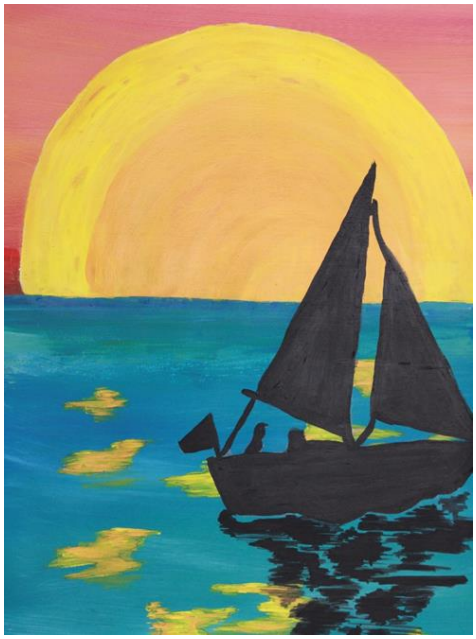

# Safeguarding Adults Review (SAR)

# Overview Report

# **Louise**

Jointly commissioned by Nottinghamshire Safeguarding Adult Board and Nottinghamshire Safeguarding Children Partnership

Lead Reviewers: Sarah Williams and Professor Christine Cocker

Independent Safeguarding Consultants, Safeguarding Circle

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# 1. Introduction

1.1 Nottinghamshire Safeguarding Adults Board (NSAB) and Nottinghamshire Safeguarding Children Partnership (NSCP) have commissioned this Safeguarding Adult Review (SAR) after Louise (born in 2003) completed suicide while detained in hospital under s3 of the Mental Health Act 1983 (MHA) in autumn 2022. Louise had a significant history of self-harm and suicidal behaviour from the age of 14, and had moved between secure residential units and psychiatric hospitalisations (either under the MHA or informal) from mid-2019 until her tragic death. She was diagnosed with Emotionally Unstable Personality Disorder in 2021.

1.2 Louise was generous, kind, spirited and cheeky, a big character who was very popular with her peers and the staff who worked with her, who described '*howling with laughter'* at Louise's dry, sarcastic wit. She was intelligent and creative, a talented poet and artist - the art on the cover is an example of Louise's work. Louise loved animals and wanted to work with them, but had been unable to take up a work placement with a veterinarian because of the risk she could self-harm with the surgical instruments. She had masses of family photographs on display in her room and talked about them often and was particularly close with her brother who is a year older than her. Louise's mother described her as "*adorable*" as a child, but that she faced many challenges that she did not necessarily understand when she was younger, although her awareness of her conditions grew as she matured.

1.3 Practitioners agreed that as an adult, Louise had insight into her mental health needs and had clear views on what she found helpful in terms of her psychotherapy. She appreciated honesty in respect of her treatment, even if she did not agree with what was proposed. She yearned to live independently, but her presentation appeared to be getting worse not better, with voices in her head telling her to harm herself and others. Practitioners explained that although Louise self-harmed very frequently and with alarming severity, she never wanted to die, but rather was eliciting care to feel safe after a childhood characterised by trauma and abandonment. However, there was always a risk that she would take it too far one day. The degree of skill and vigilance required to keep Louise alive was immense, and this was a huge emotional pressure for the dedicated team working with her. Even during periods when she appeared to be self-harming less often, her eating disorder would escalate – a different form of self-harm. Louise was profoundly compassionate to others and it is a tragedy that she could not extend that compassion to herself.

1.4 The authors are grateful to Louise's mother for meeting with us, helping us to understand this kind, loving young woman, who tried to protect her family from feeling hurt or distressed by the behaviours that arose from her mental health needs, and always wanted to live a 'normal' life. We wish to express our sincere condolences to Louise's family and friends for their loss. The authors are also grateful to the professionals who worked with Louise for sharing their insight into her experiences so honestly. It was clear that Louise was held in great affection by those who worked with her, and they had worked tirelessly to try to help her. Overall, the quality of care Louise received was impressive, with a caring, committed professional network offering person-centred support. However, her mother believed that the frequent moves Louise experienced between placements and hospital settings were harmful to her, disrupting the relationships that she valued, including those with practitioners which could have better supported effective safeguarding. Her death had an enormous impact on her family as well as on practitioners, and the memories they shared were very moving.

# 2. Scope of Review

## Purpose of a Safeguarding Adult Review

2.1. The purpose of having a SAR is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died; its purpose is:

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults;
- To review the effectiveness of procedures (both multi-agency and those of individual organisations);
- To inform and improve local interagency practice;
- To improve practice by acting on learning (developing best practice); and
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

2.2. There is a strong focus on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect Louise from harm. The learning produced through a SAR concerns 'systems findings', which are the underlying issues that helped or hindered in the case and are systemic rather than one-off issues**.** Systems findings identify social and organisational factors that make it harder or easier for practitioners to proactively safeguard, within and between agencies.

## Themes

2.3. This review focusses on the period of January 2020 until the day before Louise's death in late 2022. The NSAB and NSCP prioritised the following themes for illumination through the SAR:

- How well did services supporting Louise as a child and young person have an understanding of her as an individual, and with a trauma informed approach? Was Louise's voice heard and responded to?

- To what extent did social care, police and health services take a co-ordinated approach to ensure her individual needs were identified and met? Were practitioners sufficiently skilled and experienced to explore and respond to mental health needs?

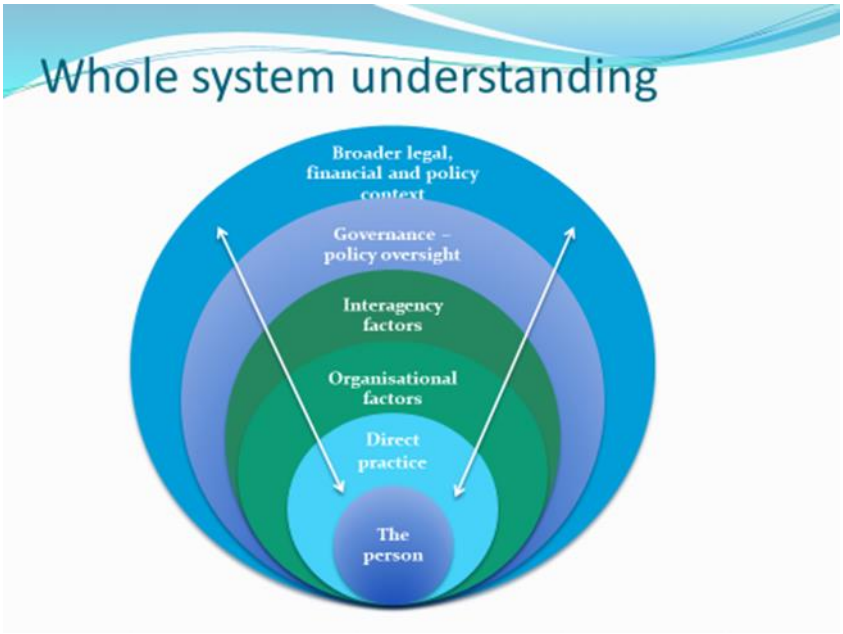
- Were the transitions arrangements from children's to adults' services thorough enough to meet Louise's needs? To what extent did adults' services recognise Louise's needs as a young adult, within the framework of Transitional Safeguarding?

2.4. Due to an ongoing criminal investigation, the events on the day of Louise's death are outside the scope of this review.

2.5. The period of the review incorporated the national lockdowns in relation to the Covid-19 pandemic, that had a significant impact on Louise and the services attempting to support her which are referenced in the narrative chronology. However, these challenges were managed in accordance with best practice and government guidance at that time, so are not the focus of the learning in this review.

## Methodology

2.6. The case has been analysed using a learning together approach, through the lens of evidence-based learning from research and the findings of other published SARs.[1] Learning from good practice and a discussion of the legal framework have also been included. By using that evidence-base, the focus for this review has been on identifying the facilitators and barriers with respect to implementing what has been codified as good practice. The review has adopted a whole system focus. What enables and what obstructs best practice may reside in one or more of several domains, as captured in the diagram below.[2] Moreover, the different domains may be aligned or misaligned, meaning that part of the focus must fall on whether what might enable best practice in one domain is undermined by the components of another domain.




2.7. The overarching purpose of the review has been to learn lessons about the way in which professionals worked in partnership to support and safeguard Louise. Agencies provided reports setting out a description of their involvement with Louise, with a chronology of key events. The authors used these to draw together an Early Analysis Report, summarising the agency returns to provide a framework for multi-agency discussions at learning events with front-line practitioners who worked directly with Louise and the leaders who oversaw the services involved in supporting her.

## Involvement of Louise's family

2.8. Louise's mother was invited to meet with the reviewers and a meeting date was arranged, but this was delayed at her request. Consequently, this meeting took place after the conclusion of the review process, and the authors have revised the report to incorporate her views, reflecting on how these have impacted the findings and recommendations. We are very grateful to her for sharing her insight into Louise's needs and the professional response to these. She was fair and measured during this discussion, setting out examples of good practice and positive relationships that some practitioners were able to build with Louise. However, she also expressed her concerns about the level of inconsistency in the care Louise received, as she

[1] Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement. London: LGA/ADASS

[2] Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews.' Journal of Adult Protection, 17 (1), 3-18.

moved frequently between placements, and could not understand why she was not better protected from self-harm. *[Louise was let down in so many different ways… she was passed around too many times."*

# 3. Background

3.1. Louise had a long history of self-harming, and she was placed into foster care after a self-harm incident which resulted in her being admitted to hospital. While there were incidents of self-harm, these were managed by her foster carers, and she settled well. She was later placed with new carers to be close to school and friends. Initially she engaged well, but then started to isolate herself, refused to eat and her mental health deteriorated swiftly. An incident followed in which Louise called her carers to say she had self-harmed but refused to say where she was. When located by the Police, she was hospitalised. At this time, she reported allegations of sexual assault by a person known to and trusted by Louise. The foster placement came to an end due to her suicide attempt and subsequent hospitalisation, and overall concerns about her mental health.

3.2. Following these events, Louise moved to a specialist service locally. She engaged in positive activities, but despite support she continued to present with high-risk self-injurious behaviours that required additional input from CAMHS, Therapeutic Services Team, Social Care, the GP and Looked After Children's Nurses. Her increasing behaviours resulted in her having 1:1 support and she was not allowed to spend any amount of time on her own. The need for a Deprivation of Liberty order was questioned with her social worker, who escalated the situation and gained a secure order via the courts when she was moved to an out-of-area Secure Unit.

3.3. During her admission to the Secure Unit, there were numerous reported incidents of self-harm, including ligature, head banging, cutting and scratching. Louise was also reported to have suicidal thoughts. She was interviewed by Police in relation to the allegations of previous sexual assault she had made, and she later stated that the investigation impacted on her self-harm behaviour. A new placement for Louise was identified at a specialist mental health residential unit in a different local authority area. The introduction letter was shared with Louise, and she reportedly took it well but became worried about leaving the current placement.

