Public Document Pack



Scrutiny Committee Agenda

Date: Thursday, 4th September, 2025

Time: 10.30 am

Venue: Council Chamber, Municipal Buildings, Earle Street, Crewe

CW1 2BJ

The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and at the foot of each report.

It should be noted that Part 1 items of Cheshire East Council decision making meetings are audio recorded and the recordings will be uploaded to the Council's website

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. Apologies for Absence

To note any apologies for absence.

2. **Declarations of Interest**

To provide an opportunity for Members and Officers to declare any disclosable pecuniary interests, other registerable interests, and non-registerable interests in any item on the agenda.

3. **Minutes of Previous Meeting** (Pages 3 - 8)

To approve as a correct record the minutes of the previous meeting held on 26 June 2025.

4. Public Speaking/Open Session

For requests for further information

Contact: Jennifer Ashley

E-Mail: CheshireEastDemocraticServices@cheshireeast.gov.uk

There is no facility to allow questions by members of the public at meetings of the Scrutiny Committee. However, a period of 10 minutes will be provided at the beginning of such meetings to allow members of the public to make a statement on any matter that falls within the remit of the committee, subject to individual speakers being restricted to 3 minutes.

5. Suicide Prevention and Mental Health Community Support (Pages 9 - 38)

To consider the attached report.

6. **Domestic Homicide Review: EMMA** (Pages 39 - 64)

To consider the attached report.

7. Adult Safeguarding Review - BELLA (Pages 65 - 126)

To consider the attached report.

8. Substantial Development or Variation of Service (SDV) - Stage 1 Process (Pages 127 - 132)

To consider the attached report.

9. Work Programme (Pages 133 - 136)

To consider the Work Programme and determine any required amendments.

Membership: Councillors S Adams, L Anderson, D Brown, C Bulman (Vice-Chair), S Corcoran, N Cook, B Drake, J Pearson, H Seddon, M Sewart, M Simon, J Smith, L Wardlaw (Chair) and J Snowball

Public Deament Pack Agenda Item 3

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Scrutiny Committee**held on Thursday, 26th June, 2025 in the Council Chamber, Municipal
Buildings, Earle Street, Crewe CW1 2BJ

PRESENT

Councillor L Wardlaw (Chair)
Councillor C Bulman (Vice-Chair)

Councillors S Adams, S Corcoran, N Cook, B Drake, J Pearson, H Seddon, M Sewart, M Simon and D Edwardes

OFFICERS IN ATTENDANCE

David Tesse – Probation Service
Rebecca Lane – Probation Service
Richard Burgess – Cheshire East Place, NHS
Jill Broomhall - Director of Adult Social Care Operations
Sandra Murphy – Head of Service, Adult Safeguarding
Richard Christopherson – Localities Manger, Safer Communities
Katie Small - Democratic Services Manager
Jennifer Ashley - Democratic Services Officer

1 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Lata Anderson.

Councillor David Edwardes attended as a substitute.

2 DECLARATIONS OF INTEREST

There were no declarations of interest received.

3 MINUTES OF PREVIOUS MEETING

RESOLVED:

That the minutes of the meeting held on 13 March 2025 be approved as a correct record.

4 PUBLIC SPEAKING/OPEN SESSION

There were no registered public speakers.

5 APPOINTMENTS TO SUB-COMMITTEES, WORKING GROUPS, PANELS, BOARDS AND JOINT COMMITTEES

RESOLVED:

That Councillor Liz Wardlaw and Councillor Carol Bulman be appointed to the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee for the 2025/26 municipal year.

6 EARLY RELEASE FROM PRISON

The committee received a presentation from Rebecca Lane and Davie Tesse from the Probation Service which provided details of the Prison Early Release Scheme.

Members were informed of the support those released from prison were provided with, along with details of housing offers, employment opportunities and health related services, including mental health support. It was highlighted that pre-release multi agency meetings are held to ensure that an appropriate accommodation plan is in place to ensure no one released is homeless.

It was confirmed that Cheshire East Council works closely with the Probation Service to ensure the impact on services and the community is minimal however, if necessary, Multi Agency Public Protection Arrangements are implemented.

RESOLVED:

Members that representatives for their attendance and noted the presentation.

7 CHESHIRE AND MERSEYSIDE NHS PROPOSALS FOR HARMONISED FERTILITY TREATMENT POLICY

The committee received a report from the NHS Cheshire and Merseyside Integrated Care Board (ICB) that informed the Committee that at the ICB meeting on 29 May 2025, the ICB approved the recommendation that the ICB commences a period of public consultation regarding the proposal to harmonise the existing 10 Fertility Policies in place across the nine Local Authority Place areas in Cheshire and Merseyside into a single policy for Cheshire.

The ICB had a duty to engage with Local Authority Health and Overview Scrutiny Committees (HOSC) to seek confirmation as to whether the HOSC believed the proposals constituted a substantial change to NHS services, known as a Substantial Development of Variation of Services (SDV).

The committee were informed that proposals included changes to:

- the number of NHS funded IVF cycles available to patients, with proposals resulting in no change for people registered with a GP Practice in Cheshire East
- changes to eligibility with regards Body Mass Index and Smoking, with proposals resulting in no change for people registered with a GP Practice in Cheshire East
- changes to definition of childlessness, which would result in a change for patients registered with a GP Practice in Cheshire East
- changes to Intra Uterine Insemination commissioning, which would not be a change to patients registered with a GP Practice in Cheshire East
- wording on the lower and upper ages for fertility treatment, which would result in a change to Cheshire East, however, would bring policy in line with National Institute for Health and Care Excellence guidance.

Following discussions, Councillor Seddon proposed that the proposals did constitute a Substantial Development of Variation of Service. Councillor Pearson seconded the motion. The committee voted 4 for the proposal, 6 against. Therefore the motion was lost.

RESOLVED:

That the Committee AGREED that the proposals did not represent a substantial development or variation to services in relation to Cheshire East and would therefore not be part of further discussions on the matter with the Joint Health Scrutiny Committee.

In addition, the Committee AGREED that an item be added to the work programme for September relating to the process of presenting any future SDV proposals to the Scrutiny Committee.

8 REVIEW OF PREVENT AND CHANNEL GUIDANCE - STATUTORY DUTIES

The committee received a report on the changing landscape and statutory responsibilities in relation to PREVENT.

The committee were updated that Local Authorities, alongside partner agencies listed in the Counter Terrorism and Security Act 2015, have a statutory responsibility to comply with the Prevent Duties. The Local Authority is also responsible for delivering the multi-agency Channel Panel Programme.

As a result of missed opportunities prior to recent events, such as the Southport killings in 2024 and the death of David Ames MP in 2021, significant changes had been made to the Channel Panel and PREVENT, and local strategies and policies had been updated to reflect national changes.

It was noted that Cheshire East Council was subject to an annual assessment by the Home Office on their PREVENT duties, and Cheshire East had exceeded or met every assessment level.

Cheshire East Council was to submit a funding bid to Home Office to allow for the provision of training in schools and colleges to make students more aware of the risks of accessing extreme content online, and would extend this training to older individuals with learning difficulties in higher educational establishments.

RESOLVED:

That the content of the report and presentation be noted.

9 DOMESTIC HOMICIDE REVIEW

The committee received a Domestic Homicide Review report that had been commissioned by the Safer Cheshire East Partnership in 2021 following the murder and suicide of Mr and Mrs S.

Members were informed that the purpose of the report was to establish what lessons could be learnt from the way in which local professionals and organisations works individually and together to safeguard victims.

Although the Domestic Homicide Review did include areas of good practice and projects that were initiated during and post COVID, the review also made several multi agency recommendations which included:

- Carers identification and recording by all agencies
- Completion of Carers Assessments
- Dementia Awareness Training
- Legal literacy particularly using the Mental Capacity Act
- Suicide Awareness including its impact
- Assertive interventions by Professionals, rather than leaving people alone
- Recognition of Domestic Abuse in the context of Dementia or other longer term conditions vs Carer Stress

RESOLVED:

- (1) That the content of the report be noted;
- (2) That a letter be sent on behalf of the committee to the Home Office to raise concerns of the length of time it is taking for Home Office Quality Assurance processes to be concluded.

10 WORK PROGRAMME

The committee considered the work programme.

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RESOLVED:

That the work programme be noted and the following items be added:

- Safer Cheshire East Partnership Action Plan / Annual Report
- Leighton Hospital Expansion Programme update relating to implementation of new systems at A & E

In addition, it was agreed that Officers would seek further information relating to the commissioning of services detailed in the Commercial Determinants of Health paper that was recently presented to the Health and Wellbeing Board to determine if it appropriate for the Scrutiny Committee to consider.

The meeting commenced at 10.30 am and concluded at 1.00 pm

Councillor L Wardlaw (Chair)

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OPEN

BRIEFING REPORT

Scrutiny Committee

Thursday, 4 September 2025

Suicide Prevention and Mental Health Community Support

Report of: Director of Public Health

Report Reference No: 1698SC/19/24-25

Purpose of Report

The Scrutiny Committee has asked for information in relation to suicide prevention - what services are available across Cheshire East, including wider support for families impacted by those with mental health issues, how services are accessed, and are support services working?

This report and the appendix set out a response to this question.

Executive Summary

- There are two Boards that have oversight of this thematic area, the Self Harm and Suicide Prevention Board and the Mental Health Partnership Board. Both Boards report up to the Health and Wellbeing Board and prioritise work in accordance with the priorities set out in the Joint Local Health and Wellbeing Strategy Health and Wellbeing Board
- Officers who are involved in both of these Boards have led and contributed to this update to the Scrutiny Committee. Appendix One is a summary of the key support services available to the community. These services are delivered or commissioned in response to identified need. The Joint Strategic Needs Assessment is a key element in the evidence base that informs priorities and thus required services. There are a number that relate to mental health Mental wellbeing

Recommendation

That the Scrutiny Committee review and scrutinise the information provided in relation to self-harm, suicide prevention and mental health support services.

Background

- The Scrutiny Committee as part of its work plan has asked for a report on 'Suicide Prevention and what services are available across Cheshire East, including wider support for families impacted by those with mental health issues, how services are accessed, and are support services working?'
- The report and appendix set out a response focussed upon the relevant activities across four areas: Self-Harm and Suicide Prevention; Mental Health; Carers and Children and Family Services.

Briefing Information

- The Self-Harm and Suicide Prevention action plan Cheshire East Self

 Harm and Suicide Prevention Action Plan 25-27 sits as part of the

 Cheshire East Place All Age Mental Health Plan (2024-2029), overseen
 by the Mental Health Partnership Board Cheshire East Place Mental

 Health Plan
- Suicide Prevention is a significant concern for the Cheshire East Health and Care system. The Self-Harm and Suicide Prevention Board has an action plan for 2025-2027, agreed at the Health and Wellbeing Board in March this year (alongside a review of the 2023-2025 action plan). The Self-Harm and Suicide Prevention Board is a multi-agency Board that brings together all those interested and involved in work to deliver the actions.
- Appendix One sets out the priorities of the Mental Health Plan and the connectivity with the Self-Harm and Suicide prevention work. It also highlights key services and sources of information for residents. There is additional information specifically in relation to support for carers and children and families. A Mental Health Spotlight Review report focussed upon children and families went to the Children and Families Committee in November 2023 CEC Report Template
- Whilst there are support services available and significant work is underway to raise awareness of these, there continues to be concern regarding levels of mental ill health, self-harm and suicide. Officers and partners continue to work hard to counter this, but service capacity continues to be an issue.

Implications

Monitoring Officer/Legal

There are no direct legal implications associated with this briefing paper.

Section 151 Officer/Finance

There are no financial implications, or changes required to the MTFS, as a result of the recommendations in this report. All services detailed in this report are delivered through existing service budgets.

Human Resources

12 There are no HR resources implications in relation to this briefing paper.

Risk Management

There are no specific risk management implications of this briefing paper.

Impact on other Committees

14 There are no impacts in relation to other Committees in relation to this briefing paper.

Policy

- The services set out in the Appendix are primarily contributing to the 'Improving health and wellbeing' commitment. However, an individual's mental wellbeing can significantly impact upon their educational opportunities and ability to gain and retain employment, secure housing etc. so there is a link to 'Unlocking prosperity for all'.
- As set out above there are also links to the Joint Local Health and Wellbeing Strategy.

Commitment 1: Unlocking prosperity for all	Commitment 2: Improving health and wellbeing	Commitment 3: An effective and enabling council
Yes	Yes	

Consultation

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Name of Consultee	Post held	Date sent	Date returned
Statutory Officer (or deputy) :			
Ashley Hughes	S151 Officer	21/07/25	Click or tap to enter a date
Janet Witkowski	Acting Monitoring Officer	21/07/25	22/07/25
Legal and Finance			
Roisin Beressi	Principal Lawyer	21/07/25	23/07/25
Nikki Wood-Hill	Finance Manager	21/07/25	22/07/25
Other Consultees:			
Executive Directors/Directors			
Helen Charlesworth-May	Executive Director	21/07/25	Click or tap to enter a date
Rod Thomson	Interim Director of Public Health	21/07/25	

Access to Information		
Contact Officer:	Guy Kilminster	
	guy.kilminster@cheshireeast.gov.uk	
Appendices:	Appendix One: Summary of support services for Carers/Family members	
Background Papers:	Cheshire East Joint Local Health and Wellbeing Strategy Layout 1	

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Cheshire East Place Mental Health Plan Cheshire East
Place Mental Health Plan

Cheshire East Self-Harm and Suicide Prevention Plan
2025-2027 Cheshire East Self Harm and Suicide
Prevention Action Plan 25-27

Appendix 1

OPEN/NOT FOR PUBLICATION

By virtue of paragraph(s) X of Part 1 Schedule 1of the Local Government Act 1972.



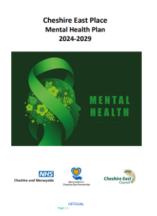
Report for Scrutiny Committee Meeting 4th September 2025

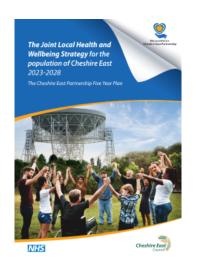
Summary of support services for Carers/Family members Updates from lead officers:

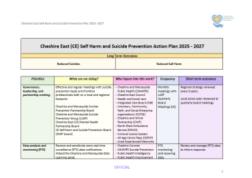
- Mental Health Partnership Board
- Self Harm and Suicide Prevention Board
 - Cheshire East Carers Hub
 - Children and Families

Contents

- 1. Governance, Partnership and Collaboration
- 2. Mental Health Partnership Board update
- 3. Self Harm and Suicide Prevention Partnership Board update
- 4. Cheshire East All Age Carers Hub update
- 5. Children and Families update











Governance, Partnership and Collaboration

Both the Self Harm and Suicide Prevention and Mental Health partnership work together aligning priorities to the <u>Joint Health and Wellbeing Strategy</u>

- Cheshire East Self Harm and Suicide Prevention Action Plan 25-27
- Cheshire East Place Mental Health Plan 2024-2029
- Children and Young People's Plan
- Cheshire and Merseyside ICB Children and Young People's Mental Health Plan

Mental Health Partnership update

Mark Hughes - Programme Lead: Complex Needs (Learning Disabilities, Mental Health and Neurodiversity

Keith Evans - : Head of Service Mental Health and Learning Disability

Cheshire East Place Mental Health Plan (2024-2029)

The plan covers how we will strengthen our efforts to help people in Cheshire East stay healthy and thrive, whilst addressing the fact that we need to do more to support people with mental health problems, including those that live with severe and enduring mental illness.

The plan is monitored by the Mental Health Partnership Board, which consists of partners from across health, social care, the voluntary sector, carers and people with lived experience.

Six key priorities that have been developed to deliver the plan vision:



Cheshire East Place Mental Health Plan

Priority 1- Children and Young Peoples Mental/Wellbeing

- Undertake a **joint strategic needs assessment** to help us better understand the emotional and mental wellbeing needs of children and young people and ways we can support and work with families to improve emotional and mental wellbeing. This will include areas such as the impact of social media and bullying.
- Deliver a more enhanced Early Intervention Children and Young People Mental Health Service to bring together colleagues from early years, education, health and the voluntary sector to support children, families and professionals
- Deliver Multi-agency Institute of Health Visiting (IHV) Perinatal and Infant Mental Health Training via
 Champions to promote understanding of the concepts of perinatal and infant mental health, the impact it
 can have for the developing baby, infant, parents, wider family and society and what we can do to support
 good family mental health and wellbeing from the Antenatal period.
- Development of Family Hubs with a focus on improving maternal mental health in pregnancy and during parenthood and children and young people's mental health
- Roll out a range of **evidenced based programmes** including the My Happy Minds Programme in Cheshire East to support all Local Authority primary schools and academies to deliver an effective curriculum that teaches children and young people the skills to thrive and the skills to bounce back when challenge hits.
- Develop the connectivity between community mental health services and early help provision to reduce the number of children who need additional support and care in hospital.
- Give children, young people, their parents, and carers more opportunities to have their say and ensure they become fully embedded in the development of mental health services at place and across the Integrated Care System.

Children and Young Peoples Mental Health and Emotional Wellbeing

Priority 4 - Building Sustainable Communities

Building Sustainable Communities Reduce mental health inequalities across communities in Cheshire East

Actions – Increase mental health support for carers

Measured by - increase in the % of adult carers who report as much social contact as they would like (Fingertips Public Health data)

Progress update: Feedback from the Parent Carer Forum in Cheshire East has been that carers are experiencing a rise in mental health concerns. The forum are seeking greater collaboration and support with the Cheshire East Carers Hub to address this.

Self Harm and Suicide Prevention Partnership update

Guy Kilminster - Public Health Improvement Head of Service Lori Hawthorn - Public Health Improvement Officer

Priority 3 – Early Intervention and Prevention

Early Intervention and Prevention The Self Harm and Suicide Prevention Partnership action plan is part of **our all-age Mental Health Plan**; **priority 3**, early intervention and prevention.

