them as above. Pathway House's records also state that a paramedic attended Miss A before she left the hotel and she attended the hospital of her own volition later that day.

12.2.14 Pathway House's records state that Miss A returned to Pathway House just after midnight on the 30th March 2016 intoxicated and with alcohol in her possession. She threatened to harm herself and the police were contacted but advised that Milton Park, as a hospital should have the facilities to hold her and could section her under the MHA if necessary. Miss A then said she did not want to stay at Pathway House but wished to stay in a hotel; staff helped her try to find a hotel to stay in, but were unsuccessful and she remained at Pathway House.

12.3 31st March – 18th April 2016

12.3.1 During this period, Miss A had, as part of her care plan, increased unaccompanied access to the community; the extent of her misuse of alcohol and the level of her sexual vulnerability became more apparent – binge drinking, bringing alcohol back into Pathway House and meeting men.

12.3.2 On the 31st March 2016 the Pathway House Manager emailed the Interim Care Coordinator and advised her that Miss A was staying out against advice, getting heavily intoxicated and therefore missing therapeutic sessions and activities. If this continued, her placement would have to be reconsidered.

12.3.3 The view of Pathway House was that it was not a suitable environment to manage Miss A's misuse of alcohol and to secure her agreement to the necessary restrictions on her behaviour to ensure her safety.

12.3.4 When Miss A was intoxicated, she could be uncooperative, challenging and refuse to engage in her support plan; when sober, she would be apologetic and generally engage in therapeutic activities.

12.4 19th April 2016 – 8th May 2016

12.4.1 The CPA Review arranged for the 6th April 2016 was cancelled as the Interim Care Coordinator was unable to attend. On the 19th April, the Interim Care Coordinator contacted Milton Park to propose a review date of 10th May but this was not convenient as several key members of the team would not be able to attend. The plan was for Milton Park to propose some alternative dates.

12.4.2 On both the 24th and 26th April 2016, Miss A returned to Pathway House from the community intoxicated; staff checked she wasn't bringing any alcohol into the home.

12.4.3 On the 1st May 2016, Miss A phoned Pathway House intoxicated and reported that she had been raped by someone called Daniel and said she had spoken to a female police officer.

12.4.4 On the 2nd May 2016, the Police were contacted by a local pub as a woman, believed to be Miss A, was making phone calls threatening to kill herself; the woman had had three glasses of wine and was described as strange when she entered the pub. She was asked to leave but said if she did she would kill herself. The informant believed the phone calls were to the woman's parents. There is no record of the outcome of the contact.

12.4.5 On the 2nd May 2016, Miss A had gone to St Neots to find her lost phone and cigarettes; Pathway House received several phone calls from her during the day; on one occasions she spoke of killing herself and she also said she had been thrown out of all the pubs in St Neots. She returned to Pathway House at 19.40, having left at 9.45.

12.4.6 On the 3rd May 2016, the Police were contacted by staff at Milton Park as Miss A had disclosed on the 1st May 2016 that she had been raped at the Premier Inn in St Neots on the 29th April 2016. The Police tried to speak to Miss A but she would not discuss or even confirm the incident had occurred and was angry that the Police had been informed. Pathway House record reporting the alleged rape to the Bedford Borough Safeguarding Vulnerable Adults Team on the 6th May 2016; they were advised that no action would be taken unless Miss A chose for them to do so.

12.4.7 On the 3rd May 2016, the Manager at Pathway House emailed the SPFT to raise concerns re the placement and to inform them of the allegation of rape that had been reported to the Police. She advised that Miss A was frequently staying away for nights over the weekend and is becoming extremely intoxicated and socially vulnerable. She asked for an emergency review to take place within two weeks and discussed the possibility of discharge if the SPFT did not attend as Miss A was no longer accepting support.

12.5 9th May 2016 – 7th June 2016

12.5.1 On the 9th May 2016 the Interim Care Coordinator's supervisor, the Lead Social Worker, had a phone conversation with the Manager at Pathway House about current risks, concerns and safeguarding. The Lead Social Worker queried Miss A's lack of engagement as there was evidence that she was attending psychology sessions weekly and had a positive relationship with her key worker. Concerns also expressed re the placement meeting her physical needs such as diet, hepatitis C status, money and being away from the placement at weekends. 'Overall however level of risk was reduced and she was in a safer environment.' Pathway House had arranged appointments with her GP practice re her hepatitis C treatment on the 18th and 24th May 2016 but she failed to attend. Other GP clinic appointments were made for the 2nd March 2016 re pain in her back and hand and the 7th June 2016 re her medication and its side-effects, neither of which she attended, and for the 28th April 2016 for test results that Miss A cancelled herself.

12.5.2 On the 13th May 2016, the Interim Care Coordinator phoned the Bedford Borough Council Adult Safeguarding team to establish if they were taking forward the Safeguarding Concern raised as a result of the alleged rape and if not, the rationale for their decision. They could not find any record of Safeguarding related advice/ discussion or referral. They advised that Pathway House submit a safeguarding concern to the Bedfordshire Safeguarding Vulnerable Adults Team.

12.5.3 The Interim Care Coordinator emailed the Pathway House Manager and Miss A's keyworker with the details as above and the contact phone number requesting they made contact with the details of what happened for consideration of a s42 enquiry under the Care Act 2014.

12.5.4 Also on the 13th May 2016, the Interim Care Coordinator contacted Pathway House to offer support around safety planning for the weekend. The Pathway House Support Worker called back; after a discussion between Miss A and the Team, Miss A had agreed to contact the placement 'every morning and evening', to 'not get too drunk' and to return to the placement if she felt intoxicated or vulnerable. Miss A was described as 'agreeable when sober but conflictual when drunk and didn't stick to plans'. The original care plan, starting on the 12th February 2016, had included one weekend a month away from the placement but this had become most weekends. Miss A was not committing to or engaging with activities.

12.5.5 On the 13th May 2016, the SPFT records that the Interim Care Coordinator was emailed by a member of staff from Pathway House that he would make contact with the local Safeguarding Adult Team again. This is not accepted by Tracscare as their records show that they had already contacted the Bedford Safeguarding Vulnerable Adults Team on the 6th May 2016.

12.5.6 On the 16th May 2016, the Interim Care Coordinator was emailed by the Bedford Borough Council Safeguarding Vulnerable Adults Team confirming their conversation with the member of staff from Pathway House in relation to Miss A's

allegation of rape. She was advised that, given that Miss A had capacity and did not want to take any further action regarding her disclosure about an unknown member of the public, there was very little that can be done as her wishes had to be respected.

12.5.7 On the 19th May, a CPA Review meeting was held at Pathway House, attended by Miss A, her parents, the MDT, an IMHA and the Interim Care Coordinator. Concerns were raised re Miss A's substance misuse and her not following agreed plans. If there was no improvement, Pathway House were to consider giving her notice. A further two month stay was agreed to enable Miss A to complete her therapy and for an alternative placement to be found. She was advised that it would facilitate her therapy if she ceased spending time away from Pathway House. She asked if she could be prescribed something to help deal with her anxieties, but despite this happening, she only took the medication for a couple of weeks before she started missing doses and ultimately stopping taking it. This Review is not recorded in the SPFT Serious Incident Report; this is due to an omission in SPFT records caused by the Interim Care Coordinator being involved in an accident after the Review and subsequently off work.

12.5.8 On the 3rd June 2016, Pathway House staff referred Miss A to the AMHP Team for an assessment under the MHA. This was screened out as the Team decided her risk behaviours were related to alcohol misuse, not to any primary mental disorder and that she would not therefore be detainable under the Act. Miss A's parents' records show that she arrived at their home at 10 am on the 3rd June 2016 and spent the weekend with them. Neither they nor Miss A were aware of this referral for an assessment under the MHA.

12.5.9 On the 7th June 2016, Milton Park staff reported Miss A missing to the Police; they had been contacted by Costa Coffee Shop staff saying Miss A appeared confused and not her normal self. Staff searched the areas she was known to frequent but couldn't find her. She was due medication and staff believed she was at risk of sexual exploitation as 'she uses sex to access social contact. Staff did not believe she was at current risk of suicide'. The Police were later informed Miss A had returned safely to the placement.

12.6 8th June 2016 – 20th June 2016

12.6.1 On the 8th June 2016 the previous Care Co-ordinator returned to work

12.6.2 On the 8th June 2016, while on leave in the community as agreed in her care plan, Miss A jumped from a bridge into a river in Cambridgeshire while she was intoxicated. She was pulled out by members of the public and taken to Hinchingbrooke Hospital by ambulance, though she had no injuries apart 'from some water on the lungs'. It was recorded on her initial attendance at the hospital that there was a risk to her welfare and mental wellbeing and that the Police should be notified if she absconded.

12.6.3 An off-duty member of Staff from Pathway House saw Miss A with the ambulance crew; they informed Pathway House. Having been provided with Miss A's

new mobile phone number by her parents, staff called her and were advised by the ambulance crew that she was being taken to hospital.

12.6.4. Miss A left without having been seen and there is no record that she was seen by or referred to mental health services. This would not be unusual as she was only at the hospital for less than hour. There is no record that either the Police nor Milton Park were contacted by the hospital.

12.6.5 On the 8th June 2016, Miss A's parents contacted Pathway House while she was missing to advise that they had been contacted by an ambulance crew member who advised them that she had jumped off a bridge into a river and that she was being taken to hospital. He described her as 'very disorientated and a danger to herself'. They informed Pathway House of what had happened and later spoke to them again to discuss Miss A returning to the care home having discharged herself from hospital.

12.6.6 Pathway House's records state that, having left the hospital, Miss A contacted them and staff came out to meet her and returned her to the placement. Miss A's parents' records state that they contacted Pathway House, not Miss A. Miss A told placement staff she had fancied a swim as it was a nice day but told her parents later that she was having suicidal thoughts. Placement staff reported she was anxious about a recent change in her medication and requested a MHA assessment. Miss A agreed to 'stay on site' within the premises/grounds of Pathway House and Milton Park but left and was put to the Police as a Missing Person. Placement given contact details for MH rapid response team and AMHP team.

12.6.7 On the 9th June 2016, Milton Park's records state that Miss A was referred by her Responsible Clinician for the second time to the Bedfordshire AMHP Service for an AMHP assessment under the MHA. Miss A's parents understand that the referral was made by the Manager of Pathway House as the Responsible Clinician was away that day.

12.6.8 On the 9th June 2016, the Police were contacted by Milton Park staff as Miss A had left the placement without staff support – she would often agree in principle to 1:1 support in the community but then refuse it in practice. Police records refer to the incident on 8th June 2016. Her father advised the Police that she was still in St Neots with a member of the public who was trying to calm her down as she was intoxicated. Cambridgeshire Police took her back to Milton Park.

12.6.9 On the 9th June 2016, having been returned to Pathway House by the Police, Miss A was verbally and physically aggressive to staff before going out and buying a bottle of vodka. She stated she would kill herself if she was sectioned.

12.6.10 On the 10th June 2016, the referral for an AMHP assessment is again screened out as the Duty AMHP felt that this was an alcohol misuse issue and suggested alcohol intervention rather than the use of the MHA, as that should be used as a last resort.

12.6.11 On the 10th June 2016, Miss A's Responsible Clinician was advised that the second AMHP referral had been closed by the Bedfordshire AMHP Service; he submitted the third referral for an AMHP assessment under the MHA that day.