3.4. Louise was reported to be considering dropping the allegations against the person known to and trusted by her, querying whether she was making things worse for them. She also indicated that something similar had happened previously when she was aged 11. Louise wrote a suicide note which was triggered by the pressures of the Police investigation.

3.5. The Secure Unit recorded numerous incidents of self-harm while Louise was in their care. A Deprivation of Liberty Order was granted, and Louise was moved to the specialist mental health residential unit in a different local authority area with the order in place. There was a clear transition plan in place for Louise to have 2:1 staffing in place, be monitored throughout the day and her bedroom door was to remain open. She would also have sessions with a therapist and support from CAMHS.

3.6. The manager at the specialist mental health residential unit stated in a conversation with the Secure Unit that Louise was settling in well and had had a big reduction in self-harming incidents. However, during that month Louise was out with her carers when she ran away from them, entered a shop and stole a stanley knife. She then contacted the Police herself and was admitted to hospital having self-harmed with the knife. She was reported missing on 2 further occasions during the same month and returned by Police. She was then seen at hospital at the end of the month due to a self-harm incident.

3.7. The following month Louise went missing on several occasions, self-harm was evident, and she required police and medical interventions. She was assessed by mental health services and admitted to hospital under Section 136. Louise expressed that she was unhappy where she was living, did not feel safe and wished to be either in a secure setting or with people she knew in her local area. When reviewed by psychiatry, she requested an inpatient informal admission due to feeling suicidal.

3.8. Louise was admitted to a Child and Adolescent Mental Health ward in a different local authority area. Following further self-harm incidents, it was agreed she would be discharged and returned to the previous specialist mental health residential unit with increased staffing in place.

3.9. Later in the month, Louise attended the emergency department following further self-harm instances. The following day a secure panel was held due to staff members being unable to safely care for her, and secure welfare was agreed.

3.10. At the end of the month, Louise went missing. She and her carer were found by the Police following Louise making contact with them after a further self-harm incident. Following assessment by CAMHS she was discharged back to the residential unit.

3.11. Louise was then transferred to a local secure residential home the following day on a temporary basis until a more suitable secure home could be identified. The day after her arrival she was informed that there would be no further action taken in relation to the allegations she had made, and that the person known to and trusted by her had also denied the allegations. Louise made further disclosures relating to the allegations she had made to the local secure residential home that day and again 5 days later, which were passed to Social Services.

3.12. While at the local secure residential home, there were numerous and frequent incidents of self-harm. Processes were correctly followed in response to the incidents, with the need to high level supervision being identified and her medication being reviewed. During this time a serious incident took place when a member of staff failed to follow the safety plan in place and Louise had ligatured, becoming unconscious.

3.13. In the autumn of the same year, Louise's admission to an adolescent low secure unit in a different local authority area was approved. A Mental Health Act assessment recommended that she was admitted under Section 3 of the Mental Health Act, and she moved to the hospital. The previous placement met with the new placement to discuss her care plan for post-18. By mid-winter it was reported at a Looked After Review that Louise had been involved in numerous incidents of self-harm since being admitted, one of which resulted in her attending the emergency department at the hospital local to the placement. A S117 High Needs Assessment was also requested as she was due to turn 18 shortly, and multi-agency teams were consulted to make arrangements for discharge into a community placement. She was deemed to have capacity regarding where to receive care and support and a placement was identified at a local residential care unit. She had transitions visits before moving into the service on her 18th birthday.

3.14. A month later a Care Planning Approach meeting was held for handover of care to adult mental health services, the three-month S117 Case Management Review was completed, and no changes were required to Louise's current care package. However, her mental health deteriorated, with numerous incidents of self-harm and attempted suicide.

3.15. During the following summer, Louise was allowed out unescorted for an hour and she took a tram to see the person known to and trusted by her. While agency documentation indicated that she was not allowed to see this individual, she was not detained under the Mental Health Act or Mental Capacity Act and agencies therefore had no legal framework to prevent contact. She subsequently presented at hospital following another incident of self-harm. She refused to

see the department of psychological medicine and was deemed to have capacity to make this decision. She was discharged the following day. A safeguarding referral was made in respect of the incident, it was agreed that a Section 42 was required, and the investigation concluded that 1:1 staffing was required.

3.16. By autumn, staff at her placement were concerned that Louise had expressed that her voices were becoming more prominent.

3.17. During the winter, Louise was seen by the Crisis Mental Health team after she had been self-harming. The team did not feel that she required a hospital admission, but 5 days later she attempted to tie a ligature round her neck, and was found by a support worker struggling to breathe. She was taken to the local hospital, where she was found in a toilet with a ligature round her neck. Her placement reported that it was struggling to keep Louise safe, but there were no mental health beds available and she was discharged back there. Later in the same month, the local Ambulance Service attended as Louise was found nearly unconscious having tied a ligature around her neck. She was taken to the local hospital, and an adult safeguarding referral was made due to the level of harm.

3.18. The following month, placement staff reported their concern about an escalation in incidents and that they were unable to keep Louise safe, and informal admission was agreed. It was also agreed that she would be seen daily by a specialist intervention team until a bed was available. She was informally admitted to the adult mental health ward at a local Specialist Hospital 4 days later, and she stated that she did not wish to return to her current placement as she did not feel it was right for her. She was initially reported by ward staff to be settled and engaging, she was on general observations and was utilising leave. She was due to return to her current placement the following month, but there were then several incidents of self-harm and ligaturing and an attempt to overdose. In the emergency department toilets she was found with a ligature around her neck, and hallucinating. Her current placement did not feel it was safe to accept her back to the placement until she had made progress. Louise was eventually discharged back to the current placement at the end of the month whilst a transition to a suitable longer-term placement could be identified.

3.19. The following month, Louise presented at another local hospital following further self-harm. While there, she was found in the toilet where she had ligatured with the pull-cord. She was placed on 1:1 observations.

3.20. Louise's current placement then served 28-day notice on her due to challenges with Louise's complex presentation and associated risks. Her 1:1 support hours were increased by the local authority to 24 hours per day to manage the risks while her social worker continued to explore alternative suitable placements, although providers reported that they did not feel they could manage the risks of self-harm.

3.21. In the early summer, the local Ambulance Service attended due to Louise self-harming. She was conveyed to a local hospital emergency department from where she absconded, and she was found trying to tie a ligature. Following a capacity assessment, she was deemed to lack the capacity to make a decision about leaving. She was detained under the Mental Health Act, she declined voluntary admission and she was transferred to an adult mental health acute inpatient ward where she was detained under section 2 of the Mental Health Act.

3.22. During admission in the adult mental health acute inpatient ward, following a high number of incidents of self-harm in the first week, she was found in a toilet cubicle having ligatured. Later on the same day, the clinical team received a call advising that Louise had reportedly made a suicide pact with a peer who was planning to meet her the following day to overdose together. Unescorted leave for Louise was suspended. Days later an ambulance was called as she had ligatured and was also believed to have taken an overdose. She was transported to the

emergency department, and the Ambulance Service made a safeguarding referral as she was detained under the Mental Health Act but had been able to abscond. It was agreed that Louise would remain on the ward as a voluntary patient.

3.23. The following month, Louise was found by Police after ligaturing. Police were concerned as this was the second ligaturing incident of the evening, and they requested a serious untoward incident investigation.

3.24. Over the course of a week in late summer, Louise went missing from the ward during unescorted leave on several occasions, self-harming on each. Police expressed concern that unescorted leave was being allowed, and made a MASH referral with their concerns. A day later Louise was found having ligatured in the ward's toilet.

3.25. As a result of the concerns raised by the Police in relation to Louise absconding and self-harming during unescorted leave, the adult mental health acute inpatient ward's senior management team and the Responsible Clinician took the decision to move her to a different ward while the concerns were investigated. Louise was admitted to the adult mental health acute inpatient ward in a local Specialist Hospital. On the two days following admission, Louise was found ligaturing in her bedroom, before she absconded for approximately 4 hours. She was found in the community having ligatured and self-harmed. She attended the local hospital emergency department before being discharged back to the Specialist Hospital. The following day she was found ligaturing in a shower room.

3.26. Tragically, in the autumn, Louise was found in cardiac arrest after ligaturing. She was transferred to adult critical care before sadly passing away the following day.

# 4. Legal and practice framework

*Deprivation of Liberty*

4.1. Article 5.1 ECHR which provides: *"Everyone has the right to liberty and security of the person. No-one shall be deprived of his liberty save in the following cases and in accordance with a procedure proscribed by law ... (d) the detention of a minor by lawful order for the purpose of educational supervision or her lawful detention for the purpose of bringing her/him before the competent legal authority, (e) the lawful detention of persons of unsound mind ...".*

4.2. For young people under the age of 18, the Family Courts can authorise a deprivation of liberty under Section 25 of the Children Act 1989 to place them in secure accommodation. This will only apply if the young person has a history of absconding and is likely to abscond and suffer harm in any other type of accommodation, or, as in Louise's case, if they are likely to harm themselves or others in any other type of accommodation. The Family Court can also, in exceptional circumstances, exercise the Inherent Jurisdiction of the High Court to make an order to authorise a deprivation of a young person's liberty on welfare grounds in accommodation which is not registered secure accommodation.

4.3. There are two primary pieces of UK legislation that provide a legal framework to deprive someone of their liberty because they are of 'unsound mind', the Mental Health Act 1983 (MHA) and the Mental Capacity Act 2005 (MCA). However, any intervention must be necessary to prevent harm to the person or others and proportionate to the likelihood and seriousness of those risks – the least interventionist approach must be used.

4.4. The Mental Capacity Act 2005 (MCA) sets out the right of a competent adult to take decisions, and applies to those over the age of 16. There can be a significant tension between the principle under section 1 of the MCA, that the fact a decision may be unwise does not mean that the

person lacks the capacity to take that decision, and the duty on a local authority and partners under section 42 of the Care Act 2014 to devise a safeguarding plan for adults with care and support needs who are experiencing abuse or neglect, where they are unable to protect themselves from that abuse. To take a competent decision, an adult must be able to understand information about the decision to be made, retain that information and apply it to the decision-making process, and communicate a decision. Practitioners must ensure they break down the information to be weighed in a manner that will best facilitate this process.

4.5. Outside of treatment under the MHA, the provision of care and treatment is only lawful if the person receiving the care/treatment has either given capacitated consent or, if the person lacks capacity, acts are done in accordance with the legal obligations under the Mental Capacity Act 2005 and the Human Rights Act 1998. The principles embedded in s4 MCA require that any decision taken on behalf of a person who lacks capacity to make it, follows the least interventionist approach, and is taken in the person's best interest. This is not just the person's medical best interest, but rather their welfare in the widest possible sense, considering the individual's broader wishes and feelings, values and beliefs. All decisions should follow careful consideration of the individual circumstances of the person and focus on reaching the decision that is right for that person – not what is best for those around them, or what the "reasonable person" would want. The person who lacks capacity to make a decision should still be involved in the decision-making process as far as is possible, and those who know them best should be consulted.