Lead officers provide quarterly updates at the mental health partnership board are provided to achieve the best outcomes for Cheshire East.

Support after a Suicide - Postvention

Amparo is our immediate support service shared when there has been a death by suspected suicide.



2 wish offer support for those who have experienced a sudden death of a child or young person.

We have a lived experienced peer led support service called <u>SoBS</u> based in Crewe and a new group opened in 2024 in Macclesfield.





Papyrus / Samaritans

Papyrus are key members of the Self Harm and Suicide Prevention Partnership Board.

A debrief service is available, for everybody after they've had an encounter with suicide.

To debrief with one of our suicide prevention advisers, call **HOPELINE247** on <u>0800 068</u> <u>4141</u>, text <u>88247</u> or email pat@papyrus-uk.org. We are here for you 24 hours a day, 365 days a year.

Step by Step is a Samaritans service providing practical support to help schools prepare for and recover from a suspected or attempted suicide.







Pilot project: Keep Safe Cope Well plans

Parents can receive support from professionals to use the plan at home with their child.

An early intervention framework used in 8 Primary schools to prevent poor mental health in teenage/adulthood.

Key outcomes are for children to have understanding and awareness:

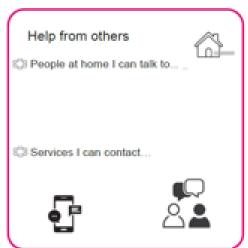
1. Coping well

2. Keeping safe

Longterm outcomes: decrease rates of mental health crisis in children presenting at A&E with self harm/suicidality.

Evaluation Autumn 2025.









Keep safe and cope well plan

Local and National support



self-harm and suicide prevention and support

Cheshire East All Age Carers Hub update Alice Clark - Programme Lead

Cheshire East All-Age Carers Hub



Cheshire East Council commissions Making Space to run the Cheshire East All-Age Carers Hub. The service provides a single point of access for unpaid carers in Cheshire East including young carers (age 5 to 18), adults (18+), and parent carers (caring for a child with additional support needs).

Key service aims include:

- Ensuring unpaid carers of all ages have timely access to information, advice and a range of support services including an opportunity to take a break from their caring role.
- To improve the mental health and wellbeing of carers, including preventing and reducing occurrence of carer breakdown.
- Identifying unpaid carers across the borough

Professionals can refer a carer to the Carers Hub (or carers can self-refer) by completing their **online form** https://cheshireeastcarershub.co.uk/ or via **telephone on 0300 303 0208**. They are based at Cheshire East Carers Hub, Crewe Business Park, Crewe, CW1 6GL.

Cheshire East All-Age Carers Hub: The Service Offer

Undertaking statutory Carers
Needs Assessments on
behalf of the Council, (for
adult carers only, young
carer assessments are
undertaken by the Council's
Young Carers Service).

Information and advice

1-1 support over the phone and face to face

Group based support / peer support/
activities – including Coffee and
chat groups, activity/hobby
sessions, male carers group, peer
support/activity groups for young
carers. These take place regularly
across the borough see the <u>Carers</u>
<u>Hub newsletter</u> for more details

Access to the Living Well Fund –
funding to enable the carer to access
support, activities, specific items that
enable the carer to have a break from
their caring responsibilities and

promotes their health and wellbeing.

Take a Break Service
-enabling carers to
get a break from their
caring role

Developing emergency and contingency plans with carers Access to tailored training to support people in their caring role, such as: understanding the cared for person's diagnosis; caring skills and coping strategies; managing challenging behaviour; managing stress; manual handling; lasting power of attorney.

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Cheshire East All-Age Carers Hub: Outcomes for carers



Improved knowledge and understanding through having access to relevant information. signposting, statutory and universal services and social capital that can support them in their caring role.

Maintain carer health, wellbeing and independence, with a life outside of their caring role.

Young carers will have the support they need to learn, develop, thrive and enjoy positive childhoods

> Increase opportunity to remain in education. training and employment.

Increased levels of confidence through feelings of being recognised for their contribution as a carer, and actively involved in decisions which affect them and the person that they care for.

Improved physical health, enabling carers to make healthy lifestyle choices such as physical activity, falls / accident prevention, moving and handling and a healthy balanced diet

Increased levels of wellbeing through having opportunities to access services that provide a break from their caring role, reducing stress and isolation.

Children and family services update Susie Roberts - Lead Public Health Consultant

Emotional and mental wellbeing need across Cheshire

Children and Young People's Emotional and Mental Wellbeing JSNA

Working together to protect, promote, prevent, empower and intervene early for all involved.

Led by Cheshire East Council, the NHS and our volunteer communities



NHS



The review involved extensive collaboration, triangulation of data, consultation, engagement with children, families and profession and service mapping.

Joint strategic needs assessment review has highlighted that across Cheshire East we need to:

- Work holistically to support the physical and mental wellbeing needs of the child, their families and professionals that work with them.
- Promote protective factors and resilience robustly.
- Intervene early on risk factors for mental health problems before mental health issues arise.
- Consider root causes as part of mental health presentations.
- Integrate care so it is easy to navigate and that empowers children and their families.
- Provide care for all with greater support to areas in greatest need.
- Continue to monitor emotional and mental wellbeing and robustly evaluate interventions put in place.

Cheshire and Merseyside Children's Mental Health Plan 2024-2026

Overseen by the Cheshire and Merseyside Children and Young People's Mental Health Programme Partnership on behalf of the Integrated Care Board Children and Young People Committee



INCLUSIVE:

Co-production with children, young people and families to support transformation and continuous improvement



TIMELY ACCESS:

For children and young people needing emotional wellbeing and mental health support



18-25 YEARS OFFER:

Design and develop an equitable offer of mental health support for young adults



EATING DISORDERS:

Children and Young People have timely and equitable access to high quality and evidenced based eating disorder support



CRISIS RESPONSE:

To anticipate and support children and young people who may experience mental health crisis or escalating needs



APPROPRIATE PLACES OF CARE:

Address gaps in our current support offer for children and young people with the most complex needs



SPECIALIST MENTAL HEALTH CARE

Provide high quality and evidence-based specialist mental health care based on the needs of our Cheshire and Merseyside population



INNOVATIVE:

System change and transformation to be actively driven through research and innovation

What does this look like so far in Cheshire East?



The THRIVE Framework conceptualises the mental health and wellbeing needs of children, young people and families into five needs-based groupings:



- i-Thrive is a system wide approach to navigate children and young people's mental health support.
 - **Healthy Young Minds Service launched April 2024**
- Representatives from across Cheshire East including Integrated Care Board/ NHS trusts/Council/ VCFSE feed in to the <u>Healthy Young Mind's Alliance</u> and Senior Mental Health Lead Network and connections with the CESCP/Early Help Board/Self Harm and Suicide Prevention Board/SEND Partnership Board also. The goal of this is to increase connectivity and enhance early intervention Regular updates are provided to the <u>Mental Health Partnership Board</u>.

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Key providers include supporting emotional and mental wellbeing in children and young people

The THRIVE Framework conceptualises the mental health and wellbeing needs of children, young people and families into five needs-based groupings:



- Schools and their Senior Mental Health Leads/Mental Health Support Teams where available
- Wellbeing for Education support to implementation of the Whole School Approach and the iThrive directory for schools.
- New digital offer for <u>proactive support for children and young</u> <u>people who may be neurodivergent</u>
- Family hubs, including the <u>family hubs digital offer</u> and Solihull Approach resources
- 0-19 service: face to face support, telephone support, text support.
- Visyon and Just Drop In
- Primary care
- Cheshire and Wirral Partnership NHS Foundation Trust for further specialist input via the Children and Young People's Mental Health Service (formerly known as CAMHS) including signposting and advice via the <u>Wellbeing Hub</u>
- In future- Families First Partnerships

Giving Children, young people, their parents, and carers more opportunities to have their say and ensure they become fully embedded in the development of mental health services at place and across the Integrated Care System.

- Children, young people, their parents, and carers are fully embedded in the development of services at place and across the Integrated Care System
- Actions -Increasing the involvement of young people on the Cheshire East Mental Health Partnership Board, Engagement and Co production to capture voice via Parent Carer Forum and Youth Groups on future service development
- Measured by Engagement and Co production to capture voice via Parent Carer Forum and Youth Groups on future service development
- Parent Carer Forum continue to play a key role in the development of the MH
 Partnership Boar, providing the carer voice and ensuring this is included in future service development.

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OPEN

Scrutiny Committee

Date: 04 September 2025

Domestic Homicide Review: EMMA

Report of: Helen Charlesworth May Exec Director – Adults Health

and Integration

Report Reference No: SC/04/25-26

Ward(s) Affected: All

For Decision or Scrutiny: Scrutiny

Purpose of Report

- The purpose of this briefing report is to inform Scrutiny Committee Members, about the Domestic Homicide Review following the suicide of Emma who died in September 2021. The Review was commissioned by the Safer Cheshire East Partnership in April 2022, signed off by SCEP on 27/4/23 and approved by the Home Office on 22/5/25. The Report is now ready to be published on the Councils Safer Cheshire East Partnership (SCEP) Website.
- 2 The purpose of a Domestic Homicide Review is to:
- 3 Establish what lessons are to be learned from the domestic homicide, regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate. prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

- 6 Contribute to a better understanding of the nature of domestic violence and abuse; and highlight good practice.
- A DHR is not an inquiry into who is culpable, this is for the court or coroner to decide.
- One of the objectives of the Councils Corporate Plan is for Cheshire East to be a place where a "Everyone feels safe and secure, difference is celebrated, and abuse and exploitation not tolerated". Therefore, it is important to look in depth at the circumstances leading to this tragedy and the lessons learned and what has been implemented since the Review.

Executive Summary

- 9 The full Domestic Homicide Review Report is found in the supporting documentation. It will be published on the SCEP Website and should be read in conjunction with this Briefing Paper.
- 10 Emma was 30 when she died and had 3 children. Emma had been struggling with her mental health. Her father had taken his own life a few years previously. In November 2021 the Police were called to the home address by a former partner who had found Emma deceased having committed suicide.
- 11 Statutory Guidance produced in 2013 defines the criteria for undertaking a Domestic Homicide Review as follows:
- 12 Under section 9(1) of the 2004 Act, domestic homicide review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by— (a) a person to whom he2 was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death. Where the definition set out in this paragraph has been met, then a Domestic Homicide Review should be undertaken.
- To note that the scope and definitions relating to DHRs is currently under review and will become known as Domestic Abuse Related Death Reviews. This is due to the high numbers of cases involving suicide, where a person has been subject to Domestic Abuse and has taken their own lives because of the abuse.
- 14 It is important to hear the voice of family members and friends who contributed to the Review and some of the comments are quoted below:

"Our Emma was bubbly and confident and always there for everyone."

"Emma was fun-loving, bubbly, kind and caring, and he stated she was my best friend."

"Emma was bubbly and lucky and would talk about college, excited about her future."

The DHR Review panel met 5 times to consider how Agencies worked with Emma. The Review made 8 recommendations which will be highlighted later, together with the actions that have been completed since the conclusion of the Review.

RECOMMENDATIONS

The Scrutiny Committee is recommended to:

Scrutinise and note the learning and recommendations from the EMMA – Domestic Homicide Review.

Background and Context:

- 16 Key findings from the Home Office analysis of domestic homicide reviews: September 2021 to October 2022 Key findings from analysis of domestic homicide reviews: September 2021 to October 2022 (accessible) GOV.UK considered 129 completed DHR's referred to the Home Office Quality Assurance Panel, involving 132 victims.
- In the 129 DHRs reviewed there were 132 victims: 24% had a familial relationship with the perpetrator(s), for 50% the relationship with the perpetrator was partner or ex-partner. Twenty-six per cent were victims who died by suicide.
- The average age of familial abuse victims was 55 years, older than the average age of familial perpetrators which was 35 years. Intimate partner victims were on average younger (38 years) and younger than

- preparators (43 years). The average age of victims who died by suicide was 36 years.
- Where victims were in an intimate partner relationship or who had died by suicide, 86% and 88% respectively were female. This was different where there was a familial relationship where 53% of the victims were female.
- 20 Considering nationality, 69% of familial victims were British; 80% of intimate partner victims were British and where the victims died by suicide 91% were British.
- The number of cases which have met the criteria for a DHR to be undertaken in Cheshire East has increased in recent years with the majority of cases identifying suicide resulting from domestic abuse being the factor.
- In 2024 SCEP commissioned a Thematic Review of DHR's resulting in Suicides to understand the learning from the circumstances involved.
- The Thematic Review highlighted a number of key themes for agencies and partners to consider in their dealing with those at risk of domestic abusive relationships.
- To break the cycle of domestic abuse, women and girls need access to essential resources and support.
- Collaboration between statutory agencies and local organisations is crucial to addressing emotional, legal, and financial needs. When victims have readily available information and know where to turn for help, they are empowered to seek assistance, helping society break the silence around domestic abuse and promoting awareness.
- 26 Establishing age-specific and comprehensive support systems is crucial to addressing the needs of domestic abuse survivors and reducing the risk of suicide.
- 27 Effective collaboration among domestic abuse organisations, mental health services, and statutory agencies is essential for providing adequate support to vulnerable individuals.
- Victim-survivors of domestic abuse may experience a heightened risk of suicide when they lose custody or contact with their children.
- 29 The complexity of custody disputes in domestic abuse cases requires a thorough understanding of abuse dynamics and the specific risks to children

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- Increasing awareness of the interplay between mental health and domestic abuse is vital for fostering informed communities and encouraging intervention
- A copy of the full Thematic review approved by SCEP in April 2025 and is attached to this report for further information.
- The key themes which emerged from Emma follow those highlighted in the Thematic Review. However, each set of circumstances are unique and the impact on families and friends and professionals cannot be underestimated.
- Emma was one of seven siblings, with her mum having four children from a previous relationship. After six months together, Emma's siblings moved to their father's home, leading to minimal contact. Emma and her two sisters, were raised by her parents, who lived outside Cheshire
- Emma's childhood was unstable due to her dad's heroin addiction and his domestic abuse towards her mum. Despite the abuse and her troubling experiences, including visiting crack homes, Emma defended and loved her dad and viewed the experiences as the norm. a family memebr believed that children's services, which were aware, should have intervened but left them in a dangerous environment.
- 35 Emma was accommodated in supported housing at fifteen or sixteen after telling her mum about her stepfather's abuse, prompting her mum to tell her to leave.
- Emma moved to Cheshire in 2009 to be closer to her dad, with whom she maintained a close relationship and who would offer her emotional support. In 2019, her dad died by suicide. Emma's family and friends reported that she continued to experience prolonged grief until her death in November 2021.
- 37 Emma met Ian in 2019; he relocated to Cheshire to live with her and her three children
- Emma's family and friends were aware that she would self-harm, a behaviour that had intensified since her dad's death. They urged her to seek support from services, and she would inform them that she had seen her and discussed this with her GP and was prescribed antidepressants.
- lan returned to Emma's home in the early hours of the morning the day before she died. He used a ladder to climb into the bathroom, entered Emma's bedroom, and was reportedly aggressive towards her.

- The police arrested lan for harassment and possession of a bladed article after they located him in the shed with a knife among his possessions. The following day, he was released on police bail, with the condition that he does not contact Emma or visit her home
- 41 Emma had told her friends and family about lan's relationship, describing him as controlling and verbally aggressive. She had instructed him to leave but let him stay in the shed because he had nowhere else to go. However, he continued interacting with her via Alexa and monitored her coming and going from the house via the Ring doorbell. She was encouraged to seek support from her family and friends, but they were unaware of any additional ways in which they could intervene or provide support.
- Coercion and control is referenced in Part 6 of the Domestic Abuse Act 2021, emphasising the need for agencies to be aware of this as domestic abuse. Women's Aid emphasises that domestic abuse is not always physical, as is commonly believed by victims/survivors. Coercive control is an assault, threat, humiliation, intimidation, or abuse designed to damage, punish, or intimidate the victim. This controlling behaviour is intended to make a person reliant by isolating them from assistance, exploiting them, robbing them of independence, and dictating their daily behaviour.
- Controlling and coercive behaviour is a high-risk factor and is highlighted in the suicide and homicide timeline. It is, therefore, essential to identify this critical risk factor and empower victims/survivors with the understanding that coercion and control is a crime and to improve the collective response of agencies that engage with victims/survivors.
- 44 <u>Recommendations:</u> The Review made several multi agency recommendations which can be seen at the end of the full Report and in the 7-minute briefing. These include the following.
- Training for officers focused on recognising indicators of coercion and control.
- To provide their staff access to the review to facilitate their responses and raise awareness of the use of coercion and the various strategies employed by perpetrators.
- When self-harm or suicidal ideation is identified in individuals experiencing domestic abuse, services should have established protocols/resources to support the response to the disclosure.

- To identify familial suicide as a risk factor for self-harm and suicide and to share the assessment/information with appropriate partners to facilitate a coordinated response.
- 49 Suicide Awareness including its impact
- Actions: The Safer Cheshire East Partnership seeks assurances from Partner Agencies about their responses to the learning from DHRs and oversees Action Plans. Whilst the Home Office approved the publication of this DHR in May 2025, the following actions have already been put into place.
- The SCEP commissioned Professor Jane Monckton Smith a respected specialist in the file of Domestic Abuse to provide Training to partner professionals in November 2024 on the Suicide Timeline.
- Engagement with victims of Domestic Abuse to ascertain details of their journey and experiences in dealing with the effectiveness of partner agency support.
- Training has been introduced by several partner agencies to spot the signs of Domestic Abuse together with Controlling and coercive behaviour.
- The introduction of Suicide Prevention Training available to professional staff within Cheshire East Council every 4/6 weeks.
- 55 The Domestic Abuse Strategy is being refreshed.
- The Panel and Cheshire East wishes to record its condolences to the family of Emma for their loss.