12.6.12 During the day on the 10th June 2016, there were several phone calls between the Responsible Clinician, other staff at Milton Park and the Duty AMHP at the Bedfordshire AMHP Service, some of which were described as acrimonious, to clarify the reason for the referral and the rationale for the response to it. The outcome was that the referral was again screened out as not being appropriate for an AMHP assessment to be carried out when the perceived primary issue was one of alcohol misuse.

12.6.13 On the 10th June 2016, Tracscare records record that the Responsible Clinician also contacted the SPFT to ask that they visit to undertake the AMHP assessment. There is no record of a contact to this effect on this date in the SPFT records. There is a contact to this effect dated the 2nd March 2016.

12.6.14 On the 10th June 2016, after a period of absence from Pathway House and her return by the Police, 28 days notice was given to the Care Coordinator by email to find an alternative placement as the MDT did not feel she was suitably placed at Pathway House. There is the suggestion in the Tracscare chronology that this was linked to unsuccessful referrals for AMHP assessment and Miss A declining an informal admission to the inpatient facilities at Milton Park.

12.6.15 On the 14th June 2016, after Miss A returned to Pathway House intoxicated, a strategy was agreed between Pathway House Staff and the Police on how to respond to Miss A should a similar situation arise again, namely the Police should be contacted on 101 and a reference number quoted.

12.6.16 On the 15th June 2016, the Tracscare Pathway and Medical Support Manager emailed the Care Coordinator with a copy of their current risk assessment including information that three referrals had been made for AMHP assessments; the AMHP team had advised that they considered Miss A a low risk and concerns re alcohol abuse did not warrant an assessment.

12.6.17 On the 15th June 2016, a member of the pubic advised Pathway House that Miss A was in a car park in St Neots, intoxicated and acting erratically and that they had informed the Police. Staff picked her up and returned her to Pathway House. Miss A was then served notice as her placement was no longer considered suitable.

12.6.18 In the interim, it was agreed with Miss A that risks were to be managed by, when she was settled, allowing her four hours a day unescorted except when doing voluntary work when it would be eight hours. Miss A to advise staff when she was going out, where she was going, when she would be back, to contact staff when she'd arrived where she was going, half way through her visit and when she was about to return. If she didn't make contact or was fifteen minutes late back, then staff were to ring her and contact Police if she wasn't not found. Staff were to discourage her going out intoxicated but to inform Police if she did. If Miss A deteriorated, a MHA assessment was to be requested.

12.6.19 On the 15th June 2016, Miss A's parents contacted the Assessment and Treatment Service (ATS) Team Leader in the Care Coordinator's absence to advise of the incident on the 8th June and their general concerns as to Miss A's wellbeing.

12.6.20 As a result of the above, the ATS contacted the placement who reported Miss A had been intoxicated and confused over last two days and the Police had been called out twice when she hadn't returned from community leave on time. She appeared intoxicated today but not seeking to leave Pathway House; there was to be an internal meeting with the Responsible Clinician today and it was planned to call 101 if she was fifteen minutes late returning if she goes out.

12.6.21 On the 16th June 2016, the Police were called to the Waitrose store in St Neots as Miss A very drunk and saying she was going to kill herself as a family member had died and she didn't want to live any more. The Police spoke to Miss A who 'was happy and no intention to harm herself. Her mood may change if she drinks more alcohol.' She returned, very intoxicated, to Pathway House in a taxi; the driver asked for staff to pay for damage to a seat that was covered in mud and had been urinated on.

12.6.22 On the 17th June 2016, Milton Park staff contacted the Police as Miss A had not returned from an authorised four hours unsupervised leave; staff had spoken to her on her mobile and she sounded intoxicated and very confused. An hour later, staff reported she had returned to the placement.

12.7 21st June 2016 – 28th June 2016

12.7.1 On the 21st June 2016, the SPFT was advised in writing by Pathway House (posted on the 15th June 2016) that 'due to recent behaviours and current situation. I write to advise that we hereby serve 28 day notice to (Miss A) effective 10/6/2016 and sooner if alcohol consumption continues to put her at risk', confirming the telephone conversation held on the 15th June 2016 – see 12.6.14 above

12.7.2 Also on the 21st June 2016, Milton Park emailed the ATS details of the three AMHP referrals – see 12.5.8. 12.6.5 and 12.6.9 above.

12.7.3 On the 21st June 2016, the Care Coordinator contacted Miss A's parents to discuss recent events and the notice to quit the placement. Her parents felt Miss A had never felt comfortable at the placement and thought it was anxiety rather than alcohol abuse at the root of her risky behaviour, exacerbated by her feeling different to the other patients. They had never known her to do something as risky as jumping in the river - 4.6.1 – despite two previous suicide attempts, and wished she could be placed more suitably, with other patients she had more in common with. It was explained that the risks Miss A presented with exclude her from these services, and that she had not had an assessment under the MHA, the DoLS or been assessed, at that time, as needing further restrictions.

12.7.4 The Care Coordinator also spoke to the placement on the 21st June 2016 and was advised that Miss A was not keeping to the agreed care plan. The Care Coordinator questioned the suggestion from the placement that Miss A needed 'a

specialist alcohol placement' that had been proposed by the AMHP Team as it was not based on an assessment and they had no direct experience of Miss A. The placement believed that Miss A 'was more in control of her behaviours and triggers to drinking as opposed to poor executive functioning in line with Autism diagnosis.'

12.7.5 On the 23rd June 2016, the Manager of Pathway House sent a very detailed email report to the Care Coordinator, SPFT detailing Miss A's engagement in keyworker sessions. This had been weekly in March, once a month in April, twice a month in May and once a month in June. The Manager also provided a detailed record of incidents since admission to Pathway House – totalling 26. This email confirms that the placement has broken down and confirmed that the placement could no longer manage her risks. The email also reported the Responsible Clinician's views on an appropriate new placement for Miss A, stating that in his opinion she did not need an alcohol placement as her alcohol use is secondary to her generalised anxiety, OCD and Aspergers and so she needed an Autistic specialist placement (but not LD as she is high functioning), with more structure and restriction in order to manage her substance misuse. This email contains comments from the Applied Psychologist who stated that the use of alcohol is the main barrier to Miss A achieving therapeutic gains and that further psychological input would benefit from a signed therapeutic contract whereby Miss A agreed to abstain from alcohol use during the period of treatment.

12.7.6 On the 25th June 2016, the Police were contacted by the Ambulance Trust as they were trying to locate Miss A; they had been contacted by an unknown male who said Miss A had overdosed and self-harmed and was 'in a bad state of mind …. was bi-polar and possibly taken heroin' She was found by Pathway House staff and returned to the placement, there was no evidence of self-harm and no other concerns are recorded.

12.7.7 On the 28 June 2016, the Care Coordinator made a referral to Partnerships in Care for a potential placement for Miss A in Pelham Woods, West Sussex.

12.8 29th June 2016 – 5th July 2016

12.8.1 On the 29th June 2016, the placement advised the Care Coordinator by email that, during the past week, Miss A had required the ambulance service and the Police, sometimes called by members of the public, to return her to the placement as she was intoxicated, on one occasion with a broken nose, but didn't state how many times. Miss A had lost her voluntary job as she had stopped attending. The Care Coordinator rang the Pathway House to speak to Miss A but was told she as out.

12.8.2 On the 1st July 2016, Pathway House staff contacted the Police as Miss A had left the placement, saying she was leaving and going to stay in a hotel. She was angry as a meeting with her parents had been cancelled, she has been given twenty-eight days' notice to quit Pathway House and she was not happy with her proposed new placement. There was no immediate concern for her welfare and the police did not attend.

12.8.3 On the 2nd July 2016, the Police were contacted by the Pilgrims Progress Hotel Bedford as Miss A was refusing to leave; when the Police attended, staff from Pathway House were there and took Miss A back to Pathway House.

12.8.4 Later on the 2nd July 2016, Pathway House staff contacted the Police as Miss A was 'being rowdy' having been out drinking and returned intoxicated. Staff had confiscated some alcohol and she was refusing to leave a staff office. Miss A had also made an allegation of rape to staff.

12.8.5 Miss A told the Police that she had been at the Pilgrims Progress Hotel the previous night and went out at 3 am to get some cigarettes; as she went past Bedford College she became aware of a group of five males who approached her, one of which grabbed her arm and cut her with a Stanley knife before running off. There was no sexual assault and no attempt to steal from her. There was grazing to her left forearm but staff said this was not there when they collected her from the hotel and she had not mentioned the sexual assault until they confiscated the bottle of wine from her. The Police took no further action.

12.8.6 On the 3rd July 2016, the Police records show that Miss A had phoned her father to say she was sitting in a graveyard and there was no point in going back to Milton Park. She had been asked to leave the Pilgrims Progress Hotel as she was drunk. She had £500 on her. A member of staff returned her to Milton Park. The records go on to state that a PCSO in St Neots found Miss A, she was 'in high spirits' and no concerns about self-harming. She had said what she did to her father to make him worry. She declined any help and refused a lift back to Milton Park. No further action by the Police

12.8.7 On the 4th July 2016, Pathway House staff reminded the Care Coordinator and SPFT that the notice period expired on the 8th July 2016; it was confirmed that Partnerships in Care would assess that week and the notice period was extended to the 15th July 2016. It was agreed that, if Miss A puts herself at risk and the police were involved, Pathway House would refuse to let her return as 'it is not a place of safety'. The Care Coordinator and the SPFT were advised of this on the 5th July 2016.

12.8.8 On the 5th July 2016, there was an exchange of emails between the Care Coordinator and Miss A's parents considering the suggestion that an alcohol rehabilitation placement might be more suitable and her search for a more suitable placement for her. Her parents were concerned at her escalating alcohol consumption and felt she should be assessed under the MHA and Miss A moved to a more secure placement under section.

12.8.7 On the 6th July 2016, Milton Park staff contacted the Police as Miss A had told them she didn't want to be there anymore and doesn't really want to live, though they don't believe she was at suicide risk. They had received a call from her father saying she was with a member of the public in Bedford, close to an off-licence, she was on the ground and highly intoxicated. She was returned to Pathway House by the Police.

12.9 6th July 2016 – 13th July 2016

12.9.1 On the 6th July 2016, the Manager at Pathway House emailed the Care Coordinator to advise her that Miss A had initiated sexual activity with a fellow resident the previous night; both had the mental capacity to do so and consensual sexual intercourse had occurred. Miss A was considered to have capacity in all areas of decision-making unless she was under the influence of alcohol. Earlier in the evening of the 5th July 2016, Miss A had participated in a residents' meeting, and while she might have consumed some alcohol, had not appeared intoxicated. It was considered that the risks were increasing and that the next time the Police tried to return her, intoxicated, they would not accept her back but ask the Police to find her a place of safety. It is not clear when Miss A was informed of this; her parents were not informed until early July.

12.9.2 Pathway House planned, without seeking their agreement, that the Police would use their powers under S136 of the MHA to arrange an AMHP assessment. In practice, Miss A continued to be returned by the Police to Pathway House intoxicated and they accepted her.

12.9.3 On the 7th July 2016, the Care Coordinator informed Miss A's parents that the funding panel had agreed to continue funding a placement for her and that a new placement had agreed to assess her. Miss A's parents were advised that they could, as Nearest Relative, request an assessment under the MHA and if the assessment was that she did not meet the criteria for any action, they would be given a clear explanation of why this was the case.