4.6. Deprivation of Liberty Safeguards (DoLS) is the procedure prescribed under the MCA that enables a local authority to authorise a detention of a resident of a care home or patient, who lacks capacity to consent to their care and treatment, in order to keep them safe from harm. The Supreme Court has held that in circumstances where someone who lacks capacity to take decisions in respect of this aspect of their care is under constant supervision and control and would be prevented from leaving their accommodation if they attempted to do so unsupervised, they are deprived of their liberty. The DoLS procedure must therefore be followed, or if this is not applicable an order must be obtained from the Court of Protection to authorise this.

*Suicide risk, Mental Health Act 1983 and Section 117 aftercare*

4.7. The legal framework around managing the risks to individuals who express suicidal ideation is complex and in some ways can present as contradictory. Personal freedoms must be weighed against duties placed on public bodies to protect lives and mitigate risks to vulnerable people. All public bodies must exercise their legal powers in an ethical way that complies with duties to the adult under the Mental Capacity Act 2005, Human Rights Act 1998 and Equality Act 2010. Best interest considerations are *'not an academic issue, but a necessary protection for the rights of people with disabilities. As the Act and the European Convention make clear, a conclusion that a person lacks decision-making capacity is not an 'off-switch' for his rights and freedoms. To state the obvious, the wishes, feelings, beliefs and values of people with a mental disability are as important to them as they are to anyone else, and may even be more important. It would be wrong in principle to apply any automatic discount to their point of view.'*[3]

4.8. While Article 2 of the European Convention on Human Rights (ECHR) places a duty on public bodies to prevent avoidable deaths, this must be balanced against the right to freedom from inhumane treatment (Article 3), the right to liberty (Article 5) and respect for your private and family life (Article 8). The Supreme Court has found that an NHS Trust can violate its positive duty under Article 2 EHCR to take reasonable steps to protect a formal or voluntary patient known to be suffering mental illness from the risk of suicide, if there is a 'real and immediate' risk of death.[4]

[3] Mr Justice Peter Jackson in Wye Valley NHS Trust v B (Rev 1) [2015] EWCOP 60 (28 September 2015) (bailii.org)
[4] Savage v South Essex Partnership NHS Foundation Trust [2008] UKHL 74 (10 December 2008) (bailii.org) and ***Rabone and another v Pennine Care NHS Foundation Trust*** **[2012] UKSC 2** https://www.supremecourt.uk./cases/docs/uksc-2010-0140-judgement.pdf

4.9. There are a number of provisions under the Mental Health Act 1983 that enable someone who presents as seriously mentally unwell to be lawfully deprived of their liberty. Of relevance to Louise's case, a patient who is already in hospital can be detained under section 5(2) MHA for up to 72 hours, to allow an assessment to be undertaken to determine whether they need to be further detained. A person can be detained for the purpose of assessment for up to 28 days under section 2 MHA if they are suffering from a mental disorder of a nature or degree that warrants detention in hospital for assessment (or assessment followed by medical treatment) for at least a limited period; and ought to be detained in the interest of his or her own health or safety, or with a view to the protection of others. If they are assessed as needing to remain in hospital for medical treatment, a further application can then be made under s3 MHA. Finally, under s136MHA, a police officer can take a person to a place of safety if they appear to be suffering from a mental disorder and in need of immediate care and control (unless the person is in their own accommodation in which case a warrant must be sought by an AMHP).

4.10. The Mental Health Act 1983 Code of Practice[5] reinforces that when making any decision in relation to care, support of treatment under the Act, clinicians must apply five guiding principles, including using the least restrictive option that maximises independence, empowerment, respect and dignity. The MHA contains mechanisms for a patient subject to detention to be represented by an Independent Mental Health Advocate (IMHA) and request a review before the Mental Health Tribunal (although this does not apply to s5(2)[6]) and provided powers are properly used, treatment and care plans will comply with Article 5 ECHR. Planning for safe discharge should start as soon as the person is admitted to hospital.

4.11. Section 117 of the MHA places an enforceable duty on the ICB and local authority to provide aftercare services to a person who has been detained under sections 3, 37, 45A, 47 or 48 of the MHA on discharge from hospital. An aftercare service is a service provided to meet a need arising from or related to the individual's mental disorder, to treat and prevent a deterioration in their mental disorder, and reduce the risk of the individual being returned to hospital. This can be provided for a broad range of needs arising from the mental disorder, including immediate health and social care needs as well as, for example, employment support, or development of independent living skills. This will include specialist accommodation if this is necessary to meet the person's mental health needs. The ultimate aim is to maintain patients in the community, with as few restrictions as are necessary, wherever possible. It is important to recognise that leaving care duties, where applicable, will run alongside s117 duties and do not displace them – again the '*slender thread'* of leaving care duties is not a substitute for expert support to prevent a relapse in mental health.

4.12. The duty to provide s117 aftercare services is triggered on discharge from hospital, however, discharge planning should begin as soon as the person is detained under section 3, to identify the appropriate aftercare services necessary to meet their needs before they are discharged. If the Responsible Clinician is considering discharge, they should consider whether the person's aftercare needs have been identified and addressed. The individual must be fully involved in any decision-making process with regards to the ending of aftercare, including, if appropriate consultation with their carers and advocate.

4.13. Aftercare should be kept under review to ensure this continues to meet the person's needs and will only end if both the ICB and local authority are satisfied that the person no longer needs this. It cannot be withdrawn simply because someone has been discharged from specialist mental health services, readmitted to hospital or after an arbitrary period. If aftercare is withdrawn, services can be reinstated if it becomes obvious that was premature.

[5] Mental Health Act 1983 (publishing.service.gov.uk)
[6] There is also no legal right to an IMHA for people detained under sections 4, 135 and 136 of the Mental Health Act 1983

*Transition planning: Assessment of need for care and support, mental health transitions and Continuing Healthcare*

4.14. Section 58 of the Care Act 2014 places a duty on the local authority to carry out a child's needs assessment prior to their 18th birthday, to ensure that careful planning is in place to meet their care and support needs as they transition to the adult legal framework. The Care and Support Statutory guidance[7] sets out that an assessment should be carried out if a young person is 'likely to have needs', not just those needs that will be deemed eligible under the adult statute. This includes care and support that arise from or are related to a physical or mental impairment or illness (including a condition as a result of physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury), but not needs caused by other circumstantial factors.

4.15. The guidance also sets out the reciprocal duty for relevant partners to cooperate for the purposes of transitions and paragraph 16.43 states: "*Local authorities should have a clear understanding of their responsibilities, including funding arrangements, for young people and carers who are moving from children's to adult services. Disputes between different departments within a local authority about who is responsible can be time consuming and can sometimes result in disruption to the young person or carer*." The ethos of the Care Act 2014 is that assessments should be needs-led and not restricted by available services. Diagnosis should not act as a barrier to support.

4.16. Adolescence is a period associated with increased rates of psychiatric morbidity, substance misuse and risk-taking behaviours, however, healthcare transition is often inadequately planned and executed. There is a risk of disengagement at this crucial time as a result. The 2016 NICE guidance[8] for children also advocates that for all young people in receipt of mental health services, transition planning should start when the young person is 14, with an updated assessment of their needs to ensure a smooth transition to adult services. This further advocates a care planning approach to transfer between services in complex cases. This guidance also requires staff to receive training and know how to assess risk, provide individualised care and make adjustments or adaptations to Health and Social Care processes to enable access and that they have skills to communicate with the young person. The expectation is that those providing care will anticipate and make adjustments to prevent behaviour that challenges or offer psychosocial interventions as a first line treatment for challenging behaviours.

4.17. The National Framework for Continuing Healthcare (CHC) also requires ICBs to have systems in place with local authorities to ensure clinicians are actively involved in transitional planning for anyone with significant health needs who may be eligible for CHC post their 18th birthday. This is relevant to this case because of a specific focus within the CHC Decision Support Tool on challenging behaviours, psychological and emotional needs. Formal screening for CHC eligibility should occur when a young person is 16 and eligibility determined in principle when the young person is 17.[9]

*Transitional Safeguarding*

4.18. The term 'Transitional Safeguarding' describes the need for an approach to safeguarding adolescents and young adults fluidly across developmental stages[10], despite the differences between the legal frameworks for children and adults. The Chief Social Worker and Research

[7] Care and support statutory guidance - GOV.UK (www.gov.uk), para. 16.9
[8] Recommendations | Transition from children's to adults' services for young people using health or social care services | Guidance | NICE
[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/746063/20181001_National_Framework_for_CHC_and_FNC_-_October_2018_Revised.pdf, pg331-349 of the National framework for Continuing healthcare
[10] Holmes and Smale (2018) Mind the Gap:

in Practice's Transitional Safeguarding briefing[11] highlights the important contribution made by adult social work within transitional safeguarding, pointing specifically to the expectation within the Care and Support guidance, which accompanied the Care Act 2014, of adopting a human rights-based, person centred approach. This requires practitioners from all relevant agencies to exercise legal powers mindful of the positive obligations under the Human Rights Act 1998, which enshrines the European Convention on Human Rights (ECHR) in UK law, to act to prevent real and imminent risk to breaches of Article 2 (the right to life) and Article 3 (the prohibition on torture, inhuman or degrading treatment), balanced against the person's right not to be deprived on their liberty as discussed above.

4.19. Equally important is the obligation to support safe transition into adulthood (under s58-66 Care Act) and to prevent social care needs escalating (under s2 Care Act 2014) or homelessness (and s195 Housing Act 1996) by providing advice and support before eligibility thresholds for statutory interventions are crossed. Given the facilitative nature of the legal duties to safeguard, prevent escalation of needs and assess ongoing health and social care needs it is counterintuitive to construct 'eligibility' for services at too high a level.

4.20. It is commonly understood that many care-experienced young people will require additional support from social care services, as a consequence of adverse childhood experiences and it is for this reason that the range of 'leaving care' duties and powers continue to provide support. Leaving Care obligations are owed to all care experienced young people aged 16 and 17 who have been looked after for at least 13 weeks after they reached the age of 14 (which must include some time in care after their 16th birthday). Responsibilities for planning continuing support applies to all care leavers at least until they reach the age of 21. This includes:

- keeping in touch with them [section 23C(2) of the 1989 Act],
- regularly reviewing their pathway plan [section 23C(3)(b) of the 1989 Act; the requirements for carrying out reviews are set out in regulation 7 of the Care Leavers Regulations],
- having a personal adviser [section 23C(3)(a) of the 1989 Act; the functions of the personal adviser are set out in regulation 8 of the Care Leavers Regulations], and
- providing financial assistance by contributing to the former relevant child's expenses in living near the place where they are, or will be, employed or seeking employment [sections 23C(4)(a) and 24B(1) of the 1989 Act] if their welfare and educational and training needs

4.21. In addition, Regulations[12] and statutory guidance requires '*effective channels of communication between all local authority staff working with looked-after children, CCGs, NHS England and health service providers, as well as carers – along with clear lines of accountability – are needed to ensure that the health needs (including mental health needs) of looked-after children are met without delay. Looked-after children themselves (according to age and understanding, and capacity) should also have the information they need to make informed decisions about their health and mental health needs. Staff working with looked-after children who are delivering health services should make sure their systems and processes track and focus on meeting each child's physical, emotional and mental health needs without making them feel different... Local authorities, CCGs and NHS England need to reflect the high level of mental health needs amongst looked-after children in their strategic planning of child and adolescent mental health services (CAMHS). They should also plan for effective transition and consider the needs of care leavers.*' [13]

[11] Bridging the gap: Transitional Safeguarding and the role of social work with adults (publishing.service.gov.uk).