Consultation and Engagement

No consultation is required for this report

Reasons for Recommendations

This Report sets out the learning and recommendations from the Domestic Homicide Review to ensure that service delivery is improved and to prevent further incidents of harm. The Safer Cheshire East Partnership will oversee the Action Plan.

Other Options Considered

There are no other options to consider as the Safer Cheshire East Partnership has met its Statutory Duties to undertake a Domestic Homicide Review and to share the learning.

Option	Impact	Risk
The Domestic	Domestic Abuse	Without
Abuse Act places	impacts 1 in 4 adults	conducting Domestic
statutory duties on	in the UK. The	Homicide Reviews,
public bodies to	numbers of Suicides	the risk to victims will
identify and report	related to Domestic	increase and
Domestic Abuse in	Abuse is increasing	services will fail to
order to protect	and we hold a	improve.
victims and pursue	Corporate Duty to see	
and prosecute	Safeguarding as	
offenders.	Everyone's Business	

Implications and Comments

Monitoring Officer/Legal/Governance

- Under Section 9 (1) of the Domestic Violence, Crime and Victims Act 2004 a Domestic Homicide Review is a review of the circumstances in which the death of a person aged 16 or over has or appears to have resulted from Domestic Abuse. It is held with a view to identifying the lessons to be learnt from the death.
- The Safer Cheshire East Partnership (SCEP) is responsible for commissioning DHRs under the Domestic Violence, Crime and Victims Act 2004.
- The report ensures compliance with the statutory duties placed on SCEP.

Section 151 Officer/Finance

There are no financial implications or changes required to the MTFS because of the recommendations in this report. Implementation of learning from this review will be carried out by the service within existing resources.

Human Resources

There are no HR resource implications for this report.

Risk Management

There are no Risk Management Implications for this report. The learning from the DHR is being shared via the Safer Cheshire East Partneship, and forms part of the Suicide Prevention and Domestic Abuse Strategy.

Impact on other Committees

There are no impacts on other committees.

Policy

67

Commitment 1: Unlocking prosperity for all	Commitment 2: Improving health and wellbeing	Commitment 3: An effective and enabling council

Equality, Diversity and Inclusion

The learning from the DHR is applicable to all.

Other Implications

The learning from the DHR is applicable to all communities.

Consultation

Name of Consultee	Post held	Date sent	Date returned
Statutory Officer (or deputy) :			
Ashley Hughes	S151 Officer	18/06/25	21/08/25
Janet Witkowski	Acting Monitoring Officer	Click or tap to enter a date	Click or tap to enter a date

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Legal and Finance			
Nikki Woodhill	Finance Manager	18/06/25	24/06/25
Roisin Beressi	Principal Lawyer	18/06/25	29/07/25
Other Consultees:			
Executive Directors/Directors			
Helen Charlesworth May	Executive Director Adults Health and Integration	04/08/25	27/08/25

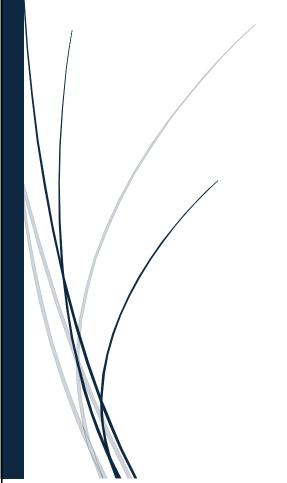
Access to Information		
Contact Officer:	Richard Christopherson – Locality Manager	
	Richard.christopherson@cheshireeast.gov.uk	
Appendices:	Appendix 1 – Cheshire East DHR – Emma – Summary Report	
	Appendix 2 – Learning Brief Cheshire – EMMA	
Background Papers:	Key findings from analysis of domestic homicide reviews: September 2021 to October 2022 (accessible) - GOV.UK	

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Domestic Homicide Review

Executive Summary for the death of Emma November 2021



Parminder Sahota: Independent Chair and Author



Preface

The Independent Chair and Review Panel send their deepest condolences to all those impacted by Emma's (pseudonym) untimely death and thank them for their involvement and support in this process.

The primary objective of a Domestic Homicide Review (DHR) is to permit the learning of lessons from the death of a person in a relationship where domestic abuse was known to have occurred. Professionals must understand the events in each instance to fully and effectively absorb these lessons and identify the necessary changes to reduce the probability of domestic abuse-related deaths.

The chair thanks the panel and persons who submitted chronologies and materials for their time and cooperation.

"Emma was bubbly and confident and always there for everyone."

Sarah

"Emma was fun-loving, bubbly, kind and caring, and he stated she was my best friend."

Toby

"Emma was bubbly and lucky and would talk about college, excited about her future."

Laura

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Section One: the Review Process

1.1.1 Introduction and Agencies Participating in the Review

- 1.1.2 The summary outlines the procedures the Safer Cheshire East Partnership (SCEP) took to review the death of Emma, who died in November 2021; she was a thirty-year-old White British female resident of Cheshire.
- 1.1.3 The following pseudonyms have been used in the review, as approved by Emma's ex-partner:

• The victim: Emma

Eldest Child: Child A, eleven years old
 Middle Child: Child B, eight years old
 Youngest Child: Child C, six years old

Ex-Partner: ScottSister: LauraFriend: JeanFriend: Toby

Friend: RebeccaPaternal aunt: KirstyEx-Boyfriend: Ian

- 1.1.4 Emma was discovered deceased by Scott–pseudonym at her home address.
- 1.1.5 The coroner's office confirmed that the coroner would likely set a date for the inquest once the domestic homicide review (DHR) was complete.
- 1.1.6 SCEP commissioned the DHR on 20 April 2022, following the Multi-Agency Statutory Guidance for Domestic Homicide Reviews (2016).¹
- 1.1.7 The independent chair was commissioned on 1 August 2022. Safer Cheshire East Partnership approved the completed report on 27 April 2023.
- 1.1.8 The panel convened for the first time with the chair on 12 October 2022. The review panel received its final feedback on 12 April 2023.
- 1.1.9 The review exceeded the six-month deadline outlined in the statutory guidance. The reason for this was as follows:

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 $^{{}^{1}\}underline{\text{https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews}}$

- The Local Authority must implement a procurement process to appoint an independent chair and author. The commencement of the Review is delayed until this process is completed, which necessitates a certain amount of time.
- The necessity to reconcile agency demand and the number of current reviews.
- The coroner was asked to furnish the council with material that would enable them to understand Emma's history comprehensively.
- Emma's family was granted additional time to review the report and provide and receive feedback.
- 1.1.10 SCEP informed Scott, Emma's ex-partner and father to their three children, about the review and the process for participating in a letter dated 16 September 2022. The chair contacted Scott via telephone, and he provided details of Emma's family and friends.
- 1.1.11 Scott and Laura, Emma's sister, approved the terms of reference. The chair contacted Kirsty, Emma's paternal aunt and three of her friends, Jean, Toby and Rebecca. Emma's mum was contacted via phone and letter; however, no response was received.
- 1.1.12 Scott and Laura were provided with a copy of the overview report and encouraged to provide feedback. The report was appropriately modified in response to their feedback.
- 1.1.13 The following agencies and independent panel members contributed to the review:

Name	Role	Organisation	
Jill Broomhall	Director Adults Social Care	Cheshire East Council	
Richard Christopherson	Locality Manager – Community Safety	Cheshire East Council	
Sandra Murphy	Head of Adult Safeguarding	Cheshire East Council	
Emma Storey	Domestic Abuse & Sexual Violence Development Lead Advisor	Cheshire East Council	
Nicky Brown	Detective Constable Review Officer	Cheshire Constabulary	
Sarah Martin	Associate Director of Safeguarding	NHS Cheshire Clinical Commissioning Group	
Bev Wrighton	Operations Manager	My CWA (Cheshire Without Abuse)	
Lindsay Ratapana	Designated Nurse – Adult Safeguarding	NHS Cheshire and Merseyside Integrated Care Board (ICB)	
Sara Scott	Head of Safeguarding	Cheshire and Wirral Partnership NHS Foundation Trust	
Veronica Clarke	PA to Jill Broomhall, Director of Adult Social Care	Cheshire East Council	
Kathryn Royal (joined the panel following the 1 st overview draft report)	Research Officer	Surviving Economic Abuse	

- 1.1.14 Parminder Sahota, an independent reviewer with eleven years of experience in Safeguarding and Domestic Abuse, completed DHR Chair training from Advocacy After Fatal Domestic Abuse in 2021.
- 1.1.15 She had been employed as a Mental Health Nurse in the NHS for more than two decades, with a particular emphasis on crisis work and working with individuals diagnosed with personality

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disorders. She was also the Director of Safeguarding and the Prevent and Domestic Abuse Lead for an NHS Trust in London.

1.1.16 Before this review, Parminder Sahota had no contact with the family members. She is independent of the Safer Cheshire East Partnership and participating agencies.

1.2.1 The Purpose and Terms of Reference

- 1.2.2 The statutory guidance sets out the purpose of domestic homicide reviews to:
 - Establish the facts that led to the death in November 2021 and whether any lessons can be learned from the case about how local professionals and agencies worked together to safeguard Emma.
 - Establish what lessons will be learned from the death regarding how local professionals and organisations work individually and together to safeguard victims.
 - Identify these lessons, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change.
 - Apply these lessons to service responses, including changes to inform appropriate national and local policies and procedures.
 - Prevent domestic violence and related deaths and improve service responses for all
 domestic violence and abuse victims by developing a coordinated multi-agency approach
 to identify and respond to domestic abuse at the earliest opportunity.
 - Contribute to a better understanding of the nature of domestic abuse.
 - Highlight good practice.
 - Ensure that Emma's voice is heard regarding her lived experiences and the impact of the domestic abuse on her mental health. Allowing her journey to be told and identifying the lessons that may be learnt.
- 1.2.3 The review assessed Emma's final years (March 2019–November 2021) to identify any history of abuse, access to community support, and obstacles faced in obtaining that support. The goal was to develop strategies to reduce the risk of deaths related to domestic abuse.
- 1.2.4 The panel agreed on fifteen terms of reference for this case.

Section Two: Background, Agency Contact and Evidence of Domestic Abuse

2.1.1 Background

2.1.2 Emma was one of seven siblings, with her mum having four children from a previous relationship. After six months together, Emma's siblings moved to their father's home, leading to minimal contact. Emma and her two sisters, including Laura, were raised by her parents, who lived outside Cheshire.

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- 2.1.3 Emma's childhood was unstable due to her dad's heroin addiction and his domestic abuse towards her mum. Despite the abuse and her troubling experiences, including visiting crack homes, Emma defended and loved her dad and viewed the experiences as the norm. Laura believed that children's services, which were aware, should have intervened but left them in a dangerous environment.
- 2.1.4 Emma was accommodated in supported housing at fifteen or sixteen after telling her mum about her stepfather's abuse, prompting her mum to tell her to leave.
- 2.1.5 Emma and Scott met in 2009 and have three children. Following their separation in 2019, Scott maintained an active role in their children's lives and remained close friends.
- 2.1.6 Emma moved to Cheshire in 2009 to be closer to her dad, with whom she maintained a close relationship and who would offer her emotional support. In 2019, her dad died by suicide. Emma's family and friends reported that she continued to experience prolonged grief until her death in November 2021.
- 2.1.7 Emma met Ian in 2019; he relocated to Cheshire to live with her and her three children.
- 2.1.8 Emma's family and friends were aware that she would self-harm, a behaviour that had intensified since her dad's death. They urged her to seek support from services, and she would inform them that she had seen her and discussed this with her GP and was prescribed antidepressants.
- 2.1.9 Two days before Emma died, her cat was fatally injured, and she informed Ian that she required solitude. However, Emma's family reported Ian went out drinking and inundated her with abusive messages, which prompted her to block him and end the relationship.
- 2.1.10 Emma agreed that Ian should spend the night in her shed as he had no alternative accommodation. She left the shed key outside for him to use and explicitly stated that he could not access the house.
- 2.1.11 Ian returned to Emma's home in the early hours of the morning the day before she died. He used a ladder to climb into the bathroom, entered Emma's bedroom, and was reportedly aggressive. Emma contacted the police to report that Ian had broken into her home.
- 2.1.12 The police arrested Ian for harassment and possession of a bladed article after they located him in the shed with a knife among his possessions. The following day, he was released on police bail, with the condition that he does not contact Emma or visit her home.
- 2.1.13 The children were with Scott as scheduled, and Emma met with her friend the evening before she died.
- 2.1.14 Ian contacted Scott on the day Emma was discovered deceased, as he conveyed concern about his inability to contact her. Scott arrived at Emma's home and found her deceased.

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2.2.1 Agency Contact

- 2.2.2 Emma received input from the following agencies during the period under review:
 - 1. Cheshire and Wirral Partnership Foundation Trust Liaison Psychiatry
 - 2. GP Practice
 - 3. Leighton Hospital, Emergency Department
 - 4. Police
 - 5. School
- 2.2.3 In March 2019, Emma reported to the police that a female individual, who was wearing an electronic monitoring tag, was at her door, threatening to harm her and damage her vehicle. Emma described the female as "obsessed" with her and reported that they had previously argued about the female's former partner. The female was arrested for a public order offence. The female had made a false claim that Scott assaulted Emma, and Emma had assaulted her children. The outcome was no further action, and Emma was satisfied with this.
- 2.2.4 Cheshire and Wirral Partnership Foundation Trust, Liaison Psychiatry assessed Emma in June 2019 after she visited the Emergency Department (ED) at Leighton Hospital because of a selfharm incident.
- 2.2.5 The risk of suicide was assessed by liaison psychiatry, which determined that the self-harm was a reaction to her dad's death the week prior. Emma cited her children from her previous relationship and her positive relationship with her boyfriend of a few months as protective factors.
- 2.2.6 She was referred to Change Grow Live² (CGL) for alcohol support, and the Mental Health Re-Enablement Team³ at Cheshire East Council: Adult Social Care (ASC) for financial assistance. The mental health re-enablement team supports individuals with goal planning, self-esteem, social inclusion, and coping. It also includes housing, debt, social clubs, and volunteering support.
- 2.2.7 CGL discharged Emma due to their inability to communicate with her.
- 2.2.8 ASC conducted three home visits but received no response. They sent Emma a letter to encourage her engagement but did not receive a response, so they closed her to the service.
- 2.2.9 Psychiatry contacted the school nurse to enquire about the children's welfare, and the assessment was shared with them and Emma's GP. Emma was informed about the Well-Being Hub⁴ (talking therapies) and DOVE bereavement counselling.⁵ She was subsequently

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² https://www.changegrowlive.org/drug-alcohol-service-cheshire-east/crewe

 $^{^3\,\}underline{\text{https://www.cheshireeast.gov.uk/livewell/living-independently/homecare/reablement.aspx}}$

⁴ https://livewellservices.cheshireeast.gov.uk/Services/5576/The-Wellbeing-Hub-l

⁵ <u>https://thedoveservice.org.uk/</u>

- discharged from Cheshire and Wirral Partnership Foundation Trust and had no further contact with Emma.
- 2.2.10 No information was provided to the panel to confirm that Emma had contacted bereavement services.
- 2.2.11 In November 2019, North West Ambulance Service contacted the police to report that Emma had consumed alcohol and drugs and might need their assistance. She was taken to the ED by ambulance; no police intervention was required. Emma did not wait to be seen at the ED, prompting the staff to call the police. Police contacted her the next day, and she expressed her intention to visit her GP.
- 2.2.12 Emma told her GP she took seven aspirin due to anxiety about her dad's inquest. She received antidepressants and reported she had a supportive partner. The practice referred her to Children's Social Care (CSC) for a welfare check, and no immediate safety concerns for the children were found.
- 2.2.13 CSC informed the children's school of the above, and they subsequently engaged in a conversation with the children to discuss their wishes and feelings, a toolkit to encourage them to express their thoughts, feelings, and experiences. No issues were identified.
- 2.2.14 The school continued to support the children using the toolkit and conducted home visits during the COVID-19 pandemic.
- 2.2.15 Emma continued to experience symptoms of depression following her dad's death. In October 2021, she disclosed this information to her GP and initiated a trial of antidepressants. She reported that she had increased her medication dosage to good effect, as she had found it beneficial, and her last visit to her GP was nine days before her death.
- 2.2.16 The school contacted Emma three days before her death about child B's lateness. She was offered free access to the breakfast club, and they discussed arranging a meeting to discuss punctuality support.
- 2.2.17 Emma's cat was hit by a car two days before her death. She called Scott to say lan had not paid the vet bill, forcing her to use her Christmas savings. The children did not attend school. The school contacted Emma and informed them they had received distressing news. The family link worker called Emma and left her a message.
- 2.2.18 The children did not attend school the following day, and Emma advised the school that they were still processing the news. The family link worker attempted to call Emma but received no response.

2.3.1 Evidence of Domestic Abuse

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- 2.3.2 The school completed the feelings and wishes toolkit with Child A and B in March 2020. Child A reported that Ian was "not very nice; he ignores me." Child A was recommended for the next steps of intervention, and the school agreed to continue monitoring the children.
- 2.3.3 In November 2020, Emma sought police help to remove Ian from her home, feeling vulnerable and fearful due to his controlling behaviour, where he limited her time with family and demanded her attention. Emma reported they had both been drinking; however, she was dissatisfied with the relationship and had difficulty ending it.
- 2.3.4 Emma declined to make a complaint about the controlling and coercive behaviour, believing their relationship would last since there was no violence. The police completed a Vulnerable Person Assessment⁶ (VPA), which was recorded and recorded. Emma repeatedly said, "You have to see it to believe it," but offered no details, expressing difficulty ending the relationship.
- 2.3.5 Ian stated Emma called the police out of spite and was experiencing mental health issues. Emma reported suicidal ideation and depression after completing the domestic abuse, stalking and 'honour'- based abuse risk assessment⁷ (DASH), a standard risk was identified, with no further references to domestic abuse or controlling and coercive behaviour. Referrals were made to Cheshire CARES⁸ (enhanced support for victims to cope and recover from crime) and CSC.
- 2.3.6 CSC notified the school of the above. They completed the toolkit, and Child C described Ian as "Angry; he is unkind to me. He keeps shouting, and when I ask for a cookie, I say, "Please," and he says no. Mummy—She cuddles me." The school shared the information with CSC.
- 2.3.7 In August 2021, Emma told her friend Toby that Ian was becoming controlling and obsessive after cheating on her and installing an Alexa, hallway and bedroom cameras, and a Ring doorbell. Toby discussed the cameras with Ian and noted that while Ian was a gadget enthusiast, Emma was unfamiliar with these devices.
- 2.3.8 Emma told Toby she had ended the relationship with Ian.
- 2.3.9 Emma phoned the police the day before her death after her ex-boyfriend broke into her home. The police conducted a DASH risk assessment and referred her to the domestic abuse hub.