12.9.4 On the 8th July 2016, Miss A's notice expired but an extension was agreed to the 15th July 2016 to allow for a further referral for a MHA assessment to be made; further extensions were agreed to the date of her death as no alternative placement had been approved by the SPFT.

12.9.5 On the 9th July 2016, Pathway House staff contacted the Police as they were concerned that Miss A was intoxicated and wouldn't be able to return to the placement. Three hours later, staff advised the Police that she had 'returned safe and well'.

12.9.6 On the 12th July 2016, Pathway House staff contacted the Police as Miss A had not returned at the agreed time from an agreed four hour period of unsupervised leave. The Police also received a phone call from Miss A's parents to advise that she was in the Cornerstone public house with a man she had just met, and both were intoxicated. The man had said he would pay for Miss A's taxi back to Pathway House. Further notes on the Police Call Log state that Miss A was being followed by staff members around St Neots. They were concerned about her behaviour, suggesting she needed placing under s136 (MHA)'. The Police spoke to her at length in Café Nero in St Neots and had no immediate concerns for her welfare, she had no intention of self-harming and wanted to remain in St Neots and return to Pathway House later that afternoon, which she did.

12.9.7 The Missing Persons record for the above incident contains some further information: the suggestion that the Police could use s136 MHA so that mental health

professionals can assess her came from the Care Coordinator, who the Police advised 'it didn't work like that and that if they believe she needs to be detained, then another robust act should be placed on her as Police were not MH professionals'.

12.9.8 On the 12th July 2016, Partnerships in Care assessed Miss A and offered her a place; Miss A did not like the placement and said she didn't want to move there.

12.9.9 An assessment visit to Crawley Road, Horsham was arranged for the 13th July 2016; Miss A said she would not go to a more restrictive placement or have two assessments so close together. It was rearranged for the 19th July 2016.

12.9.10 On the 13th July 2016, Miss A's parents' records state that Miss A contacted them in a very distressed state to tell them that she had been given 48 hours notice to leave Pathway House. They contacted the Care Coordinator that day and on the 14th July 2016 contacted the Care Quality Commission, who advised that a 48 hour notice to terminate the placement would not be legal.

12.9.11 There is a discrepancy between the records of Tracscare and the SPT and Miss A's parents. Tracsare state that 48 hours notice was not given, but that, if Miss A had not been detained under the MHA and she left the placement and needed to be returned by the Police they would not accept her as they considered they could not support her safely. SPT record that Miss A had been given 48 hours notice to leave, with the 15th July being the deadline.

12.9.12 SPT also record that they were advised by the Pathway House Manager that the 48 hours notice would not be enforced provided Miss A re-engaged with her care plan, having dis-engaged from therapeutic activities, and because an alternative placement had been identified. However, they restated the conditions under which they would enforce the 28 days notice of the termination of the placement. It was agreed that the Care Coordinator and the Lead Practitioner would visit Pathway House on the 18th July 2016 if necessary.

12.9.13 The confusion around whether or not Miss A had been given 48 hours notice of the termination of her placement appears indicative of a lack of coordinated and shared planning. The Care Coordinator had been given 28 days notice of the termination of the placement by email on the 10th June 2016; this notice had not been formally rescinded but had been extended to the 15th July 2016 to allow more time to find an alternative placement. It therefore technically still stood, hence the advice, albeit by a new member of staff, to her parents that the placement would terminate on the 15th July 2016. It was, however, rescinded on the basis described in 12.9.12 above.

12.10 13th July 2016 – 28th July 2016

12.10.1 On the 13th July 2016, Miss A's parents expressed concern about their daughter's wellbeing and mental state to the Care Coordinator and she agreed to ask Bedfordshire AMHP team why an assessment under the MHA hadn't previously taken place and to make a referral for such an assessment on their behalf.

12.10.2 On the 13th July 2016, the Care Coordinator contacted the Bedfordshire AMHP Service to make a referral for Miss A to be assessed under the MHA by an AMHP on behalf of her parents as Nearest Relative. This referral, the fourth referral of Miss A for an AMHP assessment under the MHA to the Bedfordshire AMHP service, was picked up by the Duty AMHP, who happened to be the AMHP candidate who declined the referral for an AMHP assessment on the 4th March 2016.

12.10.3 The Duty AMHP asked that Miss A's parents contact her direct if the referral was being made by them as Nearest Relatives. As a result of that telephone contact on the 14th July 2016, the Duty AMHP closed the assessment process as she understood Miss A's parents to be objecting to its going ahead.

12.10.4 On the 14th July 2016, Miss A was seen by the second Consultant Psychiatrist, in the absence of her Responsible Clinician, with a view to making a medical recommendation for Section 3.

12.10.5 On the 14th July 2016, Pathway House's records show that the second Consultant Psychiatrist assessed Miss A: during the assessment he received a message to contact Miss A's parents; with her permission, he did so. They advised him that a possible placement had been identified in Sussex, with a visit planned for the following Tuesday – the 19th July 2016 – and gave him the impression they would not support Miss A being detained under the MHA until this visit had happened.

12.10.6 As a result of speaking to Miss A's father on the 14th July 2016, the second Consultant Psychiatrist asked the Bedfordshire AMHP service to place the referral in abeyance until the following week, after Miss A would have been assessed by a possible new placement. It would appear that this request was not forwarded to the Bedfordshire AMHP Service.

12.10.7 On the 14th July 2016, the AMHP Team contacted the ATS to advise that they had not undertaken the MHA assessment as they had not received the medical recommendation to support any application for a section. They'd also spoken to Miss A's parents as the Nearest Relative and advised them that the assessment would most likely result in a s3 admission which applies for up to 6 months, not just for seventy-two hours to facilitate a move to a new placement. Her parents objected to this, so the assessment was abandoned with no further action to be taken.

12.10.8 On the 15th July 2016 the Brighton and Hove AMHP Practice Manager had telephone and email contact with the Bedfordshire AMHP Service regarding s117 aftercare and Brighton and Hove AMHP Service's general practice regarding referrals for assessments under the MHA.

12.10.9 On the 15th July 2016 the Brighton and Hove AMHP Practice Manager also contacted Pathway House by phone regarding the medical recommendation. The Pathway House Manager stated that the consultant psychiatrist met with Miss A last night and does not think that an assessment under the MHA is required at present as she is going to visit a possible alternative placement. She had also consented to an informal admission, if professionals assessed that it was required.

12.10.10 On the 13th July 2016, Miss A was advised of the plan agreed on the 4th July 2016; she advised her parents on the 13th July. They spoke to the Manager at Pathway House to express their concern that Miss A would be made homeless, but were advised that the plan would only be put into effect if she required a place of safety, which Pathway House was not.

12.10.11 On the 14th July 2016, in an email exchange between them, Miss A's parents advised the Care Coordinator that they had spoken to the CQC, who said that there two main criteria, namely that a patient cannot be discharged unless they are in a fit state to look after themselves or they are being discharged to appropriate accommodation, to be met before the placement could discharge Miss A and that, in the CQC's view, neither were met.

12.10.12 On the 15th July 2016, the Bedfordshire AMHP Service prepared to assess Miss A under the MHA; as the 15th July 2016 was a Friday, the AMHP who would be on Duty on the 18th July 2016 was allocated the assessment.

12.10.13 On the 18th July 2016, the Bedfordshire Duty AMHP contacted Milton Park having commenced the practical arrangements for the assessment – contacted a s12 Doctor – and was advised that they had withdrawn their request for an assessment under the MHA.

12.10.14 On the 18th July 2016, the Care Coordinator and the Lead Social Worker visited Miss A at the placement; she spoke of her fear of being sectioned as it reminded her of the five years she spent as an inpatient for an eating disorder when she was younger. She spoke of being able to visit the possible new placement but liked the second option, which had an assessment booked, better.

12.10.15 Miss A spoke about her use of alcohol to manage her anxiety and the incident when she jumped into the river; she said she'd stopped taking her prescribed medication, was intoxicated, felt as if she was hallucinating and needed to get off the bridge. Issues of capacity were discussed with the Manager at Pathway House and it was agreed Miss A didn't meet the criteria for the DoLS but the complexity of consent within the context of the diagnosis of Asperger's Syndrome, anxiety and impulsive decision-making was acknowledged.

12.10.16 The Police records show that on the 16th July 2016, staff at Milton Park advised them in the early afternoon that Miss A had left the placement at 8.10 am and gone to Bedford. 'Staff seemed concerned that they are not allowing her entry. This will leave her homeless (sic). It was pointed out this wasn't a matter for the Police.' She returned at 7.13 pm, drunk and refused to leave. The Police attended but Miss A wasn't causing any problems and hadn't been evicted. Pathway House records show that staff did contact the Police, but there is no mention of a conversation about eviction; staff requested support to find Miss A, but that the Police considered her 'absent' as opposed to 'missing.' Miss A returned independently at 19.55.

12.10.17 On the 19th July 2016, Miss A visited Crawley Road, Horsham, a second potential new placement for an assessment, and was pleased when, on the 22nd July 2016, she was offered a place

12.10.18 On the 20th July 2016, the Police were contacted by a member of the public about a female – Miss A – shouting and swearing and who appeared drunk. Pathway House staff came and collected her.

12.10.19 On the 21st July 2016, the Care Coordinator was in contact with the Bedfordshire AMHP Team seeking clarification as to why the MHA assessments had not taken place, the one in March 2016 and the three in June 2016.

12.10.20 On the 26th July 2016, the assessments from both specialist placements were sent to the Specialist Funding Panel with Miss A's preference given.

12.10.21 On the 26th July 2016, Pathway House staff suggested to Miss A that she visit Partnerships in Care so she could have more than one option to consider; she advised that she liked Crawley Road and didn't like too much choice but agreed to think about it. It is believed that the move to Crawley Road had been agreed for the 2nd August 2016.

12.10.22 On the 27th July 2016, Miss A left Pathway House in the morning to attend an appointment with her GP; she didn't return to Pathway House but was in regular telephone contact with staff during the day. Several times during the evening, she advised them she was about to return. She had also been in contact through the evening with her parents, who also encouraged her to return to the placement. Miss A's parents were also in contact with Pathway House and asked that they contact the Police, the final time at 11pm. They were advised that contact would be made at 1am if Miss A hadn't returned, which they considered too late.

12.10.23 At 2 am on the 28th July 2016, when Miss A had not returned and she had not been in contact for forty five minutes, the Police were alerted and she was registered as a Missing Person. At 5 am, the Police contacted Pathway House to advise them that Miss A had died in a traffic accident at 3 am and that they would arranging for two local police officers to advise the family face-to-face. The Metropolitan Police informed Miss A's parents of her death and the Care Coordinator contacted them later that day.

13. Analysis and Recommendations

13.1 This Safeguarding Adult Review is focused on the events that culminated in Miss A's death on the 28th July 2016 and on whether her death was predictable and should have been prevented.

13.2 In particular, this Review will consider:
1. How effective was the multi-agency involvement and contribution to assessment and understanding of risk
   a) at key stages of Miss A's care and at the time of the decision to move Miss A to a residential unit

b) in the way information relating to risk and support needs was shared with staff directly responsible for Miss A's care and support and

c) in the referrals to and responses from the AMHP Service

2 Are there lessons to be learnt from these experiences and from this case for future multi-agency risk assessment work, and that will enable agencies to consider how they could do things differently in the future, to prevent similar harm occurring again.