[12] The Care Planning, Placement and Case Review (England) Regulations 2010

[13] P.9 of 'Promoting the health and wellbeing of looked after children' March 2015 from the Dept. for Education and Dept. for Health (this is currently being revised).

4.22. Whilst the leaving care duties are hugely important, it should be noted that the Supreme Court was explicit that the legal powers afforded local authorities under s23C to provide ongoing support to care leavers do not supplant the legal duties owed under the National Framework for CHC and Care Act to provide ongoing care and support to those reaching 18 with eligible needs. Leaving care powers are *'a far cry from a power to provide the full range of community care services … section 23C(4)(c) is an extremely slender thread on which to hang such extensive and burdensome duties. In my judgment, if Parliament had intended to confer a power of this scope, it would have done so expressly.'*[14] Therefore, as a care leaver with long-term behavioural and mental ill health, Louise was eligible for assessment and support through all these statutory processes.

4.23. There are three principles for transition set out in the Children Act 1989 guidance for care leavers[15] which should govern practice when talking to the young person and when making any decision about them (p9):

'• Is this good enough for my own child?
• Providing a second chance if things don't go as expected.
• Is this tailored to their individual needs, particularly if they are more vulnerable than other young people?'

4.24. Tailoring any plan to a child's individual needs requires consideration of the specific challenges presented by their experience as a Looked After Child and additional risks or needs associated with personal characteristics and circumstances, including disability. Consideration should be given to relevant clinical guidance and quality standards published by the National Institute for Clinical Excellence (NICE). Of particular relevance in this case was guidance regarding transition from children to adult services. It is the role of the Independent Reviewing Officer (IRO) to ensure that the care plan agreed for the young person considers the young person's views. This includes evaluating the quality of the assessment of the young person's readiness and preparation for any move. Although Louise experienced multiple placement moves as a child and an adult, these were in general planned moves in response to her increasing or decreasing mental health and support needs. In Nottinghamshire, the IRO is able to stay involved reviewing a care-experienced young person's support after 18 (until 21) if the young person is in agreement. Louise did want this to happen and one review meeting took place after Louise turned 18. This is good practice.

4.25. An evidence base for Transitional Safeguarding and Safeguarding Adult Reviews has been published[16]. This evidence-base is drawn from recent publications on Transitional Safeguarding[17] [18] and provides a framework for Safeguarding Adults Reviews (SAR) analysis where SARs are about young adults. The framework for analysis invites a further set of questions, namely what has enabled best practice where this is found and what have been the obstacles or barriers to best practice where these are also found. This then informs the structure and content of a SAR about a particular young person, which will have a unique set of circumstances.

[14] 15 LJ Elias [pg52] in R (Cornwall Council) v Secretary of State for health and others [2014] EWCA Civ 12. The Supreme Court, also confirmed that duties (now under the Care Act) provide 'the exclusive statutory basis for securing the long-term care and were not displaced by provisions under the 1989 Act, which are transitional in character.' The Supreme Court concluded s23C powers purpose is 'not to supplant the substantive regime, but to ease the transition (usually) to adult independence.' [pg30 R (Cornwall Council) v Secretary of State for health and others [2015] UKSC 46

[15] Department for Education (2010) The Children Act 1989 Guidance and Regulations Volume 3: planning transition to adulthood for care leavers: https://www.gov.uk/government/publications/children-act-1989-transition-to-adulthood-for-care-leavers

[16] Preston-Shoot, M., Cocker, C. and Cooper, A. (2022), "Learning from safeguarding adult reviews about Transitional Safeguarding: building an evidence base", The Journal of Adult Protection, Vol. 24 No. 2, pp. 90-101. https://doi.org/10.1108/JAP-01-2022-0001

[17] Office for the Chief Social Worker and Research in Practice (2021) Bridging the Gap: Transitional Safeguarding and the Role of Social Work with Adults. London: DHSC.

[18] Holmes, D. (2021) Transitional Safeguarding: The Case for Change, Practice, DOI: 10.1080/09503153.2021.1956449

4.26. The model comprises four domains. In line with 'Making Safeguarding Personal' principles, the first domain focuses on practice with the individual. The second domain focuses on how practitioners worked together. The third domain considers best practice in terms of how practitioners were supported by their employing organisations. The final domain summarises the contribution that Safeguarding Adults Boards can make to the development of effective practice with young people with Transitional Safeguarding needs. This model enables exploration of the facilitators and barriers of good practice. The analysis that follows draws on information contained within the chronologies and group discussions during the learning event. Where relevant, it also draws on available research. It follows the whole system framework for analysis presented above, beginning with the components of direct work with individuals and moving outwards to the legal, policy and financial context within which adult safeguarding is situated.

*Responsibility across boundaries*

4.27. At times, the fact that Louise moved across local authority boundaries had implications in respect of who was responsible for taking action to safeguarding or support her. There are two key tests that will apply to different duties for health and social care. Ordinary residence is used to determine which local authority or ICB is responsible for supporting someone with health or care and support needs. The test for ordinary residence is the area that a person "…*has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or long duration*."[19] However, if the person goes into hospital or NHS accommodation, or is placed by a local authority in specified accommodation (including a care or residential home, supported accommodation or a shared lived scheme), they will be 'deemed' to remain ordinarily resident in the area they were ordinarily resident prior to moving into these placements.[20] Where the person lacks capacity to take a decision where they will live, the 'voluntary' aspect of the test should be disregarded, and instead the facts should be weighed to establish whether "…*the purpose of the residence has a sufficient degree of continuity to be described as settled.*"[21]

4.28. The second relevant test is that of 'physical presence', which means that responsibility will rest with whichever area the person is physically located at the time of an incident or admission.

4.29. Periods when a child is accommodated by the local authority under its duties under the Children Act 1989, are also excluded for the purpose of determining ordinary residence. The Supreme Court has held that because the deeming provisions under the Care Act and Children Act shared an underlying purpose, a looked after young person's ordinary residence will remain with the local authority that placed them if they continue to live in specified accommodation when they turn 18.[22] Although she moved repeatedly to residential units and hospitals in different local authority areas both as a child and an adult, Louise remained ordinarily resident in Nottinghamshire for the purposes of the Children Act and Care Act through the period relevant to this review as the 'deeming' provisions applied to these placements.

4.30. However, it is important to note that a recent 2023 decision by the Supreme Court[23] has clarified that when someone who is subject to s117 and has capacity to take decisions in respect of where they will live is placed in accommodation in a new local authority area, if they are subsequently detained again under s3, the s117 duties will transfer to the new local authority

[19] *Shah v London Borough of Barnet* [1983] 1 All ER 226 (HL)

[20] Section 39 Care Act 2014, the Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014 and the Care and Support Statutory Guidance, Chapter 19

[21] Care and Support Statutory Guidance, Chapter 19, para. 19.32

[22] *R (Cornwall County Council) v Secretary of State for Health* [2015] UKSC 46

[23] *R (on the application of Worcestershire County Council) v Secretary of State for Health and Social Care)* [2023] UKSC 31

area. This has now been incorporated into the Care and Support statutory guidance.[24] In Louise's case, because she was placed in Heathcotes Moorgreen in Nottingham immediately prior to being admitted to Bassetlaw Hospital where she was subsequently detained under s3, responsibility for her s117 aftercare would have transferred to Nottingham City Council. The same ICB (Nottingham and Nottinghamshire ICB) covers both areas so would remain responsible for the health element of her s117 aftercare. Nottingham City Council and the ICB would therefore have been jointly responsible for planning for Louise's discharge when she was ready to step down to the community from Highbury Hospital.

4.31. For clarity:

4.31.1. The local authority which looks after a child or young person will remain responsible for their care wherever they are placed under the Children Act 1989, as well as providing leaving care support until the care leaving turns 25. Consequently Nottinghamshire's CSC remained responsible for meeting Louise's needs as a child as well as ongoing leaving care duties after she turned 18.

4.31.2. Where young people are placed out of a local authority area, services such as CAMHS support and education services become the responsibility of the relevant organisations in the receiving area. There is often a postcode lottery in terms of the response from receiving health partners as although there is existing guidance[25] which states that the local authority must notify the ICB for the area in which the child is living in writing (para34, p16), there is no national protocol or procedure that determines the response from NHS Trust where the placement is based in terms of waiting lists or parity of service. This is not a new issue.

4.31.3. The local authority responsible for meeting a person's needs under the Care Act 2014 is where the person is ordinarily resident, unless they have no settled residence, when the test is physical presence, and the local authority carrying out the assessment is responsible for arranging a Care Act advocate to support the individual if they need this to engage with the assessment. Nottinghamshire's Adult Social Care were responsible for meeting Louise's care and support needs.

4.31.4. The local authority where the individual is physically present is responsible for organising an Approved Mental Health Practitioner (AMHP) to assess whether to make an application to detain the person under s2 or s3 of the MHA, although in limited circumstances, the AMHP can suggest that another area should do this if they consider this more appropriate. During Louise's detentions under the MHA, this will have been the local authority where each hospital was located as she moved between local authority boundaries.

4.31.5. The local authority where the individual is physically present (including temporarily) when an incident that needs to be investigated takes place is responsible for carrying out any safeguarding inquiry under s47 of the Children Act 1989 or safeguarding enquiry under s42 Care Act 2014 and will be responsible for arranging a Care Act advocate to support the individual if they need this to engage with the investigation.

4.31.6. Under the Mental Health Act (s130D) the registered establishment or hospital managers where the individual is detained is responsible for organising an advocate.

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24 At chapter 19, para. 19.64

25 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1100188/Promoting_the_health_and_well-being_of_looked-after_children_August_2022_update.pdf

Where a person is subject to a conditional discharge it is their responsible clinician who must arrange this.

4.31.7. The local authority where the individual is ordinarily resident (Nottinghamshire) will be responsible for carrying out a Best Interest assessment and authorising a DoLS application under the MCA. Independent Mental Capacity Advocates, appointed in line with legal duties under s35 Mental Capacity Act 2005, can only work with an individual once they have been instructed by an appropriate person/ body. For accommodation decisions and care reviews this is likely to be the local authority responsible for the arrangements. For serious medical treatment decisions this will be a medical practitioner who has responsibility for the person's treatment. For adult protection cases this will be the local authority coordinating the adult protection proceedings. For the IMCA roles in DOLS this will be the Supervisory Body.