Section Three: Key Issues

Coercion and Control

3.1.1 Victims/survivors or agencies do not always recognise coercion and control and the tactics used in this. The offence of controlling or coercive behaviour is defined under Section 76 of

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 $^{{}^{6}\,\}text{https://www.cheshire.police.uk/SysSiteAssets/media/downloads/cheshire/hyg/sharing-assessments-about-vulnerable-people.pdf}$

⁷ https://safelives.org.uk/resources-for-professionals/dash-resources/

 $^{{\}tt 8}\, \underline{\sf https://www.cheshire-pcc.gov.uk/support-for-victims/cheshire-cares/}$

the Serious Crime Act 2015. Consequently, the statutory guidance for coercion and control must be implemented with a focus on the identification of the offence.

- 3.1.2 Coercion and control is referenced in Part 6 of the Domestic Abuse Act 2021,¹¹ thus emphasising the need for agencies to be aware of this as domestic abuse. Women's Aid¹² emphasises that domestic abuse is not always physical, as is commonly believed by victims/survivors. Coercive control is an assault, threat, humiliation, intimidation, or abuse designed to damage, punish, or intimidate the victim. This controlling behaviour is intended to make a person reliant by isolating them from assistance, exploiting them, robbing them of independence, and dictating their daily behaviour.
- 3.1.3 Controlling and coercive behaviour is a high-risk factor and is highlighted in the suicide and homicide timeline. It is, therefore, essential to identify this critical risk factor and empower victims/survivors with the understanding that coercion and control is a crime and to improve the collective response of agencies that engage with victims/survivors.

Self-Harm and Domestic Abuse

- 3.1.4 Emma had one ED visit following self-harm; she was assessed by psychiatry, and the self-harm was viewed as a response to her dad's recent death. At this assessment, Emma reported a positive relationship with her partner. Emma's family and friends reported there had been additional instances of self-harm, which they believed she had sought help for.
- 3.1.5 Self-harm is a behaviour that some people employ to cope with internal anguish. According to research, there is a link between domestic abuse and self-harm. In addition, females who had separated from their partners were more prone to taking overdoses.¹³
- 3.1.6 The NICE guideline recommends that individuals who present with comparable symptoms to Emma receive routine enquiries regarding domestic abuse. The review determined that Emma had described her partner in a positive light during the presentation to ED and the subsequent psychiatric assessment. Furthermore, she had communicated the same to her GP. Therefore, the enquiry may not have felt appropriate.

Familial Suicide

3.1.7 Parental suicide has been linked to increased suicide and suicide attempts.¹⁴ Emma's dad's death was a substantial risk factor, and according to her family and friends, she felt lost without him. Psychiatry had notified Emma of bereavement counselling, and her GP had prescribed anti-depressant medication.

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⁹ hhttps://www.legislation.gov.uk/ukpga/2015/9/section/76

¹⁰ https://assets.publishing.service.gov.uk/media/642d3f9e7de82b001231364d/Controlling_or_Coercive_Behaviour_Statutory_Guidance_-_final.pdf

¹¹ https://www.legislation.gov.uk/ukpga/2021/17/part/6/crossheading/controlling-or-coercive-behaviour

¹² https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control/

¹³ Dalton TR, Knipe D, Feder G, et al Prevalence and correlates of domestic violence among people seeking treatment for self-harm: data from a regional self-harm register emergency Medicine Journal 2019;36:407-409.

 $[\]frac{14}{\text{https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/offsprings-risk-for-suicidal-behaviour-in-relation-to-parental-death-by-suicide-systematic-review-and-metaanalysis-and-a-model-for-familial-transmission-of-suicide/C450526CAF5F329AF48E656660DEB6A7}$

- 3.1.8 Emma informed her GP in November 2021 that she had increased her antidepressant medication and continued to be affected by her dad's death, which occurred in May 2019. The record did not contain any discussions regarding bereavement counselling or whether she had independently accessed it.
- 3.1.9 Cheshire and Merseyside have issued their suicide prevention strategy¹⁵ (2022-2027), which addresses several risk factors, such as family-related difficulties. Locally conducted workshops to raise awareness of suicide, risk factors, and how to make the community safer were part of the strategy.

Section Four: Conclusion

- 4.1.1 The purpose of the review is to determine the circumstances behind the death of Emma in November 2021 and 'articulate life through the eyes of the victims.' 16
- 4.1.2 Emma was a single parent of three children, and their father, Scott, continued to provide and care for them. Since 2019, Emma has been in a relationship with Ian.
- 4.1.3 Emma experienced a challenging childhood; her dad had a heroin addiction, and she and her siblings frequently accompanied him to crack houses. The siblings also observed domestic abuse that her dad inflicted on their mum.
- 4.1.4 Emma attended three primary and two high schools; however, she was frequently absent due to her parent's inability to take her to school. The children remained in the family home, though the children's social care was aware of her and her siblings and the home environment. Consequently, Laura and her siblings lost confidence in the organisations that were supposed to protect them, as they were left in an unsafe environment.
- 4.1.5 Emma was forced to leave home at fifteen or sixteen after her mum learned about her stepfather's physical abuse. Emma's mum disbelieved her and instructed her to leave.
- 4.1.6 Emma's friends and family all felt that her dad's passing in 2019 was a significant risk factor for her. Emma kept her dad's ashes because she wanted to be buried with them and felt lost without him. Her friends and family had encouraged her to seek support.
- 4.1.7 Emma's friends described her as sociable, but after her dad died and with the lockdown, she spent more time at home and was isolated. Following her dad's death, her family and friends also observed an increase in her self-harm. Emma informed her friend, Kirsty, that she had discussed self-harm with her GP. The GP, however, did not have a record of this.
- 4.1.8 A report exploring the impact highlighted isolation as a significant risk factor for victims of domestic abuse and the lack of face-to-face contact.¹⁷ A study also discovered that restrictions kept victims in abusive situations and that partner and family abuse worsened. In addition, the

V2

 $^{^{15}\,\}underline{\text{https://champspublichealth.com/wp-content/uploads/2022/11/Suicide-Prevention-Strategy-2022-2027-compressed.pdf}$

 $^{{}^{16} \}underline{\text{https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf}$

¹⁷ https://www.womensaid.org.uk/wp-content/uploads/2021/11/Shadow_Pandemic_Report_FINAL.pdf

- lockdown permitted the perpetrators of domestic abuse, controlling, and coercive behaviour to increase or hide their abuse. 18
- 4.1.9 Laura, Emma's sister, observed that Emma would seek emotional support from her dad; however, his death rendered this support obsolete. The lockdown further exacerbated Emma's isolation, which diminished her opportunities to interact with others and remained in the house with her children and Ian. School staff visited the family at their doorstep following the lockdown regulations.
- 4.1.10 Emma had told her friends and family about lan's relationship, describing him as controlling and verbally aggressive. She had instructed him to leave but let him stay in the shed because he had nowhere else to go. However, he continued interacting with her via Alexa and monitored her coming and going from the house via the Ring doorbell. She was encouraged to seek support from her family and friends, but they were unaware of any additional ways in which they could intervene or provide support.

Section Five: Recommendations

5.1.1 Recommendation One: Coercion and Control

Cheshire Police

1.a Cheshire police to implement training for officers focused on recognising indicators of coercion and control, as well as ensuring adherence to domestic abuse risk assessments for all victims and survivors of domestic abuse.

Cheshire Police, Cheshire and Wirral Partnership Foundation Trust Liaison Psychiatry, GP Practice, Leighton Hospital, Emergency Department, and My CWA

1.b To provide their staff access to the review to facilitate their responses and raise awareness of the use of coercion and the various strategies employed by perpetrators. With a particular emphasis on the mental health of the victims/survivors being targeted by perpetrators and the significance of coercion and control within the homicide and suicide timeline.

Safer Cheshire East Partnership (SCEP)

1.c SCEP to collaborate with victims/survivors of domestic abuse to create awareness campaigns/resources that highlight and address the realities of coercion and control.

5.1.2 Recommendation Two: Self-Harm and Domestic Abuse

Safer Cheshire East Partnership (SCEP)

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¹⁸ https://www.ukri.org/about-us/how-we-are-doing/research-outcomes-and-impact/esrc/how-the-covid-19-lockdowns-affected-the-domestic-abuse-crisis/#:~:text=Key%20findings%20and%20recommendations&text=domestic%20abuse%20problem-,restrictions%20kept%20victims%20in%20abusive%20relationships%20for%20longer,partner%20and%20family%20abuse%20increased

2.a SCEP and DAFSU to develop supplementary guidance to the DASH risk assessment for risks associated with suicide.

<u>Cheshire Police, Cheshire and Wirral Partnership Foundation Trust Liaison Psychiatry, GP Practice and Leighton Hospital Emergency Department</u>

2. b When self-harm or suicidal ideation is identified in individuals experiencing domestic abuse, services should have established protocols/resources to support the response to the disclosure. This may include facilitating referrals for the victim/survivor or making referrals on their behalf. Additionally, it is essential to consider reporting victims/survivors to MARAC and obtaining guidance for those who do not consent to domestic abuse agency referrals.

5.1.3 Recommendation Three: Familial Suicide

Public Health

3.a. Continue to deliver training on the suicide strategy and raise awareness of the risks that may lead to suicide.

<u>Cheshire Police, Cheshire and Wirral Partnership Foundation Trust Liaison Psychiatry, GP Practice and</u> Leighton Hospital Emergency Department

3. b. To identify familial suicide as a risk factor for self-harm and suicide and to share the assessment/information with appropriate partners to facilitate a coordinated response.

<u>Cheshire and Wirral Partnership Foundation Trust Liaison Psychiatry, GP Practice and Leighton Hospital</u> <u>Emergency Department</u>

3. c. To provide accessible information on support services to at-risk people and identify potential barriers to accessing support.

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Background

Emma, aged 30 and a single mother of three, experienced a childhood marked by domestic abuse and parental substance misuse. She moved to Cheshire to be near her father, whose suicide in 2019 significantly impacted her mental health.

Emma's relationship with Ian was characterised by coercive control and emotional abuse. Days before her death, Ian broke into her home, leading to his arrest.

Key Learning Points

Missed Early Interventions: Services did not respond to Emma's childhood vulnerabilities.

Impact of Bereavement: Lack of support worsened Emma's mental health.

Coercive Control Risks: lan's escalating abuse highlights the dangers of manipulation and dependency.

Suicide Prevention: Emma's trauma and declining mental health required proactive intervention.

This case highlights the importance of a trauma-informed, multi-agency safeguarding approach.

Learning for Practitioners

Emma's case highlights the following key lessons:

Early Intervention is Crucial – Childhood adversity, including domestic abuse, parental substance misuse, and school absences, should trigger proactive safeguarding responses to prevent long-term harm.

Recognising Coercive Control – Coercive and controlling behaviour is a high-risk factor for homicide and suicide. Practitioners must identify non-physical forms of abuse, ensuring victims are aware that coercive control is a crime.

Routine Enquiries for Domestic Abuse – Self-harm and mental health struggles are often linked to abuse and coercion. Routine screening in healthcare settings, especially after self-harm or relationship breakdowns, is essential.

Suicide Risk and Bereavement Support – Parental suicide increases vulnerability. Mental health professionals and GPs must ensure consistent follow-up, offer bereavement support, and assess ongoing risk factors.

Multi-Agency Collaboration – Effective safeguarding requires enhanced coordination among healthcare, law enforcement, and social care. Risk assessments, information sharing, and early intervention can help prevent harm.

Coercion and Control

Coercive control is a criminal offence under Section 76 of the Serious Crime Act 2015 and is recognised as domestic abuse in the Domestic Abuse Act 2021. It involves manipulation, isolation, and control, often without physical violence.

A high-risk factor in suicide and homicide, coercive control must be identified early, with agencies improving awareness, intervention, and victim support.



Self-Harm and Suicide

Self-harm is often a coping mechanism for emotional distress and is linked to domestic abuse, particularly in women who have separated from partners. NICE guidelines recommend routine domestic abuse enquiries for individuals presenting with self-harm.

Emma's self-harm was initially attributed to bereavement, and no concerns were raised due to her positive portrayal of her relationship. This highlights the need for consistent and proactive questioning in healthcare settings to identify and address hidden risks.



Familial Suicide

Parental suicide is a significant risk factor for suicide and self-harm. Emma's father's death deeply affected her, yet there was no recorded follow-up on bereavement counselling.

The Cheshire and Merseyside Suicide Prevention Strategy (2022-2027) highlights family-related risks and promotes community awareness. This case underscores the need for proactive support, regular follow-ups, and improved access to bereavement interventions.





OPEN

Scrutiny Committee

Date: 04 September 2025

Safeguarding Adults Review - BELLA

Report of: Helen CHARLESWORTH-MAY - Executive Director

Adults Health and Integration

Report Reference No: SC/07/2025-26

Ward(s) Affected: ALL

For Decision or Scrutiny: For scrutiny

Purpose of Report

- The purpose of this Report is to inform the Scrutiny Committee about the Safeguarding Adults Review regarding "BELLA". The Safeguarding Adults Board appointed an independent author, Frances Millar, to facilitate the review and write the final report, which accompanies this briefing. It has been approved by the Safeguarding Adults Board and is ready to be published on the SAB website.
- The Safeguarding Adults Board have a legal duty to undertake a Safeguarding Adults Review, when it suspects that an adult at risk has died due to abuse or neglect and agencies could have worked better to support the individual. Cheshire East Council is committed to creating safe communities with accessible services, where people can live free from abuse or harm, and to creating a culture of learning where lessons can be learned to prevent future harm. This Safeguarding Adults Review meets the Strategic objectives of the Council.

Executive Summary

A referral was made to Cheshire East Safeguarding Adults Board regarding BELLA, as she experienced life changing injuries due to being hit by a train on 27th January 2024. The Safeguarding Adults Review Panel met on 18th March 2024, and the Safeguarding Board agreed that

the criteria for a statutory Safeguarding Adults Review were met. The scope of the SAR covered the period 1/1/23 – 27/1/24. BELLA and her mum were able to contribute to this Review.

- BELLA is a 26-year-old woman who was diagnosed with Autism in 2017. She also lives with the impact of a traumatic brain injury and non-epileptic seizures. She is creative and enjoys hobbies including arts, crafts, music, singing and climbing. These hobbies, together with her love of animals allows her to "self sooth", regulate her emotions and reduce anxiety.
- Professionals who have worked with Bella describe her as an articulate and self-assured individual when she is not experiencing a difficult mental health crisis. She has a strong sense of independence and knows her own mind, often making decisions with clarity and conviction. Bella is softly spoken and, at times, finds it more comfortable to communicate through text rather than verbal conversations, which helps her express herself more effectively. Overall, professionals see Bella as someone who is deeply connected to the things she values most, with her dogs being a cornerstone of her emotional support system. By recognising and respecting these protective factors, those around her can better support her journey towards stability and wellbeing.
- BELLAs complex case included incidents of self-harm, mental health crisis and challenges associated with cross border provision. Her care and support needs meant that she was eligible for assessment and services as defined by the Care Act 2014 and the review highlighted the support being provided by her Care Team and Family.
- Whist there had been previous safeguarding concerns, the Safeguarding Adults Review focused on the significant incidents which occurred in January 2024, the second one resulted in her being hit by a train and sustaining life changing injuries:

26th January 2024

- **1820 hours:** Ambulance service reported a call from Bella stating suicidal intent and her presence on the train tracks. British Transport Police (BTP) officers were dispatched.
- While en route: A train driver spotted Bella on the tracks, stopped the train, and brought her to next main station.
- At main trainline station: Bella engaged with officers but was timid and nervous, holding a teddy bear named Chester. She confirmed suicidal intentions and agreed to attend Hospital voluntarily.
- **Hospital interaction:** Due to sensory sensitivities, Bella waited in the police vehicle until a room became available. A senior mental health

practitioner assessed Bella and concluded this was a behavioural issue rather than a mental health crisis. Bella's support worker, agreed to supervise Bella at home.

• **Outcome:** Bella was escorted to her home address by the Police and under the supervision of her support worker.

27th January 2024

- 1016 hours: A train driver reported seeing Bella near the train station.
 Bella walked onto the track and was struck by the train despite emergency braking.
- Response: Paramedics stabilised Bella at the scene before transferring her to Salford Royal Hospital with life-threatening injuries, including leg, pelvis, chest, and head trauma. Bella's father was informed and accompanied her to the hospital
- 8 As part of the Safeguarding Adults Review all Agencies within and external to Cheshire East, submitted Individual Management Reports to indicate how and why they had been in contact with BELLA. The Author collated this information and provided an analysis in line with the key lines of enquiry. A Practitioner Event provided valuable insight into the case. Within the final report the Author was able to identify key message regarding Transitions between Care Settings, Multi Agency Communication and Coordination, Mental Health and Autism Care, Safeguarding Practices and Risk Management.
- Bella and her mum also contributed to the SAR. Prior to the incident Bella described feeling unheard and invisible with her distress being dismissed as being "behavioural", rather than a way of demonstrating her deteriorating mental health. Whilst her mum felt that the concerns she raised about Bella were often not taken seriously. They both wanted this SAR to make a difference to other families in similar circumstances.
- The details of the SAR are not contained within this Report, as they are contained within the SAR Report itself and can be found at the end of this report.