13.3 The Independent Author is aware of and had access to the Serious Incident Review Report that the ELFT has undertaken and that was completed on the 8th February 2017. The Review acknowledged that:

- 'this incident (the death of Miss A) has already been investigated through a Care Act (2014) Section 42 Safeguarding Review and the Serious Incident Reviewers have had access to the statements and interview notes of all interviewees for the Section 42 review and to the final version of the Enquiry Overview
- ELFT directors are aware that it has been agreed that this incident will form the subject of a Safeguarding Adults Serious Case Review (sic) commissioned by Bedford Borough Council (sic). Other involved organisations will also be providing individual agency reports for this review
- Therefore, it has been agreed that the scope of this Serious Incident Review will be limited to the contact of the patient or others acting on her behalf with ELFT services, largely the North Bedfordshire AMHP Service
- The panel are also aware of the Independent Review of Bedfordshire AMHP services commissioned by the Service Director for Bedfordshire and which is currently in draft form'

13.4 The above contains certain inaccuracies, which while not impacting on the quality of the Review or the validity of its findings, should be recognised:

- Section 42 of the Care Act (2014) relates to 'Enquiry by a local authority'
- A Section 42 Enquiry is carried out when an adult, amongst other criteria. 'is experiencing, or is at risk of abuse or neglect'.
- The first Enquiry was limited to the actions on the part of the Bedfordshire AMHP Service in responding to requests for the assessment of Miss A under the MHA
- A further Section 42 Enquiry was initiated by Bedford Borough Council and delegated to ELFT to carry out. This further Enquiry was to consider the treatment of Miss A by Pathway House and an allegation that they had planned to evict Miss A without adequate support and safeguards. This Enquiry was integrated into this Review and not therefore formally completed. The information that had been gathered for both Enquiries was made available to the Independent Author.
- There is no such Review as a 'Safeguarding Adults Serious Case Review'; Section 44 of the Care Act (2014) establishes 'Safeguarding Adult Reviews' and the criteria under which Safeguarding Adults Boards must commission such a review.
- The Safeguarding Adults Review was commissioned by the Bedford Borough and Central Bedfordshire Safeguarding Adult Board

13.5 The Independent Author has also had access to the Independent Review of the Bedfordshire AMHP Service referred to above and the Serious Incident Review completed by the SPFT.

13.6 This Review will not therefore repeat the investigations and analysis that were thoroughly undertaken as part of these reviews, which can be found in Appendices D, E, F and G attached, but findings and recommendations will made on the basis of the Section 42 Enquiry into the actions of the Bedfordshire AMHP Service.

13.7 The referral of Miss A to Tracscare occurred after an extended period at what was intended to be a short-term placement, when a placement providing a high level of support was unable to provide the stability and safety that Miss A was unable to provide for herself. The referral was made after a number of alternatives had been considered and rejected.

13.8 Although it falls outside of the time frame of this Review, the referral by the SPFT to Tracscare and their subsequent assessment does require comment, as, in many ways, it sets the stage for what happens during the placement. The referral, as described by the Responsible Clinician in his report to the Coroner states that Miss A "requires a locked rehab facility…… would require DOLS as she is informal." This is quite a different placement to that which Miss A's parents, and presumably Miss A, thought was being sought for her. As far as her parents were aware, Miss A was being placed on a locked ward on a short-term basis as part of the standard assessment process. They were also unaware of any assessment that she lacked capacity under the MCA, as is required for the Deprivation of Liberty Safeguards (DoLS) to be applicable to her.

13.9 The Pre-Admission Assessment Report, completed by the then-General Manager at the Milton Park Therapeutic Campus, contains no reference to Miss A's capacity or the need for the DoLS to be considered. It is noticeable that it contains more than one spelling of her forename and in one section, refers to her by an incorrect name. It also recommends that Miss A is assessed by the Speech and Language Team and has a 'Sensory assessment by Occupational Therapy', neither of which assessments appear to have been carried out. The report also recommends that Miss A transfer to Pathway House at or within 12 weeks as appropriate based on clinical assessment.

Finding 1:

The basis and expected outcomes of the placement at Milton Park were not clear, shared with Miss A or her parents, directly linked to her assessed needs or coordinated with her Care Programme Approach care plan.

Recommendation 1:

That the Board seek assurance that the Sussex Partnership NHS Foundation Trust has reviewed and, as necessary, revised its procedures for commissioning residential placements to ensure that all parties are enabled to be fully aware of the assessed needs of the person being placed, the expected outcomes of the

placement and be appropriately involved in their identification and commissioning.

Finding 2:

The process by which Miss A was assessed, offered a placement and admitted to Milton Park was ambiguous and lacking in detail and without a clear care plan with desired outcomes

Recommendation 2:

That the Board seek assurance that Tracscare have reviewed and, as necessary, revised its assessment and admission procedures to ensure that all parties are aware of the purpose, nature and intended outcomes of any service that is commissioned

Recommendation 3:

That the Board seek assurance that the Sussex Partnership NHS Foundation Trust has robust quality assurance procedures in place to ensure that commissioned placements meet their contractual obligations and expectations through the development and maintenance of a skilled workforce and risk management, safeguarding and care management processes and procedures.

13.10 A formal assessment of Miss A's capacity to consent to her admission to "Milton Park Hospital" was completed by her Responsible Clinician on the 30th December 2015. It states that Miss A does have an impairment/disturbance in the functioning of the mind or brain, but concludes that she does have the capacity at that time to make that decision. That assessment did not involve any discussion or information gathering from Miss A's parents or anybody with previous knowledge of her, only a staff nurse from the Hospital. The assessment states that Miss A's capacity should be reviewed "At the regular MDT."

13.11 The MDT Review form for the 12th January 2016 is blank where 'Mental Capacity Assessments or Best Interests decisions made' should be recorded. The forms for the meetings on the 9th February, 23rd March, 20th April, 15th June and 13th June 2016 state "Appears to have capacity day to day", but make no further reference to Miss A's capacity. The lack of a MDT Review during May 2016 is explained by there being a CPA Meeting held on the 19th May 2016, but the recording of that meeting contains no mention of Miss A's mental capacity.

13.12 The MCA specifies that mental capacity is both decision and time specific, a fact recognised in the assessment completed on the 30th December 2015. Statements such as "Appears to have to capacity day to day" do not comply with the Act and the lack of any formal review of her capacity, despite the above assessment stating that Miss A does have an impairment/disturbance in the functioning of the mind or brain, when she was prescribed and accepted psychotropic medication, displayed self-

destructive behaviour including a probable suicide attempt and was inconsistent in cooperating with agreed care plans is a cause of concern.

Finding 3:

Despite there being a clear statement from her Responsible Clinician on the 30th December 2015 that Miss A met the first stage of the two-stage functional test of capacity, there was no further consideration given to the impact of this on her behaviour and the possible need for a further assessment of her capacity and therefore her treatment/care plan or the legal options available to safeguard her

Recommendation 4:

That the Board seek assurance that Tracscare has reviewed and, as necessary, revised its policies and procedures to ensure that assessments under the Mental Capacity Act 2005 are completed and reviewed effectively and appropriately.

Recommendation 5:

That the Board seek assurance that the Sussex Partnership NHS Foundation Trust and Tracscare have reviewed and, as necessary, revised their policies, procedures and practice to ensure that all legal options, including those under the Mental Capacity Act 2005, are considered to appropriately safeguard patients/service users.

13.13 Despite Miss A being admitted to Milton Park due to concerns as to her mental health and autism and the resulting behaviour she demonstrated, there is no record of a formal Risk Assessment being completed at that time. The MDT Review held on the 12th January 2016 states that Risk Assessments are "Currently being completed by (the Applied Psychologist working at Milton Park)" He was under the clinical supervision of a Clinical Psychologist. The subsequent MDT Reviews are recorded as having reviewed the Risk Assessment.

13.14 On the 3rd March 2016, a referral was made by Milton Park to the Bedfordshire AMHP Service (the Service) requesting an assessment of Miss A under the MHA; the referral was supported by a risk assessment that detailed the various diagnoses and the risks they posed.

13.15 The referral and the risk assessment were forwarded to the two AMHPs on duty, who were supported by two colleagues, one of whom had recently completed the nationally accredited AMHP training but hadn't been warranted by the local authority; they were therefore referred to as an 'AMHP candidate'.

13.16 The Section 42 Enquiry identified that there was no clear process for the management, recording and record storage to support the procedure contained in the 'Approved Mental Health Professional (AMHP) Manual'. This is of relevance as the decision to screen out the referral for an assessment was made by the AMHP

candidate and there is no evidence that there was any oversight of that decision by either of the AMHPs on duty.

13.17 Section 13 of the MHA requires the local authority to provide AMHPs to undertake assessments; it therefore logically follows that only a warranted AMHP should make the decision to screen a referral out. The AMHP Manual contains no clear procedures to be followed to provide oversight to non-warranted AMHPs.

13.18 Part of the justification for the screening out of the referral was that the risks were identified as 'social vulnerability and substance misuse' but there was 'no clear evidence of presenting mental disorder and risks associated with that mental disorder'. However, the risk assessment clearly contained details of such disorders, namely Anorexia Nervosa, Obsessive Compulsive Disorder, Emotionally Unstable Personality Disorder and Asperger's Syndrome.

Finding 4:
That the referral for an assessment of Miss A by an AMHP was inappropriately screened out due to a lack of clear procedure to provide professional supervision and oversight to non-warranted AMHPs, compounded by a lack of a robust and efficient recording process for the management of such referrals, including a storage and retrieval process for such records

Recommendation 6:
That Board seek assurance that the AMHP Service has been effectively reviewed and appropriate remedial action implemented and monitored to ensure that its procedures and practice are fit for purpose and in accordance with the requirements of the Mental Health Act 1983 and its subsequent revisions.

Finding 5:
That the professional practice of the AMHPs on duty on the 3rd and 4th March 2016 and the AMHP Candidate fell below the standard required by both legislation and the AMHP Service's own practice Manual

Recommendation 7:
That the Board seek assurance that appropriate steps have been taken, in accordance with the AMHP Service's internal procedures, with regard to the members of staff who were or should have been involved in the decision to screen out the referral from Milton Park

13.19 On the 14th June 2016, a Risk Assessment was completed by Miss A's key worker, which identified Miss A as being at "High Risk" and outlined actions to be taken in specific situations. The assessment has no review date and makes no reference to her mental capacity.

13.20 On the 6th July 2016, a formal Risk Assessment and Management Plan was completed for Miss A by the Multi-Disciplinary Team. The copy provided to this Review was not signed. The Plan is a considerable document – it runs to 50 pages. It is a concern that a similar Plan was not produced at the time of Miss A's admission and

subsequently regularly updated. There is no evidence that Miss A's family was consulted in the completion of the Plan.

Finding 6:

There was no evidence of a formal or interim risk assessment being undertaken on Miss A's admission to Milton Park despite the concerns about her mental health and autism. There is reference to risk assessments being completed and further references to these being reviewed but no formal assessment recorded until June, some five months post-admission, but this contains no reference to her mental capacity and has no review date. When a formal Risk Assessment and Management Plan is completed in July, it is a comprehensive document but there is no evidence that Miss A's family were consulted during its completion

Recommendation 8:

That the Board seek assurance that Tracscare has reviewed and, as necessary, revised its policies and procedures to ensure that timely and effective Risk Assessments and Management Plans are developed, implemented and reviewed within individual supervision and multi-disciplinary team meetings, with particular reference to periods of transition between and within services.