# 5. Analysis of Agencies' Actions

## Louise's voice: a person centred and trauma informed approach

*How well did services supporting Louise as a child and young person have an understanding of her as an individual, and with a trauma informed approach? Was Louise's voice heard and responded to?*

5.1. The understanding and insight shown by the frontline practitioners who attended the learning events into Louise's needs was impressive. Across all of the agencies and placements, practitioners were able to discuss Louise's personality, wishes, feelings and needs in a nuanced way, which demonstrated the degree of engagement with her as an individual. The positive relationships Louise built with staff was an enormous strength and kept her safer as they were able to recognise and respond to her moods and care-eliciting behaviour. They were also able to agree safety measures with Louise, such as a 'traffic-light' system where Louise would indicate how she was feeling in terms of self-harm and risk, so that staff could adjust their risk-management strategy in real time, whilst empowering Louise in respect of her active participation in her own safety. Louise also told staff that when she took her long hair down she was at risk of self-harm, enabling them to increase their vigilance.

5.2. During the learning event, practitioners commented that it could be unhelpful to separate trauma and mental health, as the issues were inextricably linked. They felt that Louise was clearly suffering from depression and complex post-traumatic stress disorder (PTSD), and that although this could be seen from her records, now this would have been formally recorded as a way to ensure that she could access all of the services she needed, albeit they acknowledged that diagnosis should not be the gateway to services as this should be needs-led. Practitioners also discussed Louise's diagnosis of EUPD, which they felt could be stigmatising, and that this should have been resisted clinically as personality is not fixed at such a young age, particularly for young people whose emotional development may be delayed by trauma. They felt that a diagnosis of complex detachment disorder may have been more age-appropriate.

5.3. Relational care is an approach to caregiving that emphasises building and maintaining meaningful relationships between carers and care recipients, by attending to emotional, social, and psychological well-being. The importance of relational care for Louise could be seen in respect of the numbers of agency staff who worked with her. They did not necessarily have the experience and understanding of supporting people with high levels of trauma that were expressed through self-harm, and did not understand Louise's needs specifically. Louise felt less safe with agency staff and an escalation of risk could be seen when she was placed on wards with high levels of agency staff, who then felt anxious and intimidated about caring for her. This can manifest itself as ambivalence from those staff members towards the particular

patient, who then is at risk of malignant alienation,[26] although this was not observed in Louise's case.

5.4. It is unclear whether agency staff at Nottinghamshire Healthcare Trust had sufficient training to understand the specific care Louise required, in particular in respect of trauma-informed care or the high level of observation she needed as part of her safety plan. Trauma-informed training had been offered to all staff and the uptake of this had been high, but opportunities for reflective practice run by clinical psychologists were inconsistent between wards and tended to reflect whether the culture on the ward was psychologically minded. Managers had identified the risks arising from high levels of agency staffing on wards, and have since taken proactive steps to reduce their use on wards where patients have high levels of self-harm.

5.5. Services tried a range of therapeutic approaches to address Louise's trauma, including risk tolerance work, but she did not want to do group sessions around stabilisation and grounding strategies or dialectic behavioural therapy (DBT) as she believed these did not work. During her placement at Clayfields, staff worked closely with the local CAMHS to develop a care approach, including through promoting relational security, training her care team on the PACE model and attachment/developmental trauma. Eye Movement Desensitisation and Reprogramming was also attempted. However, making more intensive therapies conditional on Louise completing and implementing these programmes was not helpful in the longer term, as it may be impractical in such complex cases to keep waiting for people to be stable to offer deeply therapeutic work. This was a particular issue for Louise as, due to her fluctuating needs, her placements rarely lasted more than 6 months, which disrupted the therapeutic process. It was difficult to build relationship security when Louise constantly had to reestablish new relationships with new staffing cohorts and even while in placements, she did not know where she was going to be living next. This caused her significant anxiety and due to her attachment driven behaviour, this could result in her pushing people away. Louise's mother noted that after her tragic death, she spoke to some of Louise's friends who had been detained with her, who felt that moves between placements needed to be supported with a more careful introduction process to reduce the risk of retraumatising young people who have experienced multiple disruptions.

5.6. Louise reported that although the sexual assault she experienced as a teenager, perpetrated by a trusted adult in her life, led to the deterioration in her mental health and self-harming behaviours resulting in her admission to care, she felt that her relationship with her family had led to more entrenched trauma. Her social workers and staff at her placements reported that they had attempted to engage with Louise's mother to promote contact, including offering to fund taxis for lengthy journeys to placements, but this was rarely successful and practitioners queried whether contact was more harmful than beneficial to Louise. However, Louise's mother felt unsupported with respect to contact, noting that she felt unsafe travelling to unfamiliar placements, which could be in deprived areas. Louise's mother noted that she spoke to Louise every day by videocall or phone, but that Louise hid her self-harm from her, and this was not shared with her mother by professionals as Louise had not consented to this. It appears that insufficient weight was given to the benefits of this daily remote contact to Louise, which was often stopped for periods when she self-harmed (discussed further below). Louise's mother thoughtfully reflected that although she was offered help from agencies in different ways, she did not feel that she was provided with the information she needed to help her to understand how to best respond to Louise's needs. Louise valued her relationship with her half-brother (who she was raised with), who she remained in contact with. Although it may have been unsuitable to engage Louise's mother in her therapy given Louise's express wishes, further work needed to be carried out with her family to help then to understand why certain decisions were being taken in her therapeutic interests and how they could collaborate with the team around Louise to support her and better respond to the behaviours she presented with. This was particularly

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

important in the context of long-term planning for Louise's eventual return to the community, strengthening her support network outside professional support.

5.7. The decision on the part of police not to progress a criminal prosecution in respect of the sexual assault was extremely distressing for Louise and triggered a sharp increase in her self-harming. This decision was taken for good reasons – criminal proceedings trials in respect of sexual offences are notoriously brutal for victims, with protracted timescales for hearings to take place[27] and the requirement for any relevant information about the victim to be disclosed to the perpetrator's defence team. For Louise, this would have included details of her mental health diagnosis and self-harm and for these issues to be used to undermine her allegations in cross-examination would unquestionably have been re-traumatising and very harmful for her. Home Office data shows that for the year ending September 2021, just 1.3% of rape offences resulted in a charge or further court proceedings[28] and that conviction rates had dropped 70% in 4 years.[29]

5.8. Officers showed good practice in visiting Louise twice to explain the reasons for this, to ensure she had time to absorb the decision. However, Louise continued to express her distress that she had not been believed. It may have been beneficial for Louise to have an opportunity to discuss this with a survivor who had been through the court process. Further, the length of time taken to take this decision was very harmful to Louise, and it is unclear what, if any, victim support was provided to her.

5.9. Louise's social worker challenged Heathcote Moorgreen that the constant 1-1 supervision may amount to a deprivation of her liberty and advised that they should consider seeking authorisation for this arrangement under the standard Deprivation of Liberty Safeguards, which was appropriate. However, a DoLS authorisation was not sought and it does not appear that this was questioned further. Because Louise was not subject to DoLS and the order authorising deprivation of her liberty was made through the family court, Louise did not have access to an Independent Mental Capacity Advocate. Further, because she did not oppose her detention under the Mental Health Act, she did not access an Independent Mental Health Advocate.

5.10. Practitioners felt that Louise may have benefitted from an independent advocate to understand the assessments or deprivation of liberty she was being subjected to. The role of an independent advocate is to support that the to communicate their wishes and feelings and holding the relevant public bodies to account for timely, fair and lawful decision making that reflects the best interests of that individual. The independent nature of the service enables challenges to be brought through judicial channels where appropriate and a skilled advocate with local knowledge may be able to help identify alternative options that will be acceptable to the individual and mitigate the need for a higher level of intervention.

5.11. Louise felt that a Tier 4 mental health unit was the right placement for her and felt more 'normal' amongst a group of peers experiencing similar issues to her, so she did not seek to challenge her s3 detention. However, practitioners acknowledged that in light of the fact that Louise's family did not visit her often in person, provision of robust advocacy services may have been beneficial and that as a matter of good practice, this should have been provided even in situations where she may not have met the statutory criteria for this to be a legal right. The hierarchical environment of a hospital in particular can make clinical decisions difficult to challenge, particularly for a young person like Louise who had spent several years in different care environments. For a person in a situation where they may feel powerless and voiceless, confident advocacy may be support them to feel part of the decision-making process, in

[27] 1,000 days between rape offence and case completion in UK, data shows | Rape and sexual assault | The Guardian

[28] How many violent attacks and sexual assaults on women are there? - BBC News

[29] Why do so few rape cases go to court? - BBC News

particular in respect of some of the planning that may support them to achieve their long-term goals.

5.12. The impact of Louise's death on those who worked with her was marked and has clearly been highly traumatic for many of them. Managers commented that it was not uncommon for practitioners working directly with Louise to have high levels of sick leave, noting the stress that came from constantly worrying that she may have died overnight. It is vitally important that all staff, including agency staff are carefully supported through reflective clinical supervision to avoid burn out or desensitisation in complex cases involving chronic high-risk, and to minimise the risk of secondary trauma. Some services, such as Clayfields, discussed the strategies they had implemented to support staff including clinical supervision, debriefs after serious incidents and having an external counselling service for staff.

### Systems finding

5.13. Practitioners demonstrated a nuanced understanding of Louise's personality, wishes and needs, as well as the impact her adverse childhood experiences had on her mental health and emotional needs. This knowledge was used to develop personalised care plans and risk management strategies, and trauma informed practice was evident across all of the agencies involved. Offering support to family members to help them understand and meet the needs of a young person with complex behavioural needs can strengthen their support network in the community and improve the quality of contact. Handovers between practitioners and placements were generally planned, with clear information sharing, personal introductions and farewells and evidence that teams followed up to ensure Louise had settled after she moved on from a placement. However, at times these happened in an unplanned way, and the disruption of multiple moves retraumatised Louise. Although Louise consistently participated in multi-agency meetings to determine her care plan in accordance with good practice, in light of her expressed wish to live independently, advocacy services may have provided opportunities to strengthen her voice in the decision-making process.