RECOMMENDATIONS

The Scrutiny Committee is recommended to:

Scrutinise and note the learning and recommendation of the BELLA Safeguarding Adults Review.

Background and Context

- 11 The purpose of a Safeguarding Adults Review is to:
- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about how local professionals and agencies worked together to safeguard BELLA
- Highlight areas of good practice to be shared
- Identify how and within what timescales any actions will be acted on, and what is expected to change.
- Contribute to a better understanding of the nature of Adult Safeguarding
- Ensure that the experiences of BELLA are heard regarding her experience of accessing care and support in Cheshire East.
- Prior to January 2024 the Review highlighted a 28-month period where BELLA was demonstrating episodes of risky behaviour, including multiple suicide attempts, in and outside of care settings. She had also made allegations of rape and sexual assault, with an ongoing criminal investigation.
- At the same time, she was experiencing some relationship difficulties with her family due to disputes about religion, and challenges in relationships with specific carers, continuity of Care Coordinators/ Social Worker and consistency of staff from the same Care Agency
- 14 BELLA had multiple admissions between Emergency Departments, Mental Health Units, Acute Medical Wards, and private Mental Health facilities. However, the SAR found that communication was not always robust or undertaken across agencies

15 One care episode showed that BELLA was denied the opportunity of a Mental Health Assessment as she stayed in Police car due to intolerance of closed spaces and people, therefore she was discharged home transported by British Transport Police. Conversely on the last hospital admission prior to the incident in January 2024, BELLA was discharged home following being on section 2, as her presentation was considered to be behavioural rather than a mental health crisis post attempt on life previous day. Previous assessments indicated hospital that environments were not the best place for Bella to be assessed and therefore she was sometimes not admitted to hospital or was discharged earlier than expected.

16 **Briefing - Key Learning**

17 Good Practice and Protective Factors

- Examples of compassionate, flexible, and person-centered care were evident:
- Adapted assessment environments
- Attention to Bella's relationship with her pets
- Persistent carers escalating concerns despite resistance
- Rationale: Good practice exists and must be celebrated to drive cultural and practice improvements.

Recommendation: Strengthen organizational culture through positive learning, reflective practice, and recognition of effective care.

18 Autism-Specific Care and Trauma-Informed Practice

- Bella's autism and trauma history were not consistently considered in care planning.
- Fluctuating capacity was present but often overlooked or poorly documented.
- Interventions often focused on 'behavioural' presentations, missing underlying mental health distress and trauma responses.
- Rationale: The Autism Act 2009, NICE guidance, and neurodiversity research all point to the need for bespoke, strengths-based, sensory-aware responses.

Recommendation: Implement a specialist autism and trauma-informed care framework, training staff across agencies

19 Communication, Risk, and Capacity Assessment Gaps

- Risk and mental capacity assessments were inconsistently applied or recorded.
- Discharge planning lacked clarity and oversight in high-risk situations.
- Example: Discharge following suicidal ideation with no community DoLS, despite intensive supervision needs.
- Rationale: Clear documentation and legal literacy are essential for defensible and person-centred care.

Recommendation: Strengthen internal governance, record-keeping, and assurance around MCA/DOLS processes.

20 Multi-Agency Communication and Discharge Coordination

- Poor coordination and lack of joint discharge planning were evident.
- Multiple agencies involved, yet no single point of oversight.
- Cross-border working introduced further fragmentation.
- Rationale: Consistent MDT involvement and joint risk planning is a national expectation under CQC standards and Care Act duties.

Recommendation: Mandate multi-agency discharge plan assessments for high-risk cases, with shared templates and expectations.

21 Exploitative Relationships and Missed Safeguarding Responses

- Bella disclosed multiple short-term relationships and allegations of sexual assault.
- No clear safeguarding pathway, risk strategy, or exploitation panel response evident.
- Rationale: Legal and statutory duties require exploitation to be proactively recognized, assessed, and managed.

Recommendation: All high-risk safeguarding referrals to include explicit consideration of sexual and criminal exploitation risks.

22 Fluctuating Capacity and Professional Assumption-Checking

 Practitioners at times viewed Bella's risk-taking as 'lifestyle choice' without robust analysis of her capacity at the time.

- Carer and family concerns were often downplayed or dismissed.
- Rationale: The Mental Capacity Act 2005 and case law (e.g., GW v A Local Authority) emphasize the need for nuanced and situational assessments.

Recommendation: Embed professional curiosity and assumption-checking into safeguarding policies, supervision, and audit.

23 Family Inclusion and the Power of Lived Experience

- Bella and her mother described a sense of being unheard and invisible within the system.
- Their reflections were honest and brave and offer critical insights for improvement.
- "The only people who listened were the security guards."
- Rationale: Listening to families is not an optional courtesy—it is a professional and ethical duty.
- **Recommendation:** Include the voice of individuals and families in all decision-making and explicitly record how this has influenced outcomes.

Consultation and Engagement

24 No consultation is required for this Report

Reasons for Recommendations

This Report sets out the learning and recommendations from the Safeguarding Adults Review to ensure that service delivery is improved and to prevent further incidents of harm. The Safeguarding Adults Board will oversee the Action Plan.

Other Options Considered

There are no other options to consider as the Safeguarding Adults
Board has met its Statutory Duty under the Care Act 2024 to undertake
a Safeguarding Adults Review and to share the learning.

Option	Impact	Risk
- - - - - - - - - -		

The Care Act	The impact of this	Without Cheshire
places a Legal Duty	incident resulted in	East Council having
on Local Authorities	BELLA sustaining life	an effective
and partner	changing injuries.	Safeguarding Adults
Agencies to protect		Board, there would
Adults at Risk from	The Safeguarding	be no other means to
Abuse, Neglect and	Adults Board seeks	ensure that Partner
Exploitation.	assurances from	Agencies are
AND	Partner Agencies	working to prevent
The Care Act	about how they	Adult Abuse and to
places a legal duty	protect Adults at Risk	facilitate Statutory
on Local Authorities	from abuse and	Safeguarding Adult
to host a	neglect.	Reviews. The aim of
Safeguarding		a SAR is to promote
Adults Board.		learning and to
		improve service
		delivery.

Implications and Comments

Monitoring Officer/Legal/Governance

- Section 44 of the Care Act 2014 places a duty on Local Adult Safeguarding Boards to arrange Safeguarding Adult Reviews (SARS). SABs must carry out a SAR when an adult with care and support needs has died of suffered serious harm, and it is suspected of known that the cause was neglect or abuse, including self-neglect, and there is concern about how agencies worked together to protect the adults from harm. Under S44(4) of the Care Act 2014 a SAR can be undertaken in any other case concerning an adult with care and support needs.
- The aim of a SAR is not to apportion blame but to share learning that will improve the way agencies work individually and together to minimise the possibility of it happening again.
- The recommendation will ensure compliance with the Care Act and its statutory duties.
 - Section 151 Officer/Finance
- There are no financial implications or changes required to the MTFS as a result of the recommendations in this report. Implementation of learning from this review will be carried out by the service within existing resources.

Human Resources

There are no Human Resource Implications from this Review. However, Staff should be able to access appropriate AUTISM training to help inform and improve knowledge and skill and communication.

Risk Management

There are no Risk Management Implications from this Review.

Impact on other Committees

This report will be presented to the Adults and Health Committee on 22 September 2025.

Policy

- There are no Corporate Policy implications for this SAR.
- The Adult Safeguarding Board will be monitoring the Recommendations indicated in this Safeguarding Adults Review.

36

Commitment 1: Unlocking prosperity for all	Commitment 2: Improving health and wellbeing	Commitment 3: An effective and enabling council

Equality, Diversity and Inclusion

37 BELLA had Autism. One of the key lines of enquiry focussed on how well Agencies respond to Safeguarding concerns for people who are Neuro Diverse. The Safeguarding Adults Board will seek assurance from Partner Agencies about how they are improving access to support, as part of the recommendations from this Review.

38

Other Implications

There are no implications to rural communities in this Review.

Consultation

Name of Consultee	Post held	Date sent	Date returned
Statutory Officer (or deputy) :			
Adele Taylor	S151 Officer	Click or tap to enter a date	Click or tap to enter a date
Roisin Beressi	Principal Lawyer	18/06/25	25/06/25
Legal and Finance			
Nikki Woodhill	Finance Manager	18/06/25	24/06/25
Other Consultees:			
Executive Directors/Directors			
Helen Charlesworth May	Exec Director – Adults Health and Integration	30/04/25	Click or tap to enter a date

Access to Information		
Contact Officer:	ficer: Sandra Murphy – Head of Service - Adult Safeguarding	
	Sandra.murphy@cheshireeast.gov.uk	
Appendices:	Appendix 1 – BELLA – Final Report	
	Appendix 2 – Actions	
Background Papers:	Bella – SAR – Easy Read	
ι αρεισ.	Bella – 7 Minute Briefing	



Cheshire East Safeguarding Adults Board

Cheshire East SAR Bella

Final Report

Frances Millar: Independent Reviewer and Author

Board approval: 30th April 2025

Acknowledgments

First and foremost, I would like to express my heartfelt gratitude to Bella and her mother. Their courage, honesty, and commitment to sharing their experiences ensured that Bella's voice remained central to this review. Their openness has provided vital learning, and their determination to contribute to improving safeguarding practice for others is truly commendable. This report would not have the same depth or meaning without their invaluable contribution.

I would also like to thank the Business Manager and Business Officer of the Board for their coordination, administrative support, and professional assistance throughout the review process.

My thanks also go to the SAR Panel members for their time, expertise, and constructive feedback, which helped ensure the review was thorough, balanced, and focused on learning.

Finally, I would like to offer special thanks to Alan Critchley whose professional mentoring, reflective guidance, and critical challenge provided invaluable support.

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01. Who is Bella?

Bella is a softly spoken creative and determined young woman of 26 years old who finds joy and meaning in her hobbies and pursuits. She has a deep passion for her animals, which provide her with a sense of freedom, connection, and comfort. Her love for craft work, such as diamond painting art, highlights her patience and creativity, while her journey into learning the guitar and singing demonstrates her resilience and drive to explore new forms of expression and purpose.

Bella also has a strong affinity for climbing, which not only reflects her adventurous spirit but also proactively supports her emotional regulation. Climbing provides a positive outlet for her liking for heights, particularly during times of anxiety, allowing her to channel her feelings into an activity that promotes a sense of accomplishment and calm. Through these varied and meaningful pursuits, Bella channels her energy into positive, fulfilling outlets, even as she navigates significant challenges with determination.

Bella has been open to being in employment. She has undertaken roles of a kitchen porter and a care agency within the timeline of this review.

Diagnosed with autism in 2017, Bella also lives with the effects of a traumatic brain injury and non-epileptic seizures (NEAD). These conditions, combined with high levels of anxiety and occasional episodes of paranoia, have brought challenging moments into her life. Despite these hurdles, Bella continues to display a remarkable strength of character. She is supported by a caring team and her family, who provide stability and encouragement as she works to overcome her difficulties.

Bella's connection to her creative and recreational activities, along with her love for her pets and close relationships, reflect her resilience and ability to find comfort and joy in the world around her. Her story is one of perseverance, warmth, and a determination to thrive, even in the face of adversity.

02. Introduction

- 2.1 This Safeguarding Adults Review (SAR) was initiated under Section 44 of the Care Act 2014¹ following a series of incidents involving Bella, who meets the definition of an adult at risk under the Care Act 2014. The purpose of this review is to identify lessons for multi-agency working to enhance future safeguarding practice. Bella's complex case involved incidents of self-harm, mental health crisis, and cross-border care provision.
- 2.2 Bella's complex case included incidents of self-harm, mental health crisis, and challenges associated with cross-border care provision. It was evident that Bella had care, and support needs as defined by the Care Act, which requires an assessment of such needs. These needs arise from, or are linked to, physical or mental impairments / illnesses, in addition to sensory, learning, or cognitive disabilities or illnesses, substance misuse, brain injury².
- 2.3 Recent Incidents resulting to significant physical harm

26th January 2024

- **1820 hours:** Ambulance service reported a call from Bella stating suicidal intent and her presence on the train tracks. British Transport Police (BTP) officers were dispatched.
- While en route: A train driver spotted Bella on the tracks, stopped the train, and brought her to next main station.
- At main trainline station: Bella engaged with officers but was timid and nervous, holding a teddy bear named Chester. She confirmed suicidal intentions and agreed to attend Hospital voluntarily.
- Hospital interaction: Due to sensory sensitivities, Bella waited in the police vehicle
 until a room became available. A senior mental health practitioner assessed Bella and
 concluded this was a behavioural issue rather than a mental health crisis. Bella's
 support worker, agreed to supervise Bella at home.
- Outcome: Bella was escorted to her home address by the Police and under the supervision of her support worker.

27th January 2024

- **1016 hours:** A train driver reported seeing Bella near the train station. Bella walked onto the track and was struck by the train despite emergency braking.
- **Response:** Paramedics stabilised Bella at the scene before transferring her to Salford Royal Hospital with life-threatening injuries, including leg, pelvis, chest, and head trauma. Bella's father was informed and accompanied her to the hospital.

¹ Sections 44(1)-(3), Care Act 2014

² Care and Support (Eligibility Criteria) Regulations 2014.

Critical Learning: Professional Curiosity

These critical incidents highlighted opportunities to strengthen risk management, autism-informed care, discharge planning, and multi-agency communication — both in terms of information sharing and coordinated response to enable practitioners with decision making. Bella's discharge from hospital occurred within the context of significant complexity, including her autism, fluctuating capacity, and complex trauma history. This reinforces the importance of exercising caution when attributing distress to 'behavioural issues' and highlights the value of embedding professional curiosity and reflective practice when supporting individuals with such complex presentations.

03. Scope of the Review

3.1 Purpose

The purpose of a Safeguarding Adults Review (SAR) involving Bella is not to re-investigate the circumstances, assign blame, carry out employment resources functions, or determine the cause of serious harm. Instead, its focus is on learning and improving practices to ensure better outcomes for adults at risk in the future. The key aims are:

- To have focus on Bella with emphasis person-centred care and understanding Bella and her families experiences, needs, and perspective.
- Framing the issue ensuring that balancing systemic learning with compassionate care while acknowledging the uniqueness of Bella.
- To reflect on the circumstances of Bella's case and identify opportunities for learning about how local, regional professionals and agencies work together to safeguard adults.
- To evaluate the effectiveness of procedures, both across agencies and within individual organisations, and explore areas for enhancement.
- Highlight strengths and areas for improvement within the collaborative interagency and multiagency practice.
- To apply the lessons learned to strengthen safeguarding practices and develop best practices across the whole system.
- To provide a report that draws together and analyse the findings from agencies, providing constructive recommendations for future action.

3.2 Appreciative Inquiry Approach

Reflective and appreciative approaches allow for a more balanced analysis of safeguarding cases by acknowledging good practices while critically examining areas for improvement. This adopts learning and professional development without disproportionately attributing blame³. This review adopts a reflective and appreciative approach, seeking to understand the factors that influenced the actions of agencies and professionals and exploring what supported or, at

³ Cooperrider, D.L. and Srivastva, S. (1987). *Appreciative Inquiry in Organizational Life*. Research in Organizational Change and Development, 1, pp.129–169.

times, hindered their ability to safeguard Bella effectively. It recognises and values the dedication and compassion demonstrated by those involved in Bella's care. Examples of good practice include social workers and personal advisers who made her needs their priority, as well as community police officers who identified Bella as an adult with care and support needs in a high-risk situation and worked proactively with other agencies to address concerns about her safety and care placement. By building on the strengths evident in this case and addressing identified challenges, this SAR aims to contribute positively to the ongoing improvement of safeguarding practices for adults at risk. Highlighting and learning from examples of good practice, such as proactive collaboration among agencies or professionals prioritising individual needs, aligns with findings from SARs and safeguarding reviews. This approach helps improve future safeguarding practices⁴.

3.3 Timelines

The SAR covers the period from January 2023 up to the incident on the 27th January 2024, focusing on the events leading to the incidents and subsequent care provided to Bella. Additional context may be reviewed where necessary, including prior safeguarding referrals and agency interactions. The SAR aims to explore the gaps in decision-making and multiagency communication.

04. Safeguarding Adults Board SAR Referral

Cheshire East Safeguarding Adults Board (CESAB) has a statutory duty⁵ to arrange a Safeguarding Adults Review (SAR) where:

- [Amended to reflect this case] In line with the Care Act 2014, a Safeguarding Adults Review (SAR) is required when an adult with care and support needs has experienced serious abuse or neglect, and there is reasonable cause for concern about how agencies worked together to safeguard the adult. In this case, the SAR focuses on understanding the circumstances that led to Bella experiencing serious harm, with the aim of identifying learning to strengthen future safeguarding practice, and
- There is reasonable cause for concern about how the Board, its members, or others worked together to safeguard the adult.
- **4.1** A Safeguarding Adults Board (SAB), in this instance CESAB, has the authority to commission reviews in circumstances where there is potential learning to be derived from how agencies worked together, even if it is inconclusive as to whether, in Bella's case significant harm was the result of abuse or neglect. Abuse and neglect also include self-neglect⁶.
- **4.2** Board members are invited to actively participate in and support the review process, with a focus on uncovering valuable insights and opportunities to enhance future safeguarding practices. The Safeguarding Adults Review (SAR) is not about apportioning any blame nor

⁴ Local Government Association (2024). Second National Analysis of Safeguarding Adult Reviews: April 2019 – March 2023. Available at: https://www.local.gov.uk.