13.21 A CPA Review was arranged for the 19th April 2016 but was cancelled as her Care Coordinator was not able to attend. It would appear that this was rescheduled for the 19th May 2016. The minutes of the meeting state "No previous actions due to this being (Miss A)'s first CPA meeting". It is perhaps semantic to question how a first meeting can be a Review, but it is a cause for concern that either there had been previous meetings under the CPA that Tracscare were unaware of or that someone with the level of identified needs who required a placement such as that at Tracscare was not managed through this process.

13.22 It is also a cause for concern that Miss A was discharged from an inpatient facility to a residential home without also transferring to community mental health services. This should have triggered a Discharge Planning Meeting under the CPA. The failure to do so, in effect, prevented her accessing community-based services such as crisis intervention services at particular times, such as the suicide attempt; it also meant that the Police would return her to Pathway House without referring her to community services and that the community services commissioned to support patients on their discharge as part of their day-to-day support package were not available to her.

13.23 It would be easy to criticise Tracscare for not referring Miss A to the local Community Mental Health Team (CMHT) when she was transferred to Pathway House, but that would be too simplistic. While some responsibility does reside with the MDT within Tracscare, there is also a responsibility on the SPFT, as the original coordinators of Miss A's CPA and funders of her placement with Tracscare to have done so too.

13.24 It would appear that the commissioning process that identified and contracted Tracscare to provide a placement for Miss A was flawed, albeit through the best intentions. Given the complexity of Miss A's identified care and support needs, a placement was commissioned that would provide continuity of care from the inpatient facility where she was initially placed for a period of assessment and treatment into a placement, also with treatment, in the community. In effect, both Ashwood Ward and Pathway House were seen as part of a single placement, a perception that was shared by Tracscare, the SPFT and Miss A and her parents.

13.25 An attraction of such a placement to both the provider, Tracscare, and the commissioner, the SPFT, is that it would retain professional responsibility within one agency who were being funded to provide specialist care and support services. However, the logical outcome of such a placement, was that no referral was made to community services on Miss A's discharge from Ashwood Ward, which doesn't accord with the ethos of the CPA, that it is based in secondary mental health care services such as CMHTs, or person-centred service provision. It is also more likely that the above tension between commissioning practice and the CPA will occur in the case of specialist out-of-area placements.

13.26 It is also the case that, had Miss A's CPA care plan been coordinated via the local CMHT, the Bedfordshire AMPH Service would have been better appraised of her situation and might therefore have responded differently to the requests from Milton Park for Miss A to be assessed under the MHA.

Finding 7:
That the provision of appropriate care and support services to Miss A on her discharge to the residential home was compromised by a lack of clarity between the Sussex Partnership NHS Foundation Trust, Tracscare and her GP as to its management within the Care Programme Approach.

Recommendation 9:

That the Board seeks assurance from the Sussex Partnership NHS Foundation Trust and Tracscare that they have reviewed and, as necessary, revised their policies and processes, re such as the Care Programme Approach, to overview and coordinate the care and support provided to patients when they transfer from inpatient to community care settings and to ensure that timely placement and care reviews take place

Recommendation 10:

That the Board seeks assurance that GPs in its area are implementing the Care Programme Approach correctly

13.27 Tracscare first raised serious concerns about the appropriateness of Miss A's placement with them the 31st March. At the CPA Meeting held on the 19th May 2016, it was agreed to extend the placement for two months to allow her to complete certain therapeutic work. What is not apparent is any positive planning of how to manage Miss A's escalating behaviour while an alternative placement was identified; given the

predictable impact of change and uncertainty on the behaviour of someone on the autistic spectrum, this is of particular concern when a specialist autism service is involved.

13.28 Miss A was regularly involved with the Police, whether directly because of her behaviour when intoxicated or when contacted by Pathway House staff when she didn't return from the community. The failure by Tracscare and the SPFT to develop and implement a joint strategy with the Police to manage Miss A's behaviour, despite the MDT Review Forms being routinely shared with the SPFT, is also a cause of concern. Likewise, the failure of the Police to identify the need for such a strategy, normally contained in a 'trigger plan' is also a cause of concern, though it is unrealistic to expect the Police to have a detailed understanding of the causation of or the possible options for the management of Miss A's behaviour.

Finding 8:

Miss A was well-known to the Police, as were the increasing concerns about her behaviour and her placement; while it is not reasonable to expect the Police to question the professional judgement of mental health professionals, it would be reasonable to expect them to have policies and procedures in place to ensure a consistent and safe response to adults who repeatedly come to their attention

Recommendation 11:

That the Board seek assurance that the Bedfordshire Police have reviewed and, as necessary, revised their policies and procedures for responding to adults with care and support needs who repeatedly come to their attention through actual or potential self-harm and accordingly liaise appropriately with neighbouring police forces

Finding 9:

In addition to the Police not developing a strategy to manage the repeated contacts they received re Miss A, there appears to be no protocol within the Board's area to facilitate a single agency, such as the Police, raising concerns about adults with complex risk issues, such as self-neglect, in a multi-agency forum other than through a safeguarding concern.

Recommendation 12:

That the Board establish a multi-agency protocol for identifying and responding to service users/patients with complex risk issues including a clear escalation process

13.29 There is, and will remain, a lack of certainty as to Miss A's actual intentions when she jumped from the bridge on the 8th June 2016. What is beyond dispute is that this was a further escalation of the risks that she posed to herself and potentially, though indirectly, to others. While staff at Tracscare, particularly her Responsible

Clinician did make several referrals for an AMHP assessment to be undertaken on Miss A, there is no evidence that any consideration was given to action under the MCA. This is despite the Responsible Clinician having assessed her on the 30th December 2015 as having an impairment/disturbance in the functioning of the mind or brain.

13.30 Given the above assessment and her increasingly risky behaviour, consideration should have been given by Tracscare and, if they were aware of the Responsible Clinician's assessment, the SPFT to seeking an order from the Court of Protection to enable restrictions to have been place on her behaviour and access to the community.

13.31 Concerns as to the responses of the AMHP Team to the referrals for Miss A to be assessed under the MHA are not directly within the remit of this Review, but there is cause for concern in the decision to withdraw the referral for an AMHP assessment on the 14th July 2016 pending Miss A visiting a possible alternative placement. Either an assessment was required or it wasn't; while there is a duty to seek the least restrictive option in safeguarding patients, there is still a duty to safeguard.

13.32 The lack of consistency between the records of Tracscare and SPFT and Miss A's parents as to the response to Miss A's behaviour and its implications for the safety and viability of her placement at Pathway House is also a cause for concern. While it was not the case that she was given 48 hours notice to leave the placement – a 28 day notice period was coming to its conclusion - it is clear is that she considered that she had and that there was a lack of coordinated planning involving all relevant parties, including her parents, to safeguard her at this time. Given her assessment of high functioning autism, this can only have exacerbated both the stress she felt and her behaviour.

Finding 10:
Despite their increasing concerns about the viability of her placement and the ability of Tracscare to provide a safe placement for Miss A within the Milton Park Campus, neither Tracscare nor the Sussex Partnership NHS Foundation Trust investigated or pursued alternative services local to Pathway House to support Miss A.

Recommendation 13:

That the Board seek assurance that Tracscare and the Sussex Partnership NHS Foundation Trust have reviewed and, as necessary, revised their processes for managing placements, particularly those that are exhibiting escalating risks and likely breakdown, including referral to local and multi-agency services and forums to develop, implement and monitor appropriate care plans to manage risk.

Finding 11:
Despite the initial referral from the Sussex Partnership NHS Foundation Trust to Tracscare specifically referring to the possible need to use the DoLS, at no point except at her point of admission, was a formal Mental Capacity Assessment undertaken despite increasing evidence that would suggest that she might lack

capacity in some areas of decision-making; equally, at no stage of her placement was consideration given to action under the Mental Capacity Act 2005, all attention was focused on action under the Mental Health Act 1983

Recommendation 14:

That the Board seek assurance that Tracscare and the Sussex Partnership NHS FoundationTrust have reviewed and, as necessary, revised their policies and procedures for implementing the Mental Capacity Act 2005, in particular when patients who have been assessed as having an impairment/disturbance in the functioning of the mind or brain are displaying increasingly risky behaviour.

Recommendation 15:

That the Board seek assurance that Tracscare, the Sussex Partnership NHS Foundation Trust and members have developed and implemented policies and procedures to consider all legal options, including the Mental Capacity Act 2005, the Court of Protection and the Inherent Jurisdiction of the High Court, to manage risk as part of an adult's care plan.

13.33 During her placement with Tracscare, Miss A's treatment was overseen by the same Responsible Clinician, and the same Clinical Psychologist, albeit that day-to-day management of her care was delegated to other members of the MDT. According to the MDT Review forms, Miss A was only seen by the Responsible Clinician on the 30th December 2015, at the MDT Review on the 12th January 2016, on the the 1st March 2016, the CPA Meeting on the 19th May 2016 and the 20th May 2016, though she did refuse to see him after the incident on the 8th June 2016.

13.34 The Clinical Psychologist, as the Applied Psychologist's Clinical Supervisor, did not see Miss A at any stage of her placement. The Applied Psychologist did attend all the MDT meetings but not the CPA Meeting. Miss A attended eighteen of the twenty two individual psychology sessions offered to her. However, in the Applied Psychologist's report, dated the 18th August 2017, he gives an admission date for Miss A to Milton Park as the 29th January 2015 and an incorrect date for her transfer from the Ashwood unit to the Elstow I unit. There is also no mention of any assessment of her mental capacity or her impaired functioning of her mind or brain, despite the dissonance between her actions and her sometimes stated awareness of her situation and difficulties.

Finding 12:
Despite the concerns about Miss A's behaviour and the ongoing appropriateness of her placement with Tracscare, the level of direct contact between her the two clinicians responsible for her care and treatment is slight in one and in the other non-existent.

Recommendation 16:

That the Board seek assurance that Tracscare have reviewed and, as necessary, revised their policy and practice with regard to those clinicians and staff

responsible for all aspects of patients' treatment plans have sufficient and regular contact with those patients to fulfil their responsibilities effectively.

13.35 As has been stated earlier – see 15.6 – this Review has not repeated the work undertaken effectively by the Serious Incident Review conducted by the ELFT and the Independent Review of the Bedfordshire AMHP Service, but would support their findings and recommendations.

Finding 13:
The Serious Incident Review conducted by the East London NHS Foundation Trust and the Independent Review it commissioned of the Bedfordshire AMHP Service are thorough and complete.

Recommendation 17:

That the Board seek assurance from the East London NHS Foundation Trust that the recommendations of the Serious Incident Review and the Independent Review of the Bedfordshire AMHP Service have been implemented and are being effectively monitored across the agency, in particular those relating to staff support, training and organisational learning.

Finding 14:
Serious concerns have been identified not only about the procedures, processes and systems operative within the Bedfordshire AMHP Service during the period of this Review but also about the professional performance of some members of staff.