***Recommendation 1:*** *Nottinghamshire Adult Social Care and the Nottingham and Nottinghamshire ICB should take steps to raise the profile of advocacy services across partner agencies and ensure that access to these is timely and effective to promote the outcomes sought by the individual.*

***Recommendation 2:*** *When taking a decision not to proceed with a prosecution of a serious offence involving an alleged victim with a high level of mental health need, Nottinghamshire Police should consider consulting with the individual's clinical team to ensure a coordinated approach in respect of any delays and any decision not to prosecute.*

***Recommendation 3****: Health and social care partners delivering 24-hour care to an individual as well as commissioned providers (including those commissioned out of area) should provide high-quality reflective clinical supervision to support trauma-informed practice, avoid burn out or desensitisation in complex cases involving chronic high-risk, and to minimise the risk of secondary trauma. Leaders should provide assurance to the SAB that they are prioritising trauma informed practice in their respective organisations.*

## Multi-agency co-ordination to meet Louise's needs

*To what extent did social care, police and health services take a co-ordinated approach to ensure her individual needs were identified and met? Were practitioners sufficiently skilled and experienced to explore and respond to mental health needs?*

5.14. There were many examples of good practice in terms of multi-agency working within Nottinghamshire. However, there were challenges with cross boundary working, particularly

when Louise was under 18, in care and living in placements at a distance. An example of this was when Louise was living in the south of England, as the placement had mental health support available. However, when Louise was admitted to hospital following an episode of self-harming, she was seen by CAMHS in hospital, but this was not followed up with ongoing CAMHS support. Cross border referrals remain a post code lottery, and this is not a new issue. The authors understand there is a protocol between the East and West Midlands for care experienced children and young people placed out of area who provide ongoing CAMHS support, but this is not national. Similarly with education provision, two education staff based in a school outside Nottinghamshire commented that Louise being placed in a school out of borough added delays and impacted on the resourcing of specialist education services from the local school. The authors have been assured that for bordering authorities there are clear escalation protocols, but this is not the case for areas that are further afield.

5.15. In general, planning for Louise's care and co-ordination across agencies evidenced good practice. However, as Louise's needs escalated, the only option to secure her safety was detention under the Mental Health Act on generalised mental health wards. The risks associated with poorer outcomes for people with personality disorders are well understood, prompting Parliament to enact legislation and ministers to issue guidance to improve equality of opportunity. In 2002 the UK Government/ Department of Health introduced bills to 'break the cycle of rejection' and prevent personality disorder being a diagnosis of exclusion (DoH, 2002). This led to the introduction of national personality disorder development programmes. Similarly, responses to the Winterbourne View scandal led to a national programme to transform care delivered to people with learning disabilities moving away from in-patient admissions out of area to reduce the risk of abuse. Despite these initiatives, there is still recognised structural stigma.[30] Teams working with people with personality disorders sometimes find themselves feeling "stuck" in clinical dilemmas and uncertain about how best to proceed. This can manifest as *"malignant alienation",* which is an extreme ambivalence from clinicians towards the individual.[31]

5.16. This commonly happens during inpatient admissions, during which time service users can present with an intense and confusing paradox of emotions: feeling contained by being in a supportive environment and not wanting to be discharged, whilst simultaneously feeling claustrophobic and agitated about the restrictive environment on the ward and expressing a wish to leave and harm themselves. This can lead to an escalating spiral of threats, acts of self-harm and violence, with the mental distress within the service user becoming translated into anxiety within the care system. To overcome this, NICE has produced a list of quality standards[32] and advise the use of structured clinical assessment, clinicians prioritise psychological therapies and group-based cognitive and behavioural therapies which the patient is involved in choosing the duration and intensity of any interventions. Continuity of care, care plans that incorporate and focus on the person's long-term education and employment goals and tailored, skilled supervision of staff to address the significant challenges staff face when positively supporting people with personality disorders are all key components of safe, effective care. Unfortunately, as Louise's needs escalated and deescalated, she moved from residential care to hospital and back, with 5 placement moves in the last year of her life. The frequent moves were disruptive for Louise and made it more difficult to make therapeutic progress. Her mother was clear that the disruption to the positive relationships Louise was able to form with the practitioners she bonded with were harmful to her.

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

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

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

5.17. There were some differences between CSC and NHS Mental Health services in respect of potential treatment options and outcomes that were possible for Louise. A number of mental health staff talked about how Louise was not always willing or able to access treatment with the very high degree of self-harm she was exhibiting throughout her many placements. This affected her ongoing mental health and there was no opportunity for 'step down' support for her.

5.18. The DHSC's rapid review into Mental Health in-patient data[33], completed in July 2023, highlights the very real systemic issues in providing quality in-patient care and the impact that this has on safety of patients. This reports that 77% of the NHS trusts with 'acute wards for adults of working age and psychiatric intensive care units' had a 'requires improvement' or 'inadequate' safe rating. Nottinghamshire Healthcare Trust was rated as requiring improvement overall in its last inspection report from 2022.[34] While practitioners and services demonstrated good insight into Louise's needs, the wider systematic issues identified in her case regarding the lack of suitable resource to prevent admission and overreliance on medication to treat patients with personality and behavioural disorders need to be addressed. Louise's case identified the severe lack of resource, both at a local and national level to address the needs of those with severe and enduring co-occurring conditions.

5.19. Practitioners and managers spoke of the need for a range of alternative provision designed specifically for people with personality disorders or neurodiversity to minimise the need for hospital admission, but with comprehensive mental health and therapeutic input built into the offer. Dependant on the individual's needs, this should include Shared Lives to provide the type of nurturing support Louise would have needed when she was ready to step down from more intensive provision. Residential managers noted that the availability of 'respite' mental health beds that could be made available when the needs of their residents were increasing may have helped to stabilise those placements and may make providers feel more confident to accept higher-risk residents, knowing that the necessary support would be available when needed. In cases when placements are required to enable people who have been detained under s3 MHA (particularly for lengthy periods) to be safely stepped down from Tier 4 beds, leave under s17 MHA provides a framework for a safe trial of the person's ability to cope in less secure accommodation. This is on the basis that their care will continue to be overseen by hospital clinicians, and they can be recalled to hospital without delay if their mental health requires this.

5.20. Police made formal complaints and MASH referrals in respect of Louise absconding and self-harming during unescorted leave from the ward in June and July 2022, including by a serious incident on 3 July 2022 where police observed that a nurse had left Louise alone in a field after an incident when a ligature had to be removed from her neck, then she again self-ligatured and was found by police struggling to breathe. After further incidents, Highbury had assured police that Louise would not be allowed unescorted cigarette breaks, but she was able to abscond again, which was attributed to an overreliance on agency staff creating confusion about her leave status. Police raised a further complaint through PALS on 30 August 2022, which "*outlined concerns about the lack of duty of care by omission and safeguarding being applied to someone identified as high risk of suicide*", highlighting the hospital was potentially breaching Louise's Article 2 right to life.

5.21. Police acted appropriately, both in making the series of safeguarding referrals to the relevant hospital and Nottinghamshire's MASH about these incidents, then escalating their complaints when they saw no response to those referrals. The fact they convened a meeting to address their complaint showed good leadership and proactive safeguarding practice. However, the hospital should have convened a multi-disciplinary strategy meeting at an earlier stage, to examine how to more effectively risk manage Louise's leave. The importance of robust risk

[33] Available at: https://www.gov.uk/government/publications/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations#ministerial-foreword

[34] Nottinghamshire Healthcare NHS Foundation Trust - Overview - Care Quality Commission (cqc.org.uk)

management plans for s17 leave will only grow as Right Person Right Care[35] is rolled out nationally, reducing the police response to missing episodes from mental health wards. Nottinghamshire's MASH also triaged the first three safeguarding referrals for no further action, although the referral in respect of the final incident was received on 5 September 2022 and progressed to a safeguarding adults inquiry under s42 of the Care Act 2014, noting "*Protective measures and risk assessments have been put in place by B2 to reduce the risk of further incidents occurring, but they do not appear to be robust"*. Given the series of referrals, a section 42 should have been convened at an earlier stage, to provide a framework to develop a multi-agency safeguarding plan. Although as 'one-offs' each incident may not have met the threshold for s42, the series of referrals needed to be considered cumulatively at an earlier stage, although it appears that detail of the incident on 3 July was not provided to the MASH. It is important that where safeguarding referrals may be indicative of organisational neglect or abuse, those incidents are not left to that organisation to investigate internally, at a minimum to allow safeguarding partners to act as 'critical friends' in respect of safeguarding planning.

5.22. As a consequence of these referrals, the senior management team took a decision in consultation with the Responsible Clinician that Louise should be moved to a different hospital within the same Trust while these concerns were investigated. Staff on the ward were not consulted as part of this decision and frontline ward staff reported that no planning took place between the wards in respect of the transfer. However, senior leaders felt that the handover was '*reasonably thorough given the timescale involved*', with handover of care plans, risk assessments, s17 leave arrangements and observation levels, but acknowledged that this was disrupted when she was turned away from the intended ward. Louise told staff that she was not consulted, or told the reasons for her move, and although this is disputed by the Trust, it appears that any communication was ineffective. Initially, it was intended that Louise would transfer to a ward which was part of the same NHS Trust but approximately an hour away, arriving very late at night with no notice to staff on the ward. When she arrived, the team that ward told the staff transporting Louise that she could not be admitted, as the patient Louise had previously planned a suicide attempt with in June was a patient on the ward, and this would be unsafe. No one had explained the reason she was being moved to Louise and experienced this as rejection, both being removed from the first hospital without notice and being refused entry to the ward at the second hospital.

5.23. Consequently, Louise was transported to a second ward at the second hospital on the same evening, with no notice to staff on the ward. Louise had been admitted to the same ward for approximately 7 weeks in early 2022 so staff were familiar with her, but no formal transfer meeting took place to handover her care or safety plan. Moving Louise late at night meant that staff had no easy way to contact the professionals who knew her best as she was settling in. Fortunately, her therapist worked across both hospitals, and when she arrived for a session with Louise the following morning to discover that she had been moved, the therapist was able to arrange a videoconference with Louise to reassure her. However, this was very destabilising for Louise and she told staff that she felt let down by her therapeutic team, although they called her frequently over the weekend to support her.

5.24. Louise's mother noted that when Louise would self-harm, her 'privileges' would be revoked, in particular, her mobile would be confiscated for a couple of days. This meant that at the points when Louise was the most vulnerable and in need of emotional support, she was unable to contact her family. It may be that there was a reasonable clinical reason for this decision, however, this was not communicated to Louise or her family. Further, the frequency of Louise's self-harm meant that there could be very long periods when Louise had no contact with anyone from her wider support network, which was very distressing for her. It is also unclear what the legal auspices were for confiscating Louise's phone in these different settings. There is a policy in place on wards detailing what should happen if a patient has their mobile phone withdrawn,

[35] National Partnership Agreement: Right Care, Right Person (RCRP) - GOV.UK (www.gov.uk)

namely that the patient should have access to the ward phone or a payphone to support communication with the public. It is unclear whether wards complied with this policy when preventing Louise from accessing her mobile, as it is unclear which time periods the family had identified this occurring.

5.25. Leading caselaw[36] addressing the legality of removing or restricting mobile phone use from a child in the care of a local authority provides important guidance on how such restrictions intersect with human rights and deprivation of liberty. The High Court clarified that Article 5(1) of the European Convention on Human Rights (ECHR) protects physical liberty, not broader notions of personal freedom like access to technology and therefore restrictions on their use do not necessarily amount to a deprivation of liberty under Article 5(1). Instead, such restrictions are more appropriately considered under Article 8 ECHR, which protects the right to private and family life. Restrictions on mobile phone use must be proportionate, justified, and clearly documented and will require explicit authorisation by way of an application under the Inherent Jurisdiction of the High Court, as these restrictions cannot be authorised under DoLS, although there is a framework to do so lawfully for those detained under the MHA.