⁵ Part 1 – Care Act 2014

⁶ Care Act 2014, Section 42 and Statutory Guidance Chapter 14)

responsibility but about promoting a culture of learning and collaboration. Its aim is to identify areas of strength, good practice that can be shared and / or improvement in how agencies, both individually and collectively, safeguard and support adults with care and support needs who are at risk of abuse, neglect, including self-neglect, and who may be unable to protect themselves.

4.3. On 7th February 2024, British Transport Police (BTP) submitted a referral for consideration of a Safeguarding Adults Review (SAR) regarding Bella, highlighting a series of incidents reflecting her distress and risky behaviours aimed at self-harm and with suicidal ideation. One such incident occurred on the evening of Friday, 26th January 2024. At 18:20, the ambulance service informed BTP that a woman was on the phone, reporting that she was on the train tracks and feeling suicidal. While officers were enroute, a train driver spotted a woman (who we know to be Bella and will be referred to as such instead of woman from the referral) on the tracks and managed to stop the train. Bella then boarded the train, and the driver transported her to Stockport station, the closest safe location. BTP officers met Bella at the station and ensured she was taken to a place of safety. Despite appearing extremely timid and nervous, clinging to her teddy bear, "Chester," Bella engaged with the officers and expressed her willingness to attend the hospital voluntarily where she was seen and assessed by mental health professionals and subsequently discharged.

The following morning, on 27th January 2024, at 10:16, a Northern Trains driver operating a service from Crewe to Manchester Piccadilly reported seeing Bella near the train station. As the train approached, Bella stepped onto the tracks and placed herself in the train's path. Despite the driver applying the emergency brakes, the train struck Bella. Emergency services, including officers and paramedics, responded promptly. Bella, was found unconscious but breathing and was transported to Hospital with life-threatening injuries, including trauma to her legs, pelvis, chest, and head.

4.4. CESAB's Practice Review Group discussed the case on 18th March 2024. It was recorded that the group agreed the case did meet the criteria for a SAR, as it appeared Bella's life changing injuries from the significant events occurred highlighted the need for reflection and learning to better understand the challenges and opportunities for multi-agency working in supporting and safeguarding individuals in distress, like Bella. Through this review, the focus is on identifying ways to strengthen support systems and ensure effective, compassionate responses in future cases.

05. Their Voice, Our Learning

Meeting with Bella and her mother face-to-face in their home provided invaluable insight into their lived experience through exceptionally challenging times. This personal interaction was not only a privilege, but a profound reminder of why listening to individuals and their families is central to good safeguarding practice — not as a procedural step, but as a fundamental act of respect, humanity, and effective care.

During our conversation, Bella's mother shared warm memories of family holidays in Caernarfon, North Wales, while Bella talked fondly about her love of climbing and horse riding. These personal recollections gave context to Bella's identity beyond her care needs, placing her firmly as a young woman with a life rich in relationships, interests, and potential — a

perspective too often lost within systems focused solely on risk management and service thresholds.

When the conversation turned to the purpose of the SAR, both Bella and her mother spoke with raw honesty about their sense of frustration, fear, and helplessness during Bella's contact with services. Bella described feeling unheard and invisible, her distress dismissed as 'behavioural' rather than being recognised as the very real manifestation of her deteriorating mental health.

Bella said:

- "I didn't wake up wanting to feel how I did."
- "I didn't want to feel like killing myself."
- "I was scared."

Her mother reflected on her own desperate attempts to advocate for Bella and the repeated barriers she faced when trying to have her concerns taken seriously:

- "I was desperate."
- "I tried to call and call, but they didn't reply."
- "When I got through, I was dismissed they were rude."

Together, they described a cycle of missed opportunities — moments when professionals could have paused, listened, and reconsidered their assumptions. Instead, decisions were made that Bella and her mother believe directly contributed to the near-catastrophic incident that followed. Bella also reflected on who, in her view, actually listened to her:

"The only people who really listened to me in hospital were the security guards."

Bella and her mother's motivation for contributing to this review was clear: they want to ensure that "**no other family**" is left feeling as invisible, dismissed, and helpless as they did. They spoke not just out of frustration, but with hope — hope that by sharing their experience, professionals will understand the human impact of their decisions and take steps to prevent the same mistakes being repeated.

Since the incident, Bella has not only made significant physical progress in her recovery, but has also received what she describes as more holistic and person-centred care ["It feels like they get me now"], particularly in relation to her mental health. Bella spoke positively about the support now in place and clearly expressed that she no longer experiences any negative or intrusive thoughts. Bella also told us she is doing well physically, and this combination of appropriate support and recovery has left her feeling safer, more in control, and hopeful for her future.

Since the incident, Bella feels safer and more settled in her current environment, surrounded by her much-loved pets — two dogs and two cats — and with the freedom to pursue her creative interests. During the visit, the care agency staff demonstrated a thoughtful, personcentred approach, respecting Bella's autonomy while ensuring her practical needs were met. When the staff quietly took the dogs for a walk to allow us space to talk, Bella's instinctive check — "Did you make sure the dogs are okay?" — was a gentle but telling reminder that feeling safe, cared for, and listened to matters at every level, from the small everyday acts to the biggest life-changing decisions.

This meeting was not just an opportunity to gather information. It was a stark and necessary reminder that listening — truly listening — to individuals and their families is not an optional courtesy, but an essential professional duty. Bella and her mother have gifted this review their truth, their pain, and their hope. Their voices must not only be heard within this report, but must resonate in practice, policy, and culture change going forward.

- Listening is not a courtesy it is a safeguard.
- 💄 Challenging assumptions essential safeguards in practice

Bella and her mother's experiences highlight a fundamental safeguarding lesson: When individuals and families raise concerns about distress, risk, or unmet needs, listening carefully and with curiosity is essential — not only to understand what is happening, but to prevent avoidable harm.

06. Methodology

This Safeguarding Adults Review (SAR) has been undertaken using a hybrid methodology, carefully chosen to suit the specific complexities of Bella's case. The process will include an analysis of Agency Reviews, with an emphasis on critical reflection, a chronological analysis of events, and a Learning and Reflection Workshop for practitioners. This personalised approach ensures that all relevant information is captured from the professionals directly involved in Bella's care while creating space for collaborative reflection and development.

By incorporating these elements, the SAR process not only aims to provide answers and understanding for Bella's family and those close to her, but also seeks to identify systemic barriers and enablers that affect best practice. As highlighted in the Preston-Shoot et al. (2020) National SAR Analysis, it is vital to adopt a whole-system understanding when conducting reviews of this nature. The findings from that analysis demonstrates how factors that enable or obstruct good practice often reside within interconnected domains of the system. This means the focus must extend beyond individual actions to consider how organisational structures, policies, and inter-agency collaboration either align to support best practice or, in some cases, create misalignments that weaken it.

In this case, Bella is placed at the heart of the SAR process. The aim is not only to understand the circumstances leading up to and following key incidents but also to explore how the systems designed to support her have interacted and, at times, failed to do so effectively. This includes the involvement of nine NHS organisations, two police forces, two independent/private providers, and adult social care, alongside primary care services such as the GP and crisis line. Each of these agencies has played a role in Bella's life, and the SAR will explore how well their efforts have been coordinated and aligned with Bella's needs.

The Learning and Reflection Workshop is a critical part of this methodology. It provides an opportunity for frontline professionals to reflect on their involvement in Bella's care, share their experiences, and critically examine their practices. This reflective process, combined with the evidence-based insights from research such as Preston-Shoot et al.'s (2020) national analysis, offers a powerful platform for identifying lessons learned. It also creates a space to

highlight examples of good practice while addressing systemic barriers that may have hindered optimal outcomes.

Additionally, a virtual workshop will be held to review the first draft of the SAR overview report. This collaborative review phase allows stakeholders to refine findings, ensuring that the final report reflects a comprehensive and balanced understanding of the case.

Central to the SAR process is the recognition of Bella's individuality, including her family relationships, personal needs, and the protective factors in her life, such as her strong bond with her pets. The whole-system approach ensures that her experiences are not viewed in isolation but as part of a broader context where different domains of the system—such as policy frameworks, organisational culture, and inter-agency communication—interact and impact her care.

The SAR process will ultimately focus on identifying the facilitators and barriers ⁷to good practice, with the aim of making recommendations for improvement across the partnership. By placing Bella at the centre and drawing on the insights from evidence-based research, this review seeks to provide not only understanding and remedial action but also a roadmap for systemic improvement to better support individuals in similar circumstances.

07. Key Themes and Lines of Enquiry

7.1 Each line of enquiry will adopt a person-centred and whole-system perspective, ensuring that Bella's unique circumstances and experiences are at the forefront. The themes will focus on identifying both the barriers and facilitators to effective practice, drawing on evidence-based insights and reflecting on the interaction between policies, practices, and professional behaviours. This approach aims to provide a comprehensive understanding of what worked, what did not work, and how future practice can be improved to support individuals like Bella.

Based on information provided by the agencies these include:

Transitions of Care

- Examination of Bella's discharge processes from hospital admissions, to include Emergency Department and Hospital Admissions and stepping down from a Section 2 under the Mental Health Act
- Exploration whether appropriate planning, risk assessment, and support mechanisms were in place to ensure a safe and effective transition.
- Special attention will be given to how the transition process balanced Bella's autonomy, her fluctuating capacity, and the need for ongoing support, including how any identified risks were communicated across agencies.

⁷ 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

Multi-Agency Communication and Coordination

- An analysis of information-sharing practices and decision-making processes across
 the numerous agencies involved in Bella's care, with particular emphasis on the
 challenges posed by regional boundaries and differing organisational systems.
- This theme will consider whether effective communication protocols were in place, how well agencies collaborated to provide a cohesive response, and whether any systemic gaps hindered the coordination of care.
- Drawing on the Preston-Shoot et al. (2020) National SAR Analysis, the review will adopt a whole-system lens to evaluate how misalignments between agencies may have obstructed good practice.

Mental Health and Autism Care

- This line of enquiry explored how well Bella's autism, mental health needs, and fluctuating capacity were understood, assessed, and responded to across agencies, particularly in high-pressure settings such as A&E and during crisis events.
- Chronology informs inconsistent application and understanding of legal frameworks, including the Deprivation of Liberty Safeguards (DoLS) process.
- Within her care setting, the review also identified the use of restrictive practices, such as 1:1 and 2:1 supervision, and restrictions on movement and personal items, without clear evidence that these were formally authorised under Community DoLS or escalated to the Court of Protection where required.
- This raises questions about the system-wide understanding of when to apply formal legal frameworks, particularly where individuals experience fluctuating capacity and high-risk presentations. In such cases, the review will consider whether the importance of seeking timely legal advice, including consideration of inherent jurisdiction, to ensure that restrictive interventions were appropriately authorised and the individual's rights are safeguarded.
- Consideration that the learning reflects a wider opportunity for strengthening legal
 literacy across agencies, ensuring that practitioners not only recognise when legal
 processes should be triggered, but also understand the importance of embedding
 legal safeguards into person-centred care planning, particularly for autistic adults with
 complex needs.

Safeguarding Practices and Risk Management

Risk Identification and Response

- Agencies' responses to Bella's risks of self-harm, absconding, and other behaviours will be evaluated under Section 42 of the Care Act 2014, which mandates safeguarding enquiries for adults at risk.
- The review will consider compliance with the Care and Support Statutory Guidance (DHSC, 2023), ensuring a person-centred and outcomes-focused approach.
- Safeguarding Procedures and Protective Factors

 The review will assess the application of safeguarding principles from the Care Act 2014, such as empowerment, prevention, and partnership, while examining whether Bella's protective factors, such as her relationship with her pets, were incorporated into her safeguarding plan.

Fluctuating Capacity and Decision-Making

 The review will assess whether Bella's fluctuating capacity were assessed under the Mental Capacity Act 2005 (MCA), with focus on adherence to its five key principles and the Code of Practice, particularly in balancing her autonomy with safeguarding measures.

Professional Responses to Distress

Responses to Bella's distress and self-harm will be reviewed with reference to:

- NHS England's 'Positive and Proactive Care' (2014) on reducing restrictive interventions.
- The Suicide Prevention Strategy for England (2012) for multi-agency approaches to suicide risk.
- NICE Guidelines NG116: Self-Harm (2011), promoting trauma-informed, empathetic care.

Crisis Planning and Multi-Agency Follow-Up

The review will evaluate crisis planning and follow-up care to capture coordinated and timely multi-agency responses.

08. Parallel Investigations

Parallel investigations are currently underway, including an inquiry led by the Care Quality Commission (CQC) and a separate ongoing Police investigation relating to allegations of sexual assault. Both processes have been carefully considered to ensure that efforts are not duplicated, and that each investigation remains focused on its specific remit. The CQC inquiry aims to assess the standards of care provided, identify any regulatory breaches, and recommend improvements, while the Police investigation seeks to establish whether any criminal offenses have occurred. Clear communication channels have been established with the Police who have been very supportive in this process, to facilitate information-sharing where appropriate, ensuring that both investigations are thorough and complementary, rather than overlapping or conflicting. This collaborative approach again demonstrates the importance of interagency cooperation in addressing complex cases effectively.

09. Professionals Involvements

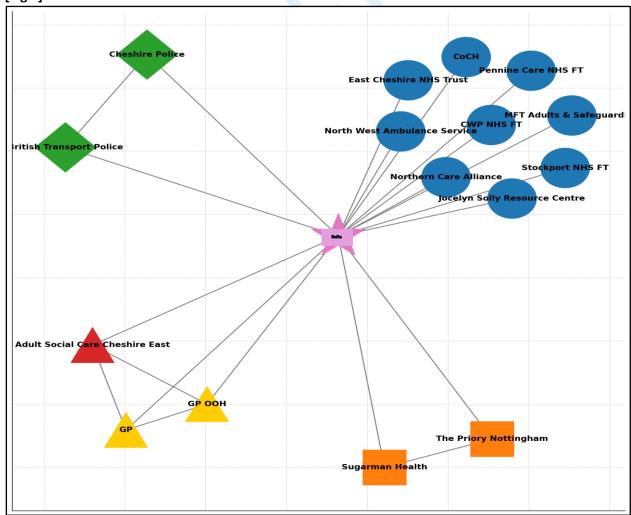
9.1 Involved agencies

The diagram below (Fig. 1) provides a visual representation of the numerous agencies involved in Bella's life, highlighting the extensive network of support and services that play a role in her care. However, this also emphasises the significant challenges of effective communication and information-sharing across such a complex, multi-agency framework. It is important to recognise that the difficulty in coordinating efforts between organisations can exacerbate the challenges of managing complex cases such as Bella's, where consistent, person-centred care is essential.

The agencies involved include nine NHS organisations, two police forces, two independent or private sector providers. Additionally, Bella's primary care contact has been grouped to encompass adult social care her GP, out-of-hours GP services, and the crisis line. Each of these stakeholders has a unique role in Bella's care, but the lack of seamless communication between them often results in fragmented support, duplication of effort, or, at worst, critical gaps in care.

Central to this discussion is the necessity of placing Bella herself at the heart of all these interactions. This means not only considering her as an individual but also recognising the importance of her immediate support network, which includes her mother, family, and cherished pets. These elements are integral to her sense of stability and wellbeing and should be acknowledged in every decision and plan of action.





9.2 A solution to improve coordination and information-sharing across these agencies is urgently needed to ensure that Bella's care is truly holistic and cohesive. This might involve creating a unified framework for communication, a shared digital platform for real-time updates, or a designated lead professional to oversee her case. Such measures would prioritise Bella's needs while reducing the strain on the various services involved. By embedding a person-centred and collaborative approach, agencies can better address the complexities of her circumstances and work together to provide more effective and compassionate care

9.3 Professionals' Description of Bella

- **9.3.1** Professionals who have worked with Bella describe her as an articulate and self-assured individual when she is not experiencing a difficult mental health crisis. She has a strong sense of independence and knows her own mind, often making decisions with clarity and conviction. Bella is softly spoken and, at times, finds it more comfortable to communicate through text rather than verbal conversations, which helps her express herself more effectively.
- **9.3.2** One of the most significant aspects of Bella's life is her deep bond with her two Labradors. These dogs are not just companions but also serve as a key protective factor in her emotional wellbeing. Professionals consistently note how her interactions with her dogs bring her comfort and stability during challenging times.
- **9.3.3** The importance of her dogs in her life has also been a source of difficulty in the past. There have been historical disputes with neighbours regarding the dogs, which have acted as a trigger for Bella, highlighting just how central they are to her sense of security and happiness. This connection emphasises the need for those supporting Bella to consider the role of her pets when planning her care and interventions.
- **9.3.4** Overall, professionals see Bella as someone who is deeply connected to the things she values most, with her dogs being a cornerstone of her emotional support system. By recognising and respecting these protective factors, those around her can better support her journey towards stability and wellbeing.

10. Synopsis of events pertinent to the review

10.1 It can be identified from the Timeline of Risky Behaviour in Figure 2 there were five key episodes. However, the review focusses on the last two episodes but does include references to other triggers within Section 10.4 of the report.

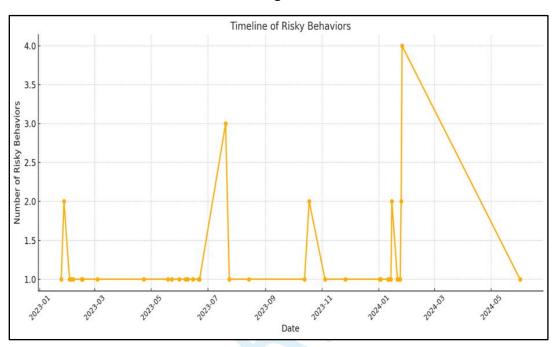


Fig 2.

10.2 Key Incidents

10.2.1 On 26 January 2024, Bella we know is a young woman with autism, epilepsy, and a history of self-harm, contacted emergency services while standing on the railway tracks, expressing suicidal intent. British Transport Police (BTP) and paramedics intervened, and she was transported to Stepping Hill Hospital. The Senior Mental Health Practitioner assessed her as having "behavioural issue" and arranged for her to return home under the supervision of a support worker provided by her Care Agency.