Recommendation 18:

That the Board seek assurance from the East London NHS Foundation Trust that all concerns re the performance of individual members of staff identified in the course of the above Reviews have been addressed appropriately.

13.36 The situation with the AMHP service is complex and is comprehensively dealt with in the findings and recommendations from the two Reports and the s42 Enquiry contained in Appendices D, E and F. However, the failings identified in the s42 Enquiry in particular require consideration within this Report.

13.37 On the 3rd March 2016, a referral was made by Milton Park to the Bedfordshire AMHP Service (the Service) requesting an assessment of Miss A under the MHA; the referral was supported by a risk assessment that detailed the various diagnoses and the risks they posed.

13.38 The referral and the risk assessment were forwarded to the two AMHPs on duty, who were supported by two colleagues, one of whom had recently completed the nationally accredited AMHP training but hadn't been warranted by the local authority; they were therefore referred to as an 'AMHP candidate'.

13.39 The Section 42 Enquiry identified that there was no clear process for the management, recording and record storage to support the procedure contained in the 'Approved Mental Health Professional (AMHP) Manual'. This is of relevance as the decision to screen out the referral for an assessment was made by the AMHP candidate and there is no evidence that there was any oversight of that decision by either of the AMHPs on duty.

13.40 Section 13 of the MHA requires the local authority to provide AMHPs to undertake assessments in its areas; it therefore logically follows that only a warranted AMHP should make the decision to screen a referral out. It also follows that an AMHP warranted by Brighton and Hove City Council could not have assessed Miss A unless also warranted by Bedford Borough Council. The AMHP Manual contains no clear procedures to be followed to provide oversight to non-warranted AMHPs.

13.41 Part of the justification for the screening out of the referral is that the risks identified as 'social vulnerability and substance misuse' but there was 'no clear evidence of presenting mental disorder and risks associated with that mental disorder'. However, the risk assessment clearly contained details of such disorders, namely Anorexia Nervosa, Obsessive Compulsive Disorder, Emotionally Unstable Personality Disorder and Asperger's Syndrome.

Finding 15:
That the referral for an assessment of Miss A by an AMHP was inappropriately screened out due to a lack of clear procedure to provide professional supervision and oversight to non-warranted AMHPs, compounded by a lack of a robust and efficient recording process for the management of such referrals, including a storage and retrieval process for such records (see recommendation 6)

Finding 16:
That the professional practice of the AMHPs on duty on the 3rd and 4th March 2016 and the AMHP Candidate fell below the standard required by both legislation and the AMHP Service's own practice Manual

Recommendation 19:
That the Board seek assurance that appropriate steps have been taken, in accordance with the AMHP Service's internal procedures, with regard to the members of staff who were or should have been involved in the decision to screen out the referral from Milton Park

13.42 On the 9th June 2016, a new referral was made to the Service, concerns re Miss A having escalated, culminating in her jumping from a bridge into the river at St Neots. She had returned to Pathway House without any assessment of her mental health having been undertaken. The referral does contain information relating to the above suicide attempt.

13.43 On receipt of the referral, the AMHP on duty contacted Pathway House, but didn't speak to the member of staff who had made the referral, but to a Support Worker. As a result of this discussion, the AMHP decided that an intervention from an alcohol misuse team would be more appropriate and that an assessment under the MHA should only be undertaken as a last resort. There is evidence provided by Tracscare that the information provided by the Support Worker did not reflect Miss A's situation and was inaccurate.

13.44 The decision to screen out this referral was based on the assessment that Miss A's behaviour was symptomatic of her misuse of alcohol rather than any underlying mental health issues; this may have been accurate based on the information provided by the Support Worker, but would not appear to be consistent with the information provided in the referral or the referral made in March. It is of concern that no attempt was made to speaker to the referrer for clarification of Miss A's situation before the decision was made, as is the fact that there is no evidence that the March referral being considered in making the decision to screen out this referral.

Finding 17:

The decision to screen out the referral was inappropriate and made on insufficient information; the lack of information was due to the AMHP on duty not seeking clarification from the appropriate member of staff at Pathway House – the Manager rather than the Support Worker – and not accessing/having access to the referral made in March.

Recommendation 20:

That the Board seek assurance that the AMHP Service has reviewed and revised its practice and procedures to ensure that any clarification required to inform a decision as to the required action on receipt of a referral is sought from the professional who made the referral or someone of equivalent status within the referring agency

Recommendation 21:

That the Board seek assurance that the AMHP Service has established robust procedures to ensure that decisions as to the management of referrals are considered in the light of previous contacts relating to their subject.

13.45 On the 10th June 2016, when he was advised that the previous day's referral had been screened out, her Responsible Clinician made a further referral to the Service for an assessment under the MHA; in the referral he was explicit about the risks Miss A posed to herself, the suicide attempt and the inability of Pathway House to manage her safely.

13.46 Her Responsible Clinician spoke to the Service to reinforce the referral, it appears that the AMHP on Duty that he spoke to was unaware of the referral. The AMHP again suggested that Miss A's behaviour was alcohol-misuse related and that she needed to be seen by the medical team, despite the fact that the Responsible Clinician was a clinical psychiatrist. There are disagreements between the Responsible Clinician's and the AMHP's recollections of the telephone conversation, but whichever version is the more accurate, it was unprofessional in its outcome – the AMHP put the phone down on the Responsible Clinician.

13.47 According to the Responsible Clinician, he rang the Service back and spoke to a different AMHP but they 'reiterated that it is all alcohol and the decision will not change'. The Service has no record of this second telephone conversation, though it must be acknowledged that the quality of the recording made by the Service is variable at best.

13.48 The Service does record a telephone conversation between the first AMHP on Duty and the MHA Office Manager at Milton Park. In it the AMHP suggested that the Support Worker the previous day had said that 'no one had seen her (Miss A) or assessed her or come up with any treatment or management plan'. Consequently, the AMHP considered that a doctor should complete a medical recommendation and the Service would then consider it.

13.49 Given that a referral had been made to the Service, it seems highly unlikely that no assessment had been carried out or treatment plan put in place. Good practice would suggest that the assessment ought to be a joint assessment between the AMHP and the doctors; this does not sit with medical recommendations being completed in advance.

13.50 In a further telephone conversation between the MHA Manager and the AMHP on Duty, the AMHP was made aware of the third referral to the Service as it hadn't been passed to him. Despite this further information, the AMHP's decision remained to screen the referral out as the level of risk was low and that the issues re Miss A's alcohol misuse were the primary concern and hadn't been addressed. If Milton Park felt the risks were unmanageable, the AMHP advised that they contact the Emergency Duty Team.

13.51 When asked, as part of the s42 Enquiry, why he didn't contact back to the Responsible Clinician, the AMHP replied 'Well, I went back to (the MHA Office Manager) and it is quite obvious why, considering my previous engagement with (him). If they had any queries, they could have come back. ……I saw it as a referral from Milton Park not necessarily the RC. I went to the people who had involvement'.

13.52 On the 13th June 2016, a different AMHP contacted Milton Park and spoke to a Senior Support Worker as to Miss A's situation. They reported that she had been stable and engaged over the weekend though she had refused to see the psychiatrist.

The Service record a follow-up phone call from the Senior Support Worker after they had consulted with their manager when it was agreed not to be proportionate to go ahead with the assessment at that time. When asked as part of the s42 Enquiry, the Pathway House Manager did not recall any conversation with the Senior Support Worker and expressed the view that the Service should have spoken to her as the Manager.

13.53 The s42 Enquiry found that there was 'a difficult interaction between the AMHP and the (Responsible Clinician)' with both 'giving different accounts of their telephone exchange'. 'From evidence reviewed and interviews undertaken it appears that personal feelings got in the way of professional best practice'

Finding 18:

That there is no clear direction within the AMHP Service's Practice Manual as to who should be contacted for further information on receipt of a referral; good practice would suggest this should be the source of the referral or a professional of similar status

Recommendation 22:

That the Board seek assurance that the AMHP Service has reviewed and revised its Practice Manual to ensure it provides robust and appropriate guidance for staff to enable them to meet the requirements of the Mental Health Act 1983

Finding 19:

That both the AMHP on Duty and the Responsible Clinician allowed personal feelings to impact on their interaction on the 10th June 2016 to the detriment of the service provided to Miss A

Recommendation 23:

That the Board seek assurance that the appropriate action has been taken re both professionals under their respective agency's internal procedures

Recommendation 24:

That the Board seek assurance that Tracscare has appropriate and effective escalation procedures in place where risk is high and there are concerns abut other agencies' responses

Finding 20:

That the AMHP Service acted inappropriately in expecting a medical recommendation to be completed as part of the decision-making process as to

whether or not an assessment under the Mental Health Act 1983 was undertaken rather than as part of that assessment

Recommendation 25:

That the Board seek assurance from the AMHP Service that it has reviewed and revised as appropriate its procedures for undertaking and completing an assessment under the Mental Health Act 1983.

13.54 The s42 Enquiry established that the MHA Office at Milton Park did not want to put at risk the relationship between Milton Park and the Service; in the words of its Manager, 'we need you guys'. This concern was repeated in an interview with the Medical Director at Tracscare. As the Lead Investigator wrote, 'Whilst it is always desirable to have positive relationships between agencies, they must primarily be professional and open to question/challenge.'

Finding 21:

The ability of Milton Park staff to question and challenge the AMHP Service, and the ability of the AMHP Service to accept professional questioning and challenging, would appear to have been limited, again to the detriment of the service provided to Miss A.

Recommendation 26:

That the Board seek assurance that both the AMHP Service and Tracscare have reviewed the nature of their relationship and have put in place processes for the escalation of any concerns that arise in the future.

13.55 The three referrals to the Service for assessments of Miss A in March and June 2016 were all screened out essentially on the basis that her behaviour was the result of her alcohol misuse rather than her mental health issues. However, there is no evidence that the staff who received the referrals – both warranted and unwarranted AMHPs – considered the opposite possibility – namely that her misuse of alcohol was a response to her mental health issues. This is despite the referrals containing details of her mental health issues, including a suicide attempt.

Finding 22:

The responses of the AMHP Service to the referrals for an assessment under the Mental Health Act 1983 failed to demonstrate a reasonable level of 'professional curiosity' and remained focused on a very limited understanding of the possible causation of Miss A's behaviour, one that reinforced the initial triage process undertaken by an unwarranted AMHP and not overviewed by a warranted AMHP

Recommendation 27:

That the Board seek assurance that the AMHP Service has reviewed and revised its processes and procedures to monitor staff's performance through professional supervision and system management.

13.56 On the 13th July 2016, the Service was contacted by Care Coordinator requesting an assessment under the MHA; an hour later, she contacted the Service again, pointing out that she had done so on behalf of Miss As parents. Again, there are allegations about the unprofessional response of the AMHP on Duty to a referrer, though these were denied by the AMHP concerned. The Service sought confirmation from Milton Park as to whether a doctor would participate in the assessment or if a medical recommendation would be left for the AMHP.

13.57 The above again raises concerns about the Service's practice re undertaking assessments – see Finding 20 and Recommendation 25 above. It also led to a delay in arranging the assessment and responsibility for the assessment being passed to a second AMHP on the 14th July 2016. The second AMHP asked that the Nearest Relative contact her direct as she would rather receive the referral from them than from a third party.