5.26. For people detained under the MHA, Chapter 8 of the MHA Code of Practice highlights that on admission, staff should assess the risks and appropriateness of them having access to their mobile and detail this in the patient's care plan. Patients should be able to use mobiles if it is appropriate and safe for them to do so and access should only be limited or restricted in certain risk-assessed situations. The MHA Code of Practice stipulates that mental health hospitals should have policies on the possession and use of mobile phones and other devices, which should not seek to impose blanket restrictions on patients, but rather that any decisions are taken on an individualised basis, clearly evidencing that the negative impacts for that person have been weighed against the therapeutic need to prevent phone use. Given the court's view that this should be considered in the context of Article 8, any decision to remove Louise's phone should explicitly address the negative impact of being deprived of contact with her family and friends, particularly during periods of crisis as, in her mother's words, "*…that's when she needed us most."*

5.27. All of the practitioners who worked with Louise across the years agreed that 'near misses' had occurred very regularly in all of her placements, as Louise could be very determined in her efforts to self-harm, fashioning ligatures out of any strings, fabrics, even the threads from carpet or her own hair. She would break ceramic or glass objects to cut with and if she was unable to self-harm in any other way, she would stop eating. Even with constant vigilance, Louise was able to use the slightest opportunity to self-injure and any of these attempts could have ended in her death. While it does not appear that in terms of her clinical formulation there was an escalation of self-harm as a result of the unplanned move, the loss of relational security and lack of staff familiarity with her current risks and risk-management is likely to have incrementally increased the risk in an already high-risk situation. Her mother believes that this contributed significantly to Louise's death, as in her experience, new staffing cohorts did not understand Louise or how to respond to her behaviours.

5.28. Nottinghamshire Healthcare Trust's rapid review following Louise's death identified this as a serious issue, and they immediately introduced a policy requiring all transfers to take place during 'office' hours, with a formal multidisciplinary team to multidisciplinary team handover. It is reassuring to see that learning from this tragedy has been immediately implemented.

## Systems finding

5.29. In general, coordination between agencies was good with effective communication and information sharing. However, there is still evidence that long-standing problems with care-

[36] *Manchester City Council v CP & Ors* [2023] EWHC 133 (Fam)

experienced young people's access to CAMHS support and other educational services when they are placed out of borough are still commonplace. In addition, limited specialist provision for people with complex personality disorders[37] nationally meant that as Louise's needs escalated, the only option to secure her safety was detention under the Mental Health Act on generalised mental health wards, an environment known to lead to an escalating spiral of need for this cohort of young people. The frequent moves were disruptive for Louise and made it more difficult to make therapeutic progress, and some steps taken to reduce the clinical risks to her may have unintentionally disrupted the strengths within her support network. There is a clear need for specialist placements for people with personality disorders or, in the interim, greater flexibility from commissioners locally to use powers under National Health Service Act 2006[38], Mental Health Act 1983 and Care Act 2014 to provide bespoke accommodation-based support. Further, high levels of agency staffing increased the risks, increasing Louise's self-harm, reducing ability of staff to recognise her escalating needs and understand how to implement risk-mitigation strategies. The safeguarding response to police referrals about Louise absconding and self-harming was not timely or coordinated, and as a consequence, Louise's final move was unplanned and poorly managed in terms of risk and impact on Louise. Where s17 leave is being considered, NHS Trusts must ensure that realistic risk management plans are used to mitigate risk.

***Recommendation 4:*** *Nottinghamshire County Council and Nottingham and Nottinghamshire ICB to use the gap analysis being undertaken to determine how to build on and strengthen the reciprocal arrangements for children in need of CAMHS and other service support to access this in a timely manner when they are living in placements out of borough. NSCP should raise this issue with the National Panel, with a view to raising this as a national issue for escalation to the Department of Health and Social Care.*

***Recommendation 5:*** *Nottinghamshire County Council and Nottingham and Nottingham ICB should consider creating a virtual CAMHS lead for all children and young people in care similar to the Virtual School Head. This would ensure that all care experienced children and young people have their mental health needs routinely reviewed and where there are problems working across boundaries, problems can be addressed quickly.*

***Recommendation 6:*** *Nottinghamshire County Council and Nottingham and Nottinghamshire ICB should develop a plan to jointly commission bespoke placements or support packages to target the needs of individuals, to ensure that there is a seamless spectrum of wraparound provision from individuals with social care needs as well as those with complex personality disorders, neurodiversity, continuing healthcare needs or who are being discharged from mental health wards or secure placements.*

***Recommendation 7:*** *Nottinghamshire Healthcare should work with commissioned advocacy groups to ensure patients newly admitted (whether voluntarily or under the MHA) or detained for further periods are introduced to that service. Advocates should be routinely invited onto wards as part of an in-reach culture to promote a rights-based, safe care environment.*

***Recommendation 8:*** *NSAB, NSCP and safeguarding partners should consider how to raise the profile of missing episodes as a safeguarding issue across the wider partnership and how to support effective safety planning for people with mental health conditions who abscond and self-harm, to promote sustainable joint responsibility for managing risk, particularly in the context of the roll out of Right Care, Right Person.*

***Recommendation 9:*** *ASC and Health partners with in-patient mental health provision should provide assurance reports to NSAB that any decisions taken to prevent people from accessing their mobile phones are taken on an individualised basis, weighing the therapeutic benefits*

[37] In Nottinghamshire, this is known as "needs around attachment and trauma"

[38] Consistent with the obligations set out in National Framework for Continuing Healthcare

*against the impact of the interference with the person's right to a private and family life, and with the necessary legal authorisation in place to take this approach.*

***Recommendation 10:*** *Nottingham Healthcare Trust should provide assurance to NSAB that steps taken to reduce reliance on agency staff on in-patient wards have been effective, in particular to ensure that there are permanent staff members covering each shift.*

***Recommendation 11:*** *Nottinghamshire Healthcare Trust should undertake an audit of internal ward transfers to ensure compliance with its new handover policy within 12 months and provide an assurance report to NSAB.*

## Transitions and Transitional Safeguarding

*Were the transitions arrangements from children's to adults' services thorough enough to meet Louise's needs? To what extent did adults' services recognise Louise's needs as a young adult, within the framework of Transitional Safeguarding?*

5.30. When Louise came into the care of Nottinghamshire County Council at the age of 15, Children's Social Care showed good practice by seeking a care order. Louise's parents had refused to agree to her return home and therefore the local authority could have relied on section 20 of the Children Act 1989, for Louise to remain in care by consent. However, in light of Louise's self-harm and mental health needs, it was appropriate for the local authority to share parental responsibility to enable them to take proactive decisions in respect of her care and to seek authorisation to place her in secure accommodation when this was necessary for her welfare. The Supreme Court has held[39] that parental responsibility cannot be used to authorise what would otherwise be a breach of a fundamental human right of a child. Consequently, parents of 16- and 17-year-olds cannot give consent to what would otherwise be a deprivation of liberty for the young person, where the young person lacks capacity to give consent themselves.

5.31. Practitioners discussed the challenges in trying to identify residential placements for Louise that could meet her needs, as many placements were unwilling to accept a young person who was self-harming. CSC's Placements team felt that mental health support was needed to advise on placements, to ensure that their search was targeted to Louise's needs. However, as there are only 13-14 secure placements nationally, options were very limited. Placements could only accept one young person who self-harmed, as their needs would conflict and may increase the risk to both young people. As a consequence of these difficulties, Louise's initial secure placement was in Exeter, which presented as a significant challenge in respect of securing mental health support from CAMHS, as she was out of Nottinghamshire's area.

5.32. CSC managers were clear that money was never an object when trying to meet a young person's needs and that although they would fund 2-1 or 3-1 support if they could not find a bed, that did not replicate secure accommodation. The ongoing national shortage of appropriate secure accommodation and registered children's homes has resulted in some High Court judges refusing to authorise wholly inappropriate deprivations of liberty and both judges and the Children's Commissioner have highlighted the paucity of appropriate beds nationally, and the impact on young people of being placed at a distance.[40] Nottinghamshire's Complex Lives team is currently working with providers to build medium-secure accommodation targeted at young people who are at risk of self-harm, which is extremely positive. However, this programme of work would benefit from strategic, operational and budgetary support from the ICB.

5.33. Careful multi-agency planning took place to facilitate Louise's step-down from secure to a residential unit, however, these plans were undermined when the pandemic struck in March

[39] Re D (A Child) [2019] UKSC 42

[40] cco-who-are-they-where-are-they-technical-report-2020.pdf (childrenscommissioner.gov.uk)

2020, and Louise had to be moved at short-notice before England went into the first lockdown, without all of the planned supports in place. When young people are placed in out of borough placements, CSC must refer to local CAMHS, and although some have a designated LAC team there are different criteria all over country. Louise could access local CAMHS Crisis but only for short periods and when she was discharged from hospital there was no CAMHS in place and referrals from the emergency department were not always made due to shift changes etc. Within 2 months, Louise's needs had escalated to the point she required a further secure placement, however, a placement was now available for her at a secure children's home run by Nottingham County Council. It provides care, education and specialist interventions for up to 20 vulnerable young people between the ages of 10 and 17. Practitioners spoke positively of the strongly collaborative approach between CSC, the children's home and CAMHS in meeting Louise's needs, and the children's home were able to approach the local adolescent mental health inpatient unit for guidance in meeting Louise's needs. During the learning event, managers reported that as a consequence of this close collaboration including clinical supervision groups organised by the ICB, the children's home was probably the secure unit best equipped to meet the needs of young people with mental health needs in the country. However, the children's home commented that although a consultant telephoned them to give an overview of the risks to Louise, they were not provided with sufficient detail about the 'serious' incident that had led to her placement move.

5.34. The CSC's Placement team faced the same challenges when trying to plan for Louise's discharge from the children's home. Practitioners reported 'hammering away on the phones' trying to find a placement, but based on Louise's profile, providers were unwilling to accept the risk of trying to care for her. This is not unreasonable, as young people who are self-harming can have a negative impact on other young people in the placement, the stress can result in staff turnover and a serious incident can impact their Ofsted rating. Practitioners commented that once a young person had been placed in secure, it was very difficult to identify a safe pathway out. In Louise's case, this uncertainty is likely to have had a detrimental impact on her mental health, her self-harming increased and sadly, she wound up being moved to a children's Tier 4 mental health unit, where she was detained under the Mental Health Act.