10.2.2 The following day, 27 January 2024, Bella deliberately walked onto the railway tracks, where she was struck by a train. This resulted in critical injuries requiring multiple surgeries. CCTV footage confirmed her actions were intentional. These incidents raised significant concerns regarding the safeguarding measures, or lack thereof, implemented in the 24 hours between the two events.

10.3 Historical Context

Bella has a complex history marked by repeated episodes of emotional dysregulation, suicidal ideation, and risky behaviours. Her autism and epilepsy compound her mental health challenges, which have led to repeated attendances at A&E, referrals to mental health

services, and placements in various care settings. Despite these interventions, Bella has often absconded, placing herself in high-risk situations, such as being found in a cave in the Peak District during a previous episode of crisis.

Her impulsivity and masking behaviours often make it difficult for professionals to accurately assess the severity of her distress. For example, staff have observed her presenting as calm and engaging following incidents of self-harm, despite expressing thoughts of ending her life earlier.

Bella has a complex history of mental health challenges, including repeated attendances at A&E, some of which resulted in mental health liaison referrals. She has expressed suicidal thoughts and, on several occasions, made serious attempts to end her life.

The team at her accommodation continues to provide steady support, ensuring that Bella has the stability she needs to navigate her challenges. Although her circumstances are complex, Bella's story highlights her strength, creativity, and the importance of compassionate, personcentered care.

10.4 Recent Social and Emotional Stressors

In the months preceding the incidents, Bella faced several significant stressors that compounded her vulnerabilities. She experienced uncertainty about her job, which was a source of anxiety, and she made the difficult decision to leave her faith community, leading to estrangement from her family and a significant loss of social support. The emotional impact of this decision was not adequately followed up, despite its significant influence on her wellbeing. This event is likely to have caused emotional strain and impacted her sense of belonging. These stressors likely contributed to her heightened vulnerability and risky behaviours during this period.

Bella disclosed engaging in multiple short-term relationships with men, raising concerns about her risks of being exploited. Despite discussions about her capacity to consent to relationships, no comprehensive safeguarding plan was developed to address these risks.

Her difficulties with emotional regulation and non-compliance with prescribed medications have exacerbated her mental health struggles. These factors, combined with impulsive tendencies and self-injurious behaviours, have created an ongoing pattern of crisis that require careful, person-centred management.

10.5 Support System and Protective Factors

Despite her challenges, Bella has protective factors that provide a foundation for resilience:

- A dedicated care team provides consistent and flexible support. For example, after high-risk behaviours, her carers ensured her pets were cared for, fed, and walked, maintaining an element of stability in her life.
- Bella's connection to her family, although was strained at times, remained and still remains a source of strength. Her mother provides valuable insights into her behaviours.

• Her love for animals and creative hobbies, such as diamond creative art and learning the guitar, serve as positive outlets for her emotions.

These strengths, combined with a stable and attentive support system, offer a foundation for hope and progress.

10.6 - Missed Opportunities

Safeguarding Referrals and Section 42 Enquiries

Critical safeguarding referrals were not consistently submitted or followed up. For example, following her prolonged hospitalisation for suicidal ideation and absconding attempts, no safeguarding referral was recorded, despite clear evidence of risk.

Mental Capacity Assessments (MCA) and DoLS

There were multiple references to MCAs and DoLS submissions, yet records indicate conflicting practices. On several occasions, Bella was discharged after being deemed to lack capacity without safety plans in place. Conversely, she was detained without clear documentation supporting the legality of these decisions.

When 1:1 or 2:1 supervision was implemented at home, no consistent Community DoL was considered to ensure her rights and safety.

Discharge Planning

Discharge meetings, while held, often lacked actionable safety plans. For example, after a high-risk admission, it was agreed that Bella would return home on a 1:1 plan, with her photo provided to police in case she absconded. Within 24 hours, she attempted to abscond again, highlighting the inadequacy of the plan.

Trauma-Informed Care

Despite Bella's disclosure of sexual assault and ongoing police investigations, her care plans lacked any reference to trauma-informed support. Additionally, her emotional response to leaving her faith community was not addressed, despite its significant impact on her mental health.

Carer Escalations

Carers frequently escalated concerns, expressing their inability to manage Bella's behaviours, such as absconding or self-injury. These concerns were at times dismissed, leaving Bella and her carers unsupported.

Critical Learning:

- **Les Escalation** from face-to-face carers must be treated as vital safeguarding intelligence.
- Safeguarding processes (including referrals and Section 42 enquiries) must be consistently triggered following high-risk incidents, even where the individual is known to multiple services.
- Legal frameworks (MCA, DoLS, Community DoLS, and potential inherent jurisdiction applications) must be applied consistently and with clear documentation, particularly where restrictive practices are in place.
- Life events and social stressors must be actively considered and followed up in care and risk planning, particularly for individuals with known vulnerabilities.
- **Contextual safeguarding** approaches should be embedded to address risks linked to exploitation, relationships, and situational vulnerability.
- **Trauma-informed care** must emphasise care planning, with clear recognition of how past experiences and identity shape risk, presentation, and support needs.

11. Practitioner Engagement

11.1 The reviewer would like to thank the practitioners who have or had direct involvement with Bella for their honest reflections at the practitioner event held on the 27th November 2024. The focus of the event was to gain an understanding of why workers responded in the way they did. By using this method, the risk of hindsight bias was reduced and enabled the reviewer to see the situation from the worker's perspective and any wider issues presented.

11.2 Participants at the event were from:

- Cheshire East Adult Social Care
- Sherbourn Health
- Pennine Trust
- Northern Care Alliance
- Cheshire Police
- British Transport Police
- General Practice
- Cheshire East Safeguarding Team
- Priory Hospital Nottingham

11.3 There was a key focus for the event utilising pause and reflect exercises in breakout rooms to discuss and feedback questions as follows:

What Standards of Care would you expect?

- What are your thoughts on Bella's Experience?
- What are your thoughts of Mum's Experience?
- What good practice did you identify?
- What learning have you observed?
- Any barriers observed to prevent effective practice?
- Key learning points?

This was replicated across different episodes of care with a very rich, meaningful and productive feedback from the groups with emerging themes as follows

11.4 Emerging Themes from the Practitioner Event:

11.4.1 Professional Curiosity and Challenge

The need for practitioners to maintain professional curiosity and engage in constructive challenge within and between agencies to better understand and address complex cases. Key points highlighted were the unpicking individual agency learning to discuss and challenge collectively in parallel to balancing legal frameworks with observations and unique assessments for individuals. Good Practice Example was the persistence of escalation despite unavailability of a local acute mental health bed.

11.4.2 Interagency Collaboration and Information Sharing

Multi-agency collaboration is crucial but often hindered by system and communication barriers. Agencies need to work cohesively to avoid fragmentation for example information-sharing between NHS Trusts and partner agencies remains inconsistent, leading to gaps in care coordination. Evidence of supporting **Good Practice Example** is how Pennine Trust shared self-soothing strategies with A&E staff and adapted care environments to reduce Bella's distress.

11.4.3 Autism-Specific Care and Individualised Support

A better understanding of autism and personalised care planning is essential for improving outcomes. Autism is not adequately addressed within the frameworks of the Mental Health Act, creating systemic issues. Bella's risky behaviours were perceived by some as often self-soothing mechanisms and not suicide attempts, highlighting the need for reframing practitioner language. **Good Practice Example** is when Bella was encouraged to engage in climbing activities, a less risky alternative to her self-soothing behaviours, showed a personcentered approach.

11.4.4 Communication and Capacity Considerations

Fluctuating capacity and communication challenges necessitate a nuanced approach to decision-making and risk management. In Bella's case, her capacity varied, yet the chronologies provided by agencies for the review indicate that it was assessed as intact 95% of the time. Also, some practitioners felt that Bella's changeable communication style sometimes made it difficult to gauge her true intentions – there was no reference to how this could be or was resolved. A **Good Practice Example** is when care staff documented Bella's daily activities thoroughly and adjusted support based on her changing needs and preferences

11.4.5 Family Dynamics and Inclusion

It was acknowledged that there are times to when managing family involvement is complex, particularly when there are disagreements between the individual and their family members. There was an understanding from some agencies that at one point Bella had become estranged from her mother which posed challenges in including her in care planning. **Good Practice Example** was that social workers balanced respecting Bella's decisions while maintaining communication with her mother where appropriate.

11.4.6 Risk Management and Safeguarding Procedures

Risk management frameworks need to be flexible and person-centered to ensure safety while respecting individual autonomy. Bella often fled situations she found uncomfortable, emphasising the need for bespoke safety planning. There was a peak in risky behaviours every 2–3 months which may suggest patterns that could inform proactive interventions. **Good Practice Example** from Care Agency effectively tailored support on a day-to-day basis, stepping up or down care as needed demonstrating the Making Safeguarding Personal and listening to the voice choice and control of Bella.

11.4.7. Good Practice and Compassionate Care

There were multiple examples shared of compassionate, person-centered care should be highlighted to strengthen future practice. Staff demonstrated kindness and creativity in adapting care environments, such as conducting assessments in cars or providing colouring materials to help Bella during time of anxiety. Staff also recognised and helped with caring of Bella's dog and cats and saw them as a protective factor, therefore ensuring the animals well-being became part of Bella's care plan.

11.4.8. Systemic Barriers and Recommendations

There was a general consensus that there are systemic challenges, such as resource constraints and fragmented systems, limit the effectiveness of care and interagency collaboration, these include lack of interoperability between health systems creates duplication and inefficiencies in addition hierarchical decision-making can undervalue the insights of frontline care staff. Practitioners agreed and shared that developing a joint care plans and patient/ person passports would help to improve consistency and reduce the burden on families who have to repeatedly share their stories.

12. Key Messages from the event

- It was recognised that risk factors may be known however many people with multiple risk factors will not go on to attempt suicide, or significant injury.
- > By building on examples of good practice and addressing identified barriers, future care can be more effective, compassionate, and tailored to individual needs.

The reviewer shared the finding of The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) NCISH | The University of Manchester pertinent to this case to include:

- High Suicide Rates Among Autistic Individuals: Autistic people, particularly those without accompanying intellectual disabilities, face a significantly increased risk of suicide.
- ii. **Challenges in Risk Assessment**: Standard risk assessment tools often fail to accurately predict suicide risk in autistic individuals, necessitating more personalized and nuanced approaches.
- iii. **Importance of Tailored Interventions**: Implementing autism-specific care frameworks and interventions is crucial to effectively address the unique needs of autistic individuals within mental health services.
- iv. **Need for Enhanced Training:** There is a pressing need for mental health professionals to receive specialised training to better understand and support autistic individuals, particularly in crisis situation

Practitioners were transparent that they were not aware of this research nor the 10 elements of safer care but acknowledged it will be good learning and therefore this to be embedded into the recommendations.

13. Analysis of Practice and Findings (with Theoretical Foundations)

SUMMARY

TABLE 1

Ref	Subject	Initial Findings
ı	Autism-specific care and complex needs	 Bella's needs as an autistic individual with complex mental health challenges were insufficiently considered in crisis planning. Agencies must ensure that the intersection of autism and mental health risks is holistically addressed in care planning.
II	Documentation gaps	Critical decisions, including the rationale for Bella's episodes of crisis and hospital discharges, were not adequately recorded, leading to gaps in continuity of care and accountability.
III	Agency collaboration and coordination	 Poor coordination across multi-agency services hindered effective safeguarding. The lack of robust communication protocols contributed to inconsistent understanding of risks and responsibilities among stakeholders

IV	Cross-border challenges	 Managing Bella's care across different regions delayed communication and created uncertainty in decision-making reflecting the need for clearer protocols in cross-border cases.
V	Behavioural vs. Mental health needs	 Practitioners approach to behavioural manifestations as potential indicators of mental health crisis, ensuring appropriate intervention.
VI	Risk-informed discharge	Comprehensive joint risk assessments should have guided discharge decisions, particularly in high-risk cases to ensure safety and continuity of care.

13.1 Overview

The review of findings highlights systemic challenges, areas for improvement, and examples of good practice in supporting individuals with autism and complex mental health needs. These insights are strengthened by integrating theoretical frameworks, research evidence, and key legislative and statutory guidance relevant to the UK context.

13.2 Systemic Challenges in Autism-Specific Care

Autism-specific needs are often inadequately addressed within health and social care systems, exposing significant gaps in service provision. The neurodiversity paradigm (Singer, 1998; Armstrong, 2010) highlights the importance of recognising autism as a natural variation in functioning, necessitating tailored and strengths-based interventions. This perspective aligns with the statutory duty under the Equality Act 2010, which mandates reasonable adjustments for individuals with disabilities, including autism, in all service settings.

The Autism Act 2009, the first disability-specific legislation in England, and the accompanying Statutory Guidance for Local Authorities and NHS Organisations (2015), require the provision of autism-specific training for professionals and the development of local autism strategies. However, gaps in care planning, such as those seen in Bella's case, highlight the need for systemic reform to bridge these gaps effectively.

The double empathy problem (Milton, 2012) identified the need for professional training in autism-specific communication, as miscommunication between autistic and neurotypical individuals often results in unmet needs. Despite guidance from NICE (2012, updated 2021) emphasising person-centred, autism-informed care, Bella's experience demonstrates inconsistent application of these principles, particularly in addressing her sensory, cognitive, and emotional needs.

Fluctuating capacity presents additional challenges, especially during emotional dysregulation (Mazefsky et al., 2013). The Mental Capacity Act 2005 provides a legal framework for assessing capacity on a decision-specific and time-specific basis. Research by Kitzinger and Kitzinger (2015) highlights the complexity of applying the Act in fluctuating situations, calling for dynamic and nuanced approaches that account for these fluctuations. There was omission of consistent practice.

13.3 Communication Gaps and Multi-Agency Collaboration

Effective multi-agency collaboration is essential in managing complex, cross-border cases using high-reliability organisation (HRO) principles (Weick & Sutcliffe, 2001). This advocates for clear communication, shared goals, and systematic protocols across agencies. These principles align with the statutory duty under the Care Act 2014, which requires local authorities to work collaboratively with health partners to promote wellbeing and prevent gaps in care.

The findings demonstrate fragmented communication, as seen in inconsistent use of multidisciplinary team (MDT) meetings and the failure to document key decisions in systems for example Liquid Logic. The Health and Social Care Act 2012 emphasises the importance of integrated care pathways, while Sloper (2004) highlights shared decision-making and consistent information-sharing as critical enablers of collaboration.

Furthermore, national guidance, such as Working Together to Safeguard Children (2018) and Adult Safeguarding: Roles and Competencies for Health Care Staff (2018), highlights the importance of robust inter-agency safeguarding procedures. However, in Bella's case, the lack of interoperable systems hindered information flow between agencies. Research by Farre and McConachie (2020) highlights the need for shared digital platforms to enhance collaboration, a challenge also identified in the Second National Analysis of Safeguarding Adult Reviews (2024).

13.4 Safeguarding Practices and Risk Management

Safeguarding areas requiring strengthening include delayed escalation, insufficient risk management, and inconsistent application of statutory frameworks. The Care Act 2014 places a statutory duty on local authorities to safeguard adults at risk of harm, including autistic individuals. Additionally, the Children and Families Act 2014 provides a legal framework for safeguarding young people transitioning to adult services.

Risk assessment frameworks must account for the unique needs of individuals, including sensory sensitivities, trauma histories, and fluctuating capacity (Wong et al., 2020; Cashin et al., 2021). In Bella's case, safeguarding failures included missed opportunities to identify and mitigate risks, such as suicidal ideation and personal trauma from a number of incidents. The trauma-informed care (TIC) framework (SAMHSA, 2014) and cultural competence theory (Sue et al., 1992) advocate for recognising trauma and cultural contexts in risk assessment and intervention.

Inconsistent application of the Mental Capacity Act 2005, particularly in relation to Deprivation of Liberty Safeguards (DoLS), reflects broader challenges in balancing autonomy and safeguarding responsibilities. Manthorpe and Martineau (2010) emphasise the need for clearer guidance in using DoLS in fluctuating capacity scenarios, a key issue in Bella's case.

The Mental Capacity Act 2005 (MCA) protects the right of individuals aged 16 and over to make their own decisions, even if those decisions might be considered unwise. However, this principle (Section 1 of the MCA) can conflict with the duty under Section 42 of the Care Act 2014, which requires local authorities to safeguard adults with care and support needs who are at risk of abuse or neglect and unable to protect themselves.

For a person to be deemed capable of making a decision, they must:

- Understand the information relevant to the decision.
- Retain that information long enough to make the decision.
- Use or weigh the information as part of the decision-making process.
- Communicate their decision effectively.

Practitioners have a duty to present information in a way that supports the individual's decision-making and consider "executive capacity" – the ability to carry out decisions and manage consequences. They must also assess the potential influence of external pressures, such as trauma or coercion, on the decision-making process.

Assessments of capacity should not merely accept decisions as "lifestyle choices" without exploring their broader context. NICE guidance⁸ advises practitioners to observe how individuals execute decisions in real-life situations, recognising the situational nature of decision-making. Factors such as adverse childhood experiences, trauma, and "enmeshed" relationships must be considered, as these can impair decision-making.

Where evidence suggests that someone may struggle to understand or act upon information outside of the assessment setting, this should be thoroughly investigated, utilising one's own Professional Curiosity. While the presumption of capacity under Section 1 of the MCA is a foundational principle, it does not override professional responsibilities to safeguard individuals from abuse, neglect, or exploitation.

There is an important distinction between a person who understands and chooses to take a risk and someone who lacks the awareness or ability to appreciate the risk and its consequences. Practitioners must remain vigilant to this difference when conducting assessments, planning care, and safeguarding individuals like Bella. In Baker J, GW v A Local Authority [2014] EWCOP20, para. 45, the judgment highlighted **There is a difference between someone who has an appreciation of risk and yet goes on to take the risk – albeit unwisely – and someone who ... lacked awareness of the risk and sufficient problem-solving ability **.