13.58 This is good practice, as it allows the AMHP to ensure that the Nearest Relative, in this case Miss A's mother, has all the relevant information to make an informed decision about making the referral. However, the attitude of the AMHP is described as 'confrontational and dismissive', a further example of Service staff being viewed negatively by referrers.

13.59 The context of the referral from the Nearest Relative is important as Miss A's parents were concerned both for her safety and not to put at risk a possible alternative placement as the placement at Tracscare was generally agreed not to be working. It would appear that they were misinformed by the AMHP as the possible duration of any admission under the MHA. At no stage does it appear that the Service was asked to assess for an admission under s3 of the MHA; they were asked to assess Miss A and part of that assessment would have been to determine, if she needed to be admitted under section, whish section was most appropriate. On the 14th July 2016, the second Consultant Psychiatrist, in her Responsible Clinician's absence, had requested an assessment with a 'view to admitting (Miss A) into hospital for medical assessment or treatment'; admission under s3 MHA is for Treatment. Given the Service's insistence that no mental health issues had been identified as causing Miss A's behaviour then an admission under s2 could well have been appropriate.

13.60 On the basis of the above, to suggest that any formal admission to hospital could be for 'up to three -six months' would appear to be unwarranted, as was the suggestion that would be no choice as to where Miss A was admitted. There is no suggestion that she could not have been admitted to the inpatient facility at Milton Park.

13.61 At the end of the telephone conversation, Miss A's mother withdrew their request for an assessment in case it jeopardised possible alternative placements. The AMHP took this to be an objection to the assessment and therefore ceased the assessment process. There is a disagreement between the Service and the SPFT as to the legality of this decision, but there is also the question as to whether the Nearest Relative can object to an assessment or only to an admission under s3 of the MHA. My own reading of the MHA 2007 Schedule 2, 4(4a) is the latter and that the assessment could and should have gone ahead so that Miss A's mother could have made a fully informed decision as to whether or not to oppose any proposed hospital admission.

Finding 23:

That the AMHP Service ceased the assessment of Miss A under the Mental Health Act 1983 inappropriately as the Nearest Relative was not objecting to the assessment, only a possible outcome of that placement which had yet to be determined.

Recommendation 28:

That the Board seek assurance that the AMHP Service has reviewed and revised as necessary its practice and procedures for managing Nearest Relative requests for assessments under the Mental Health Act 1983

13.62 Suffice to say, Miss A was never actually assessed by the Service, despite the referrals containing sufficient information to indicate the need for an AMHP assessment to be completed.

14 Conclusions

14.1 On the basis of the above analysis, the Findings and Recommendations can be seen to highlight two principle areas of poor practice that need to be addressed.

14.2 The first is the failure to implement the Care Programme Approach as it should have been, resulting in Miss A's care and support needs not being properly assessed and therefore not being met in a holistic and multi-agency manner. The most striking example of this is the failure to convene a Discharge Planning meeting under the CPA to identify Miss A's care and support needs in the community and how they might be best met. In fact a meeting under the CPA was cancelled because it had been arranged for what transpired to be a week after her transfer to Pathway House.

14.3 Given the number of patients/residents placed on the Milton Park Therapeutic Campus – according to the CQC Inspection Report from November 2016 there were 44 patients -, the number of adults who could be in a similar position to Miss A, with regard to access to community mental health services, is relatively large. A majority of those patients will be placed from outside of Bedfordshire, and so it is a reasonable

assumption that it is common practice across the country that transfers from inpatient to residential facilities occur without being referred to local community services.

Recommendation 29:

That the Board raises its concerns about the implementation of the Care Programme Approach in specialist inpatient/residential services regionally and nationally.

Recommendation 30:

That the Board seeks reassurance from Tracscare that it has addressed the proper implementation of the Care Programme Approach, particularly when patients are discharged to the residential units, with all of its placing commissioners.

14.4 The second area is the failure to consider the clear implications for Miss A of her meeting the first stage of the two-stage functional test for capacity. This should have led to her mental capacity being regularly reviewed and her behaviour being considered in the light of her having a disturbance or impairment in the functioning of her mind or brain.

14.5 Failure to do either of the above, despite her mental capacity being identified in the referral to Milton Park, meant that her behaviour may have been mis-interpreted and remedial options, that may well have been more acceptable to Miss A and her parents and therefore more successful, were not considered or explored. Recommendations to address these issues have already been identified.

14.5 Following on from the above, the following conclusions would appear to be appropriately drawn in response to the questions contained in the Review's Terms of Reference.

14.6 There were only two agencies involved with Miss A at the time of her referral to, assessment for and admission to Milton Park Hospital, Tracscare and the SPFT; as the above Analysis and recommendations demonstrate, the quality and therefore the effectiveness of multi-agency involvement and information sharing was variable. This would appear to have been compounded by the lack of involvement at times of Miss A's family.

14.7 There would appear to be several factors that will have exacerbated the above:

- A change in care coordinator cannot have helped, as the Care Coordinator both had knowledge of and a relationship with Miss A and her family that the Interim Care Coordinator could not be expected to match
- There appears to have been conflicting information as to the nature of the placement being sought and the nature of Miss A's capacity to make decisions
- The distance between the commissioner and the provider led to a reliance on communication mediums, other than face-to-face, which lack subtlety and nuance

- It is not clear how up-to-date the SPFT were kept of the progress of the placement as it was managed between the MDT meetings
- While, as an adult, Miss A was entitled to expect her confidentiality and autonomy to be respected, there were times when it would have been good practice to consult with her parents. For example, when the Mental Capacity Assessment was completed on the 30th December 2015, no contact was made with Miss A's family despite their being a potential valuable source of relevant information.

14.8 The issues of multi-agency working were also exacerbated in the case of communication between Tracscare and the AMHP Team. In this case, it has been established that personal factors overrode professional considerations.

14.9 Equally the involvement of the Police on an ever more frequent basis should have led to their being part of planning Miss A's care and support. As the specialist service, Tracscare should have initiated this involvement, but, and despite there being more than one police force involved, the Police should have identified the increasing frequency of their involvement and the implications of where Miss A lived.

14.10 The decision to move Miss A to the residential home, or more accurately to agree to her requests to do so, and the timing of her doing so, does not appear to have happened on the basis of clinical judgement and multi-agency assessment. The same can be said for the decision to include and then increase her time away from the placement, at weekends in particular, within the care plan agreed with her.

14.11 The MDT did regularly – monthly – consider and review Miss A's care and support needs and this information was shared within Tracscare and with the SPFT; however, the staff who were clinically responsible for her care, as opposed to the staff who provided the care, appear to have had relatively little contact with her.

14.12 It is not possible to know whether Miss A's death was a tragic accident or deliberate suicide, though her parents are convinced it was the former. In that sense it is not possible to state that it was predictable in the manner and time that it happened. However, given her increasingly risky behaviour, the recent probable suicide attempt when she jumped from the bridge and the likely impact of the uncertainty of her immediate future, it was predictable that she would continue to put herself in situations that could prove to be fatal at worse, but could certainly cause her serious injury. It is therefore of some concern that she was able to leave Pathway House the morning after the probable suicide attempt without any action being taken to ensure her safety.

14.13 Could, therefore, her death have been prevented? Again, it is not possible to state unequivocally that it could have been prevented, but it might have been prevented if either an AMHP assessment had been undertaken or an order sought from the Court of Protection. However, both those courses of action would only have prevented her death if Miss A was found to meet the criteria for action under the MHA or the MCA.

14.14 Even if action as outlined above had taken place, if Miss A's death was a deliberate suicide, then such action may only have delayed the inevitable.

14.15 Miss A, possibly as a result of being moved from mainstream to a special school as a young child, disliked intensely and rebelled against being 'labelled', as she saw it, with a diagnosis. This may well have compounded the conflict she felt between being able to understand the changes she needed to make in her behaviour and her inability to make those changes due to her autistic world-view.

14.16 In addition, it is predictable that the uncertainty about the changes in her immediate future would have been exacerbated by her autism; her need for structure and consistency to be provided, if not imposed externally, was ultimately not met. This is not to deny the difficulties, both practical and legal, in providing and implementing that structure and consistency, but the systems and processes that should have explored all the options available to her failed to do so.

Finding 24:
The National Autistic Society has identified five principles that should underpin work with those with autism, 'SPELL':

- **Structure – the importance of making the person's world predictable and manageable**
- **Positive – establish and reinforce self-confidence and self-esteem by building on natural strengths, interest and abilities**
- **Empathy – seeing the world from the person's standpoint, knowing what motivates or interests them, but importantly what may frighten, preoccupy or distress them**
- **Low arousal – approaches and the environment need to be calm and ordered so as to reduce anxiety and aid concentration**
- **Links – working alongside the person, their families and other professionals to reduce the risk of misunderstanding, confusion or the adoption of fragmented, piecemeal approaches; to create and maintain links between the person, their wider support networks and the community**

There is clear evidence through out the period of this Review that the services offered and provided to Miss A did not consistently accord with the above principles of good practice of working with adults with autism. For example, Miss A was enabled to disrupt the structures that were attempted to be put in place to make her world predictable and manageable; she felt less self-confident and her self-esteem deteriorated during the placement as evidenced by her suicide attempt; the independence that she both wanted and feared caused her distress as did the lack of security of her placement; she persistently sought aroused emotional states including through the consumption of alcohol and drugs; her family were not routinely involved in decision-making about how her care and support.

Recommendation 31:

That the Board seek assurance that services for adults and children with a diagnosis/assessment of autism within its area are designed and delivered in accordance with the SPELL principles

15 Recommendations

Recommendation 1:

That the Board seek assurance that the Sussex Partnership NHS Foundation Trust has reviewed and, as necessary, revised its procedures for commissioning residential placements to ensure that all parties are enabled to be fully aware of the assessed needs of the person being placed, the expected outcomes of the placement and be appropriately involved in their identification and commissioning.

Recommendation 2:

That the Board seek assurance that Tracscare have reviewed and, as necessary, revised its assessment and admission procedures to ensure that all parties are aware of the purpose, nature and intended outcomes of any service that is commissioned

Recommendation 3:

That the Board seek assurance that the Sussex Partnership NHS Foundation Trust has robust quality assurance procedures in place to ensure that commissioned placements meet their contractual obligations and expectations through the development and maintenance of a skilled workforce and risk management, safeguarding and care management processes and procedures.

Recommendation 4:

That the Board seek assurance that Tracscare has reviewed and, as necessary, revised its policies and procedures to ensure that assessments under the Mental Capacity Act 2005 are completed and reviewed effectively and appropriately.

Recommendation 5:

That the Board seek assurance that the Sussex Partnership NHS Foundation Trust and Tracscare have reviewed and, as necessary, revised their policies, procedures and practice to ensure that all legal options, including those under the Mental Capacity Act 2005, are considered to appropriately safeguard patients/service users.

Recommendation 6:

That Board seek assurance that the AMHP Service has been effectively reviewed and appropriate remedial action implemented and monitored to ensure that its procedures and practice are fit for purpose and in accordance with the requirements of the Mental Health Act 1983 and its subsequent revisions.

Recommendation 7:

That the Board seek assurance that appropriate steps have been taken, in accordance with the AMHP Service's internal procedures, with regard to the members of staff who were or should have been involved in the decision to screen out the referral from Milton Park

Recommendation 8:

That the Board seek assurance that Tracscare has reviewed and, as necessary, revised its policies and procedures to ensure that timely and effective Risk Assessments and Management Plans are developed, implemented and reviewed within individual supervision and multi-disciplinary team meetings, with particular reference to periods of transition between and within services.