5.35. The same difficulties were identified when Louise was ready for discharge from hospital and practitioners commented that this was a particular challenge for care experienced young people who had experienced high levels of trauma, as there was a need to balance autonomy with feeling care for. Louise had spent approximately 19 months in secure units or hospital by this time and had not had the opportunity for usual developmental experiences. She had never cooked for herself as she was not allowed to use cooking utensils for safety reasons. Her experiences of adults had been either neglectful in terms of her family, or adults who were paid to care for her. Louise could be quite jealous of her peers as she competed for the attention of staff. These difficulties in identifying a suitable children's placement meant that she was discharged from the children's mental health unit on her 18th birthday, as she was medically ready for discharge and the unit was not registered for adult patients. Louise's mother reported that being moved to live amongst strangers on the day of her birthday was very distressing for Louise, and was experienced as a rejection. Her mother was not able to visit because agencies believed Louise needed a period to settle before contact could take place, commenting "*We should have been able to celebrate with her properly, she didn't know anyone so couldn't even have a party, she was just so upset*."

5.36. Louise's accommodation and support was provided as part of her s117 aftercare package and jointly funded by the local authority and ICB and as such, the ICB should have played an equal role in seeking to identify her step-down placement. For young people with complex mental health needs, it is unreasonable for it to fall solely to the local authority to identify placements and this can result in bed-blocking, which places significant pressure on the wider mental health system. However, it is noteworthy that a key focus in Louise's transition planning was the need to bring her back to the Nottinghamshire area where her family and support networks were and,

as an adult, this meant that Louise was consistently placed in the local area, which is good practice.

5.37. Nottinghamshire CAMHS is currently piloting a complex case manager for care experienced young people who are transitioning to adult services. Specialist transitions workers in Adult Mental Health services will now also accept referrals for young people with mental health needs from the age of 17 years 3 months, with a view to supporting them from 17.5 years, dependent on their needs. In complex cases, transition planning will start prior to 17, to ensure that multi-disciplinary care packages can be identified and con-ordinated in a timely manner.

5.38. In respect of Louise's broader transitions, she was referred to the Preparing for Adulthood team for a transitional assessment of her care needs after the conclusion of the care proceedings. This was later than typical practice in Nottinghamshire of referring a young person at 16, but the pressure of the court process and challenges in securing the right placement and support for Louise were, understandably, the focus of her social workers. She was allocated to the Complex Lives team within Adult Social Care, which is designed to provide consistent care and support for people with complex and co-existing conditions, avoiding case transfers and providing a trauma-informed approach.

5.39. Louise's Independent Reviewing Officer was robust in ensuring that her Looked After Child Reviews were timely and focussed on her immediate and longer-term needs. Managers commented that the IRO was insistent about cohesive, proactive transition planning and would dip into Louise's care notes to check that actions had been followed through, chasing the multi-agency team when necessary. The IRO remained allocated post-18 in accordance with local policy in Nottinghamshire, where they can remain allotted until the young person turns 21 if they request this, which is good practice. However, only one post-18 review took place as Louise's mental health deteriorated and Care Planning Approach meetings took priority. Louise was allocated a personal advisor 6 months before her 18th birthday, who remained in regular contact until Louise's tragic death.

## Systems finding

5.40. Nottinghamshire Children's Social care provided good quality, person-centred support to Louise both as a child and a young adult, and huge effort was made in respect of transition planning in accordance with their duties under the Children Act 1989. However, limited options in respect of specialist residential provision or mental health beds meant that CSC struggled to identify alternative placements when existing placements were unable to manage escalating risks and this process was not supported by mental health services. Further, young people with mental health needs can have significantly delayed admissions during periods of crisis or delayed discharges and are frequently placed at distance, resulting in fragmented CAMHS support and disrupting their positive support networks. This resulted in a distressing move to a strange placement on the day of Louise's 18th birthday. Responsible agencies need to ensure that flexible joint commissioning arrangements are in place to meet these needs whilst this provision is developed and on an ongoing basis to meet the spectrum and volume of need locally.

***Recommendation 12:*** *Within the context of legal and regulatory responsibilities, Health and Social Care partners should make every effort to avoid moving young people to new placements on their 18th birthday. This is seldom in the best interests of the young person. Where this is absolutely unavoidable, all efforts must be made to ensure this is as positive a transition as possible, with familiar people supporting the move.*

***Recommendation 13:*** *NSCP and NSAB should lobby the Department of Health and Social Care (through the SAB Chair's escalation protocol) and NHS England in respect of their plans to improve access to secure accommodation that meet the needs of young people who are self-harming, that are local to them, to reduce reliance on acute admissions, avoid delays in young*

*people obtaining the treatment they need and improve their experience of mental health services.*

***Recommendation 14:*** *Health and Social Care partners should develop and promote a bespoke protocol for young people with developmental trauma, personality disorders, neurodiversity and complex behavioural or mental health needs, supporting practitioners to understand the interface with other legal frameworks including s117 aftercare responsibilities and continuing healthcare. This should include a pathway to allow for more bespoke support packages to target the needs of individuals whether in residential placements or in the community, which provide for continuity of care pre- and post-18.*

***Recommendation 15:*** *Nottinghamshire's Children's Social Care and the Nottingham and Nottinghamshire ICB should provide assurance to NSCP and NSAB that effective contingency planning is taking place for all residential placements, and that in circumstances where a provider has given notice that they are unable to manage a situation with escalating risks, proactive and timely arrangements are made for alternative provision, using escalation routes promptly if a placement cannot be identified, and detailed care or s117 aftercare plans to support the new placements or arrangements.*

***Recommendation 16:*** *Nottinghamshire Children's Social Care Commissioning should introduce requirements for trauma-informed training and models of reflective clinical supervision across all residential, supported and semi-independent accommodation providers to support young people, staff and improve the stability of placements.*

# 6. List of Recommendations

6.1 With reference to the 'Whole Systems Model located earlier in the report, the recommendations have been reordered under each of the 5 domains. We have kept the original recommendation number in this list.

## A. Direct work with Young People

Recommendation 2: When taking a decision not to proceed with a prosecution of a serious offence involving an alleged victim with a high level of mental health need, Nottinghamshire Police should consider consulting with the individual's clinical team to ensure a coordinated approach in respect of any delays and any decision not to prosecute.

Recommendation 12: Within the context of legal and regulatory responsibilities, Health and Social Care partners should make every effort to avoid moving young people to new placements on their 18th birthday. This is seldom in the best interests of the young person. Where this is absolutely unavoidable, all efforts must be made to ensure this is as positive a transition as possible, with familiar people supporting the move.

## B. Team around the Young Person

Recommendation 1: Nottinghamshire Adult Social Care and the Nottingham and Nottinghamshire ICB should take steps to raise the profile of advocacy services across partner agencies and ensure that access to these is timely and effective to promote the outcomes sought by the individual.

Recommendation 10: Nottingham Healthcare Trust should provide assurance to NSAB that steps taken to reduce reliance on agency staff on in-patient wards have been effective, in particular to ensure that there are permanent staff members covering each shift.

Recommendation 14: Health and Social Care partners should develop and promote a bespoke protocol for young people with developmental trauma, personality disorders, neurodiversity and complex behavioural or mental health needs, supporting practitioners to understand the interface with other legal frameworks including s117 aftercare responsibilities and continuing healthcare. This should include a pathway to allow for more bespoke support packages to target the needs of individuals whether in residential placements or in the community, which provide for continuity of care pre- and post-18.

Recommendation 5: Nottinghamshire County Council and Nottingham and Nottingham ICB should consider creating a virtual CAMHS lead for all children and young people in care similar to the Virtual School Head. This would ensure that all care experienced children and young people have their mental health needs routinely reviewed and where there are problems working across boundaries, problems can be addressed quickly.

Recommendation 7: Nottinghamshire Healthcare should work with commissioned advocacy groups to ensure patients newly admitted (whether voluntarily or under the MHA) or detained for further periods are introduced to that service. Advocates should be routinely invited onto wards as part of an in-reach culture to promote a rights-based, safe care environment.

## C. Organisational Support for Team members

Recommendation 3: Health and social care partners delivering 24-hour care to an individual as well as commissioned providers (including those commissioned out of area) should provide high-quality reflective clinical supervision to support trauma-informed practice, avoid burn out or desensitisation in complex cases involving chronic high-risk, and to minimise the risk of secondary trauma. Generous

leadership is required to ensure that staff have time to engage with this support, and recognise that this should be a priority.

Recommendation 11: Nottinghamshire Healthcare Trust should undertake an audit of internal ward transfers to ensure compliance with its new handover policy within 12 months and provide an assurance report to NSAB.

Recommendation 16: CSC Nottinghamshire Children's Social Care Commissioning should introduce requirements for trauma-informed training and models of reflective clinical supervision across all residential, supported and semi-independent accommodation providers to support young people, staff and improve the stability of placements.

## D. Governance

Recommendation 6: Nottinghamshire County Council and Nottingham and Nottinghamshire ICB should develop a plan to jointly commission bespoke placements or support packages to target the needs of individuals, to ensure that there is a seamless spectrum of wraparound provision from individuals with social care needs as well as those with complex personality disorders, neurodiversity, continuing healthcare needs or who are being discharged from mental health wards or secure placements.

Recommendation 8: NSAB, NSCP and safeguarding partners should consider how to raise the profile of missing episodes as a safeguarding issue across the wider partnership and how to support effective safety planning for people with mental health conditions who abscond and self-harm, to promote sustainable joint responsibility for managing risk.

Recommendation 9: ASC and Health partners with in-patient mental health provision should provide assurance reports to NSAB that any decisions taken to prevent people from accessing their mobile phones are taken on an individualised basis, weighing the therapeutic benefits against the impact of the interference with the person's right to a private and family life, and with the necessary legal authorisation in place to take this approach.

Recommendation 15: Nottinghamshire's Children's Social Care and the Nottingham and Nottinghamshire ICB should provide assurance to NSCP and NSAB that clear effective contingency planning is taking place for all residential placements, and that in circumstances where a provider has given notice that they are unable to manage a situation with escalating risks, proactive and timely arrangements are made for alternative provision, using escalation routes promptly if a placement cannot be identified, and detailed care or s117 aftercare plans to support the new placements or arrangements

## E. Broader national context:

Recommendation 4: Nottinghamshire County Council and Nottingham and Nottinghamshire ICB to use the gap analysis being undertaken to determine how to build on and strengthen the reciprocal arrangements for children in need of CAMHS and other service support to access this in a timely manner when they are living in placements out of borough**.** NSCP should raise this issue with the National Panel, with a view to raising this as a national issue for escalation to the Department of Health and Social Care.

Recommendation 11: NSCP and NSAB should seek assurance from the Department of Health and Social Care (through the SAB Chair's escalation protocol) and NHS England in respect of their plans to improve access to secure beds accommodation that meet the needs of young people who are self-harming, that are local to them, to reduce reliance on acute admissions, avoid delays in young people obtaining the treatment they need and improve their experience of mental health services.


~I love you but you cannot see all my scars you have caused loving you is
Killing me
Pain changes people
No pain, no gain pain
Losses over time but
Never gone What hurts us
heals us, we learn from pain
use pain as a fuel and
keep going - Crying isn't a Weakness
but I love you~
the pleasure of love
but a Moment~
you're heart beats
no matter how much
pain you're in - When you're
in love, love without limits
time - Space - the love isn't
found, it's built ~ I don't care
What they say - gets better
within Time!