Recommendation 9:

That the Board seeks assurance from the Sussex Partnership NHS Foundation Trust and Tracscare that they have reviewed and, as necessary, revised their policies and processes, re such as the Care Programme Approach, to overview and coordinate the care and support provided to patients when they transfer from inpatient to community care settings and to ensure that timely placement and care reviews take place

Recommendation 10:

That the Board seeks assurance that GPs in its area are implementing the Care Programme Approach correctly

Recommendation 11:

That the Board seek assurance that the Bedfordshire Police have reviewed and, as necessary, revised their policies and procedures for responding to adults with care and support needs who repeatedly come to their attention through actual or potential self-harm and accordingly liaise appropriately with neighbouring police forces

Recommendation 12:

That the Board establish a multi-agency protocol for identifying and responding to service users/patients with complex risk issues including a clear escalation process

Recommendation 13:

That the Board seek assurance that Tracscare and the Sussex Partnership NHS Foundation Trust have reviewed and, as necessary, revised their processes for managing placements, particularly those that are exhibiting escalating risks and

likely breakdown, including referral to local and multi-agency services and forums to develop, implement and monitor appropriate care plans to manage risk.

Recommendation 14:

That the Board seek assurance that Tracscare and the Sussex Partnership NHS Foundation Trust have reviewed and, as necessary, revised their policies and procedures for implementing the Mental Capacity Act 2005, in particular when patients who have been assessed as having an impairment/disturbance in the functioning of the mind or brain are displaying increasingly risky behaviour.

Recommendation 15:

That the Board seek assurance that Tracscare, the Sussex Partnership NHS Foundation Trust and members have developed and implemented policies and procedures to consider all legal options, including the Mental Capacity Act 2005, the Court of Protection and the Inherent Jurisdiction of the High Court, to manage risk as part of an adult's care plan.

Recommendation 16:

That the Board seek assurance that Tracscare have reviewed and, as necessary, revised their policy and practice with regard to those clinicians and staff responsible for all aspects of patients' treatment plans have sufficient and regular contact with those patients to fulfil their responsibilities effectively.

Recommendation 17:

That the Board seek assurance from the East London NHS Foundation Trust that the recommendations of the Serious Incident Review and the Independent Review of the Bedfordshire AMHP Service have been implemented and are being effectively monitored across the agency, in particular those relating to staff support, training and organisational learning.

Recommendation 18:

That the Board seek assurance from the East London NHS Foundation Trust that all concerns re the performance of individual members of staff identified in the course of the above Reviews have been addressed appropriately.

Recommendation 19:

That the Board seek assurance that appropriate steps have been taken, in accordance with the AMHP Service's internal procedures, with regard to the members of staff who were or should have been involved in the decision to screen out the referral from Milton Park

Recommendation 20:

That the Board seek assurance that the AMHP Service has reviewed and revised its practice and procedures to ensure that any clarification required to inform a decision as to the required action on receipt of a referral is sought from the professional who made the referral or someone of equivalent status within the referring agency

Recommendation 21:

That the Board seek assurance that the AMHP Service has established robust procedures to ensure that decisions as to the management of referrals are considered in the light of previous contacts relating to their subject.

Recommendation 22:

That the Board seek assurance that the AMHP Service has reviewed and revised its Practice Manual to ensure it provides robust and appropriate guidance for staff to enable them to meet the requirements of the Mental Health Act 1983

Recommendation 23:

That the Board seek assurance that the appropriate action has been taken re both professionals under their agency's internal procedures

Recommendation 24:

That the Board seek assurance that Tracscare has in place appropriate and effective escalation procedures in place where risk is high and there are cncerns abut other agencies' responses

Recommendation 25:

That the Board seek assurance from the AMHP Service that it has reviewed and revised as appropriate its procedures for undertaking and completing an assessment under the Mental Health Act 1983.

Recommendation 26:

That the Board seek assurance that both the AMHP Service and Tracscare have reviewed the nature of their relationship and have put in place processes for the escalation of any concerns that arise in the future.

Recommendation 27:

That the Board seek assurance that the AMHP Service has reviewed and revised its processes and procedures to monitor staff's performance through professional supervision and system management.

Recommendation 28:

That the Board seek assurance that the AMHP Service has reviewed and revised as necessary its practice and procedures for managing Nearest Relative requests for assessments under the Mental Health Act 1983

Recommendation 29:

That the Board raises its concerns about the implementation of the Care Programme Approach in specialist inpatient/residential services regionally and nationally.

Recommendation 30:

That the Board seeks reassurance from Tracscare that it has addressed the proper implementation of the Care Programme Approach, particularly when patents are discharged to the residential units, with all of its placing commissioners.

Recommendation 31:

That the Board seek assurance that services for adults and children with a diagnosis/assessment of autism within its area are designed and delivered in accordance with the SPELL principles

Appendices

Appendix A

Bedford Borough and Central Bedfordshire Safeguarding Adults Board's Safeguarding Adult Review Framework

Appendix A.docx

Appendix B

Request Form for SAR Case A 2017

Appendix B AnonymousV.docx

Appendix C

Terms of Reference for Safeguarding Adults Review Case A 2016

Appendix C AnonymousV.docx

Appendix D

East London NHS Foundation Trust – Findings and Recommendations of Serious Incident Review Report re death of Miss A

Appendix D AnonymisedV.docx

Appendix E

Findings and Recommendations of Independent Review Report re Bedfordshire AMHP Service

Appendix E Anonymised.docx

Appendix F

Findings and recommendations of a S42 Enquiry re into the action on the part of the Bedfordshire AMHP Service in responding to the requests for assessment of Miss A under the Mental Health Act 1983.

Appendix F AnonymisedV.docx

Appendix G

Sussex Partnership NHS Foundation Trust – Findings and Recommendations of a Serious Incident Review Report re the death of Miss A

Appendix G.doc

Appendix H

Glossary

ATS – Assessment and Treatment Service. This serves the same function as a CMHT within the SPFT, providing a range of specialist support and treatment to help people maintain their mental health who are over the age of 18 and experiencing moderate to severe mental health issues. The service provides access to specialist assessment and treatment and a brief interventions and care coordination for complex issues which support the person's recovery journey.

AMHP – Approved Mental Health Practitioner. A professional who has been accredited nationally and warranted by a local authority to carry out assessments under the Mental Health Act 1983 and 2009. The overwhelming majority of AMHPs are registered Social Workers.

AMHP Team – Approved Mental Health Practitioner Team. A local team that receives referrals for and makes the appropriate arrangements in response to assessments under the Mental Health Act 1983 and 2009

Care Coordinator - A Care Coordinator is responsible for ensuring that the person's health, social care needs and safety needs are met either by themselves or with the help of others, they will also be responsible for developing a support plan with the person and reviewing this at regular intervals according to the changing nature of their needs. The care coordinator will monitor service user while at an out of area specialist placement as per CPA policy and as requested by panel

CMHT – Community Mental Health Team. A multi-disciplinary team, normally jointly managed and resourced by the local authority and health, providing a range of specialist support and treatment to help people maintain their mental health who are over the age of 18 and experiencing moderate to severe mental health issues. The service provides access to specialist assessment and treatment and a brief interventions and care coordination for complex issues which support the person's recovery journey.

CPA – Care Programme Approach. Some service users have complex characteristics and are more at risk. Their mental health problems impact significantly on daily life and they need intensive support, with a higher level of engagement, co-ordination and support. They may have additional health problems, or substance misuse issues, and be socially isolated, lacking in support networks.

Under CPA a person will have a Care Coordinator who is responsible for ensuring that the person's health, social care needs and safety needs are met either by themselves or with the help of others, they will also be responsible for developing a support plan with the person and reviewing this at regular intervals according to the changing nature of their needs. The care coordinator will monitor service user while at an out of area specialist placement as per CPA policy and as requested by panel

CQC – the Care Quality Commission. The independent regulator of all health and social care services in England.

DoLS – Deprivation of Liberty Safeguards. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. The safeguards set out a process that hospitals and care homes must follow if they believe it is in the person's best interests to deprive a person them of their liberty, in order to provide a particular care plan.

MCA – Mental Capacity Act 2005. The current legislation that provides a statutory basis to the identification, assessment and management of adults who are deemed to lack the mental capacity to make a specific decision at a specific time.

MDT – Multi-disciplinary Team. This usually consisting of a range of professionals, including Psychiatrists, Nurses, Occupational Therapists, Social Workers, psychologists and support workers, working with a designated group of service users/patients

Mental Health Act Office - this is the office on the Milton Park campus dedicated to monitoring mental health act compliance and is comprised of the MHA Manager and her Assistant

MHA – Mental Health Act 1983, The current legislation that provides a statutory basis to the identification, assessment and treatment of adults with mental health issues.

MHRRS – Mental Health Rapid Response Service. Within the SPFT, this service provides an urgent response for people not under the care of the ATS, experiencing a mental health crisis. The team provides advice and support, including safety planning and signposting within 30 minutes of the call and will arrange a face to face assessment within four hours where needed. Also provides out of hours duty support for people under the care of the ATS.

SARF – The Safeguarding Adult Review Framework. The policy and procedure by which the Bedford Borough and Central Bedfordshire Council Safeguarding Adults Board meets its legal obligations under Section 44 of the Care Act 2014.

Specialist Funding Panel. At the time relevant to this review, the Pan-Sussex Non-Prescribed Specialised Mental Health Services Funding Panel sat within the care group known as the complex care pathway in SPFT. The primary purpose of the panel was to scrutinise applications for individual packages of inpatient /hospital mental health treatment for patients that required outside the current range of local and NHS England commissioned NHS Service agreements for adults aged 18 years plus. The decision making process was based on sound clinical judgement and scrutiny, with the support of CCG and SPFT management.

The Panel was made up of the following: CCG Mental Health Commissioning Manager (Chair), CCG Mental Health Commissioning Manager (Co-Chair), SPFT Manager, SPFT Clinical experts including Psychology, Psychiatry, Nursing and Occupational Therapy, CCG Quality Representative, SPFT Finance representative and SPFT Administrator.

SPFT Manager- General Manager This post scrutinised applications prior to submission to Panel, to ensure applications were both appropriate and of good enough quality before being submitted to the Panel and ensured that there were processes in place for all placements to be regularly reviewed and reported to the Panel.

CCG Quality Representative- Clinical Quality & Patient Safety Manager, BHCCG. This post ensured that appropriate minimum quality standard checks were undertaken for each provider and provided assurance to the Panel about this. It also ensured that quality and safety issues were brought to the Panel's attention through assessments/applications/reviews.

She planned to attend the CPA review as a representative of the panel to review the placement and gain an overview of units where Brighton and Hove patients are placed.

SPFT Financial Representative- Specialised Services' Commissioning Finance

Provides accurate and timely information about activity and cost on a monthly basis. Notifies commissioners and seeks agreement about changes to costs as a result of changes to individual packages of care

Trigger Plan – A defined course of action put in place by Bedfordshire Police typically for someone who goes missing three times in 30 days or if they have specific vulnerabilities in order that the responding officer knows what course of action is expected to be taken. Trigger plans contain background information about a person, such as their risk factors and history. It also contains key information around the actions you should take if you are investigating that person as missing.