13.5 Discharge Practices and Post-Discharge Oversight

Discharge planning is a critical component of safe care, particularly for individuals with complex needs and high-risk behaviours. The continuity of care theory (Haggerty et al., 2003) and transition theory (Schlossberg, 1981) emphasises the importance of structured, personcentred transitions. Furthermore, the Care Quality Commission (CQC) standards for effective discharge planning stress the importance of MDT involvement, family engagement, and robust contingency planning to mitigate post-discharge risks.

In Bella's case, the decision to discharge without robust contingency plans reflects an inadequate level of established standards. There have been occasions where such discharges from care are inconsistent with the commitments outlined in the NHS Constitution for England, which guarantees safe and effective discharge processes. Chang et al. (2021)

⁸ NICE (2018) Decision Making and Mental Capacity, London: Overview | Decision-making and mental capacity | Guidance | NICE.

⁹ Baker J, GW v A Local Authority [2014] EWCOP20, para. 45

highlight that proactive MDT collaboration is critical to addressing and managing postdischarge risks, a sentiment echoed in the Second National Analysis of Safeguarding Adult Reviews (2024)¹⁰, which identifies unsafe discharge practices as a recurring issue contributing to preventable harm.

13.5.1 Concerns Regarding Discharge Under the Mental Health Act (MHA)

The handling of high-risk individuals, particularly those detained under Section 2 of the Mental Health Act (MHA)¹¹, requires rigorous application of safeguarding principles and legal frameworks. In this case, discharging an individual who exhibited suicidal behaviour, such as attempting to jump off a hospital roof, under the justification of "behavioural problems" raises significant concerns regarding the adequacy of risk assessments and adherence to professional obligations.

Critical Learning:

Discharge decisions for high-risk individuals must be strengthened by trauma-informed, autism-aware, and comprehensive risk assessments, in line with MHA, MCA, and safeguarding legislation. Where safeguarding concerns persist, this should trigger professional challenge, escalation, and clear documentation of dissenting views.

This case highlights the need for all staff involved in high-risk discharges to have strong legal literacy, safeguarding awareness, and a clear understanding of multi-agency planning processes.

13.5.2 Behavioural Issues vs. Risk of Harm

The input provided by community staff regarding Bella's discomfort with enclosed spaces and her known behavioural triggers offered helpful insight into her preferences and sensory needs, and demonstrates good practice in seeking and reflecting Bella's voice within care planning. However, this review has identified opportunities to strengthen how risk is assessed and balanced alongside behavioural explanations, particularly when an individual presents with co-existing mental health, autism, and trauma-related needs.

Critical Learning:

Behavioural issues and mental health crisis are not mutually exclusive—what may present as a coping mechanism or behavioural response could also be an indicator of underlying distress, trauma, or unmet mental health needs. In situations where behaviours escalate to life-threatening actions, such as suicide attempts, there is an opportunity for systems to prioritise risk management and safeguarding responses, alongside understanding and accommodating behavioural triggers.

This does not negate the importance of person-centred adjustments but highlights the need for a balanced, holistic risk-informed approach.

¹⁰ Second National Analysis of Safeguarding Adult Reviews: April 2019 – March 2023 (2024).

¹¹ 1983) *Mental Health Act 1983: Elizabeth II. Chapter 20. Section 2.* London: HMSO. [Amended by the Mental Health Act 2007]

13.5.3 Understanding and Interpreting Professional Input

The decision to discharge Bella was accompanied by the presence of five staff to escort her home, indicating that some level of ongoing risk was recognised by the discharging team. However, once home, she was left in the care of a single carer who had already raised concerns about their ability to manage her safely in that environment. This escalation, alongside Bella's own messages to her mother expressing fear and a sense of being unsafe, highlights a clear disconnect between the level of risk acknowledged in the hospital and the support provided upon discharge.

Additionally, Bella's mother contacted the hospital directly, raising urgent concerns that the discharge arrangements were unsafe and warning that they placed Bella at heightened risk. This was a missed opportunity to pause, reflect, and reconsider the discharge decision within a broader safeguarding context, particularly given Bella's presentation, history of crisis behaviours, and the protective role her mother has historically played in raising valid safeguarding concerns.

Ultimately, the disconnect between the hospital's awareness of risk, the concerns raised by the carer and Bella's family, and the actual discharge arrangements highlights a critical gap in safe discharge processes — particularly for individuals with complex needs, autism, and a known history of escalating risk in community settings.

Critical Learning:

This incident reinforces the need for formal, multi-agency discharge planning processes, including documented risk assessment, consideration of fluctuating capacity, clear escalation protocols, and professional challenge where discharge arrangements do not align with the level of known risk.

13.5.4 Risk to Community Carers

The decision to discharge Bella into the care of a single carer, particularly from an external care agency, raises significant safety concerns as the single carer would potentially not have the capacity or training to manage Bella's high-risk behaviours effectively on their own, potentially endangering both Bella and the carer.

 Inappropriate delegation of responsibility: The transfer of such a high-risk individual into an inadequately supported environment reflects a failure in the discharge planning process and in safeguarding responsibilities.

This is not framed as a criticism of individual decision-making, but rather as a learning opportunity for all agencies involved in discharge planning and multi-agency risk management. It highlights the importance of ensuring that all professionals have a shared understanding of risk, and that no individual practitioner is placed in a position where they are left solely responsible for managing high levels of known and emerging risk without adequate support, supervision, or contingency planning.

13.5.5 Positive Practices and Strengths

Despite systemic challenges, several examples of compassionate, person-centred care were evident. Adaptive approaches, such as conducting reviews in familiar settings and maintaining consistent staffing, align with humanistic theory (Rogers, 1951) and the core principles of the NHS Long Term Plan (2019), which prioritise personalised care tailored to individual needs.

Key examples include recognising and addressing Bella's specific emotional and environmental needs, such as the importance of her teddy bear and appropriate human contact to provide comfort and reassurance during moments of distress. The police demonstrated sensitivity to environmental challenges by adapting their approach, ensuring Bella felt safe and supported in non-threatening settings. Similarly, carers played a crucial role in escalating concerns about risks and safety, although their voices were not always sufficiently acknowledged in decision-making.

Compassionate, personalised care extended to maintaining Bella's connection to meaningful aspects of her life, such as caring for her dog. This small but significant consideration demonstrated an understanding of how familiar routines and relationships contribute to overall wellbeing. Additionally, emotional support for Bella's mother was provided, recognising the vital role of family in managing complex care needs and the importance of sustaining their capacity to support Bella.

The use of positive behavioural support (PBS) frameworks (Gore et al., 2013) was evident in the consistent and dynamic support provided by the Care Agency. These practices align with the SEND Code of Practice (2015), which advocates for tailored strategies to meet the specific needs of individuals with autism.

Intermediaries and tailored communication strategies were employed effectively to engage Bella and address her complex needs. These practices reflect adherence to the Accessible Information Standard (2016) and the Public Sector Equality Duty, as set out in Section 149 of the Equality Act 2010, which requires public bodies, including NHS services, to eliminate discrimination, advance equality of opportunity, and foster good relations. By ensuring that communication is accessible and responsive to individual needs, these approaches highlight the importance of accommodating diverse communication styles to build trust and improve outcomes.

Positive Learning and Good Practice

Throughout Bella's care, there were numerous examples of compassionate, person-centred practice. Professionals adapted their approaches to meet Bella's sensory and emotional needs, demonstrating creativity, professional curiosity, and a strong commitment to her wellbeing.

These many positive examples highlight the dedication, compassion, and good practice that should be celebrated and embedded in future work

14. Summary of Learning for the Recommendations

Reinforce the Need for a Clear Narrative around Decision-Making

The absence of documented risk assessments and capacity assessments during key periods significantly limits the review's ability to fully understand the rationale behind key decisions made by agencies. In future practice, agencies should ensure not only that decisions are recorded, but that the narrative underpinning these decisions is transparent, including:

- The risks and options considered.
- How differing professional views were managed.
- How Bella's voice and her mother's concerns were captured and responded to. This strengthens accountability, supports learning, and ensures defensibility when decisions are scrutinised.

Explicitly Reference Concerns about Fragmented Multi-Agency Working

There are no consistent references in the chronologies in relation to multi-agency risk assessments or discharge planning meetings, despite the complexity and high-risk nature of the case. This lack of coordinated oversight created a fragmented response, increasing the likelihood of missed opportunities to safeguard effectively.

Strengthen Analysis around Risk Assessments and Capacity Assessments

Whilst agencies have indicated that risk assessments and capacity assessments were completed, it is the responsibility of each organisation to assure the quality, completeness, and appropriateness of these documents through internal scrutiny and governance processes prior to their formal sign-off and submission to the review.

As these assessments were not consistently provided to the review, independent assurance regarding their quality and appropriateness cannot be given within this report. This reflects a system learning point, highlighting the importance of robust internal assurance processes to ensure that critical assessments consistently meet required standards and are available for multi-agency learning and review.

Strengthen the Section on Autism and Trauma-Informed Responses

The absence of a clear autism diagnosis until adulthood may have contributed to a focus on 'managing behaviour' rather than understanding needs through an autism-informed and trauma-informed lens.

Specific Analysis of Exploitation and Safeguarding Responses

Despite clear indicators of exploitation risk, there is no evidence that agencies completed a specific risk assessment or invoked relevant safeguarding processes such as exploitation panels or multi-agency safeguarding meetings related to sexual exploitation or coercion. In particular after a number of allegations of sexual assaults and multiple relationships. This is a missed opportunity to proactively safeguard the individual.

Clarify the Limitations of the Review (and Reiterate the Learning Focus)

The review has not been provided with all underlying risk assessments, capacity assessments, or care plans. Where evidence is absent, the review has highlighted this explicitly to support system learning. However to note with reference to risk assessment in employment situations, it is also important to recognise the positive potentials in respect of Bella's independence and a strength based approach with positive risk taking to help Bella grow and make her own choices.

Emphasise the Need for Assurances from Agencies in Real Time

It is essential that learning from this case does not wait until the final report is published. Agencies should have already undertaken internal reflective reviews to identify immediate improvements in:

- Risk assessment processes and multi-agency information sharing and coordinated risk management.
- Embedding professional curiosity, escalation, and challenge into frontline and managerial practice. CESAB should require immediate assurance reports from all involved agencies to evidence that learning is being embedded in real-time, not deferred to a later point.

Strengthen Recommendations to Reflect Multi-Agency Issues

The review highlights that no single agency can safely manage complex cases like Bella's in isolation, however no regular or routine multi-agency review processes for high-risk cases — not just at point of discharge, but throughout the care journey.

Ensure Bella's Voice and Family Perspective are Explicit

Bella and her family described a sense of being unheard during key episodes of care and decision-making. They expressed frustration that risks were minimised and that opportunities for early intervention were missed.

Reinforce the Overall Learning Statement

This review reinforces that safe and effective safeguarding for adults with complex needs requires relentless professional curiosity, compassionate practice, and collaborative risk management. Multiple missed opportunities were identified — not just by individuals, but by the system as a whole.

15. System Learning and Recommendations

The following table (Table 2) sets out the key recommendations arising from this Safeguarding Adults Review (SAR). These recommendations are designed to address the systemic issues and practice gaps identified, while also building on the examples of positive practice evidenced throughout Bella's care. Each recommendation is framed to promote sustainable improvement.

Table 2

No.	Recommendation
1	Embedding Professional Curiosity and Assumption-Checking into Practice
2	Autism and Trauma-Informed Care Framework
3	Multi-Agency Risk Assessment and Discharge Planning
4	Documented Decision-Making and Governance Oversight
5	Strengthen Safeguarding Responses to Exploitation and Complex Risk
6	Strengthen Legal Framework Use and Oversight (MCA, DoLS, CoP)
7	Real-Time Learning and Assurance during and after Reviews

Impact audits are suggested to be integrated into all recommendations to measure not only compliance but also the effect on service users, services, and staff. This ensures that improvements are meaningful, sustainable, and address the lived experiences of all stakeholders.

16. Conclusion

The findings and analysis presented in this section are drawn directly from the chronologies, agency reports, and supporting documentation formally submitted by each agency involved in Bella's care. The analysis and the recommendations made within this review are based solely on the information provided and signed off by each agency through the SAR process. It is understood and expected that all documentation—including Mental Capacity Assessments, Risk Assessments, records of MDT meetings, and Discharge Planning documentation—was subject to internal quality assurance within each contributing agency prior to submission to this review.

This reflects an important principle: the evidence base for this review relies on the completeness, accuracy, and transparency of each agency's own records and professional reflections. Where gaps in documentation, conflicting accounts, or incomplete recording have been identified, these have been highlighted and inform the learning and recommendations set out in this report. This is not to apportion blame, but to recognise the fundamental importance of robust record-keeping, clear decision-making, and transparent multi-agency communication as essential components of safe, lawful, and person-centred care—particularly for individuals with complex and fluctuating needs, such as Bella.

The integration of these findings with theoretical frameworks, statutory guidance, and national evidence further reinforces the urgent need for systemic reform across several areas:

- Autism-informed care that recognises sensory, communication, and processing needs within all safeguarding and mental health responses.
- Multi-agency collaboration that prioritises real-time information sharing, shared risk assessments, and collaborative care planning across agencies and regional boundaries.
- Discharge planning processes that embed multi-agency challenge, person-centred risk management, and clear post-discharge oversight.
- A consistent and legally literate approach to capacity assessments, restrictive practices, and lawful deprivation of liberty.

This SAR highlights both challenges and strengths, demonstrating that good practice does exist—particularly when professionals work flexibly, creatively, and with genuine person-centred compassion. By addressing the identified gaps and building on these positive examples, safeguarding partners have a real opportunity to better align their practice with national standards and evidence-based approaches.

Ultimately, implementing the recommendations in this review will not only strengthen safeguarding systems, but also contribute to a wider culture shift—one that values curiosity over assumption, collaboration over silo working, and person-centred care over procedural compliance. This is essential if we are to prevent similar incidents and ensure adults with care and support needs, like Bella, receive the safe, compassionate, and lawful care they deserve.

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Appendix 2

Terms of Reference for Safeguarding Adults Review (SAR) - BELLA Case

Name	Bella
Address	
Date of Birth	
Dates of incidents	26 & 27/01/2024

1. Introduction:

This Safeguarding Adults Review (SAR) has been commissioned by Cheshire East Safeguarding Adults Board (CESAB) following the incidents involving Bella, a young woman with autism and epilepsy, which led to two significant suicide attempts on the railway tracks within two days, resulting in life-threatening injuries. The SAR will focus on the events leading up to these incidents, interagency collaboration, decision-making processes, safeguarding practices, and any opportunities for learning and improving safeguarding systems.

2. Purpose of a SAR:

The Care and Support Statutory Guidance under the Care Act 2014 makes it clear that the purpose of a Safeguarding Adults Review (SAR) is not to hold any individual or organisation personally accountable. Separate processes exist for that, such as criminal prosecutions, disciplinary procedures, employment law, and professional regulatory bodies like the Care Quality Commission (CQC), the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council (14.139). In contrast, the role of Safeguarding Adults Boards is to hold local organisations to account for how they protect adults with care and support needs.

The distinction is vital: for SARs to be effective learning tools, they must be seen as safe, constructive experiences that foster honesty, transparency, and openness. If SARs are approached with fear of blame or punishment, individuals and organisations are likely to become defensive, resulting in limited and guarded engagement, which undermines the whole purpose of learning from past incidents.

3. The Scope of this SAR is to:

- Complete Individual Management Reviews / Chronologies covering the period of 12 months up to and including the second incident.
- Review the circumstances leading to the incidents involving Bella on 26th and 27th January 2024.
- Examine the roles and actions of agencies involved in Bella's care and safeguarding, particularly after the first incident.
- Identify any gaps in interagency communication, safeguarding procedures, and risk management.
- Understand the decision-making processes concerning Bella's discharge and return to her home environment on 26th January 2024.
- Provide learning opportunities to improve the safeguarding of adults at risk, particularly those with complex needs, across Cheshire and beyond.

4. Key Areas to further learn from

4.1. Agency Roles and Responsibilities:

Examination of the roles of key agencies involved in Bella's care. These agencies involved include

- Bella's Care Service Provider,
- Adult Social Care,
- Mental Health Services,
- Ambulance Service
- Emergency Departments
- General Practitioner
- British Transport Police
- Greater Manchester Police
- Cheshire Police

4.2. Key Lines of Enquiries

 Whether safeguarding referrals and concerns were appropriately shared and acted upon.

• Discharge and Risk Management:

- Analysis of the decision-making process that led to Bella being discharged from Stepping Hill Hospital on 26th January 2024, despite expressing suicidal intent and a history of mental health concerns.
- Whether proper multi-agency safeguarding discussions and planning occurred after Bella was discharged.
- > Review of the role of the mental health practitioner's assessment, particularly the determination that this was a behavioural issue rather than a mental health crisis, and whether this assessment was appropriate.

Interagency Collaboration:

- The effectiveness of communication and collaboration between agencies, particularly in sharing critical information about Bella's risks and history.
- Exploration of the potential challenges of cross-border working, as Bella's care involved agencies from multiple areas, including Stockport, Cheshire, and Nottingham.
- ➤ How Bella's care plan was monitored, and if there was sufficient oversight of the support provided by the care provider, particularly in the 24-hour period between the two incidents.

Safeguarding Procedures:

- Review of Bella's known care and support needs, including her autism, epilepsy, and previous incidents of self-harm or suicidal behaviour, and how these were addressed within her care plan.
- Whether safeguarding alerts were appropriately raised and escalated, and if appropriate interventions were made following the initial incident.
- Consideration of Bella's rape allegation in January 2024 and its potential impact on her mental health and risk level.

• Gaps in Documentation and Decision Making:

Identification of gaps in record-keeping, such as in the hospital discharge process and social care records (Liquid Logic), and their impact on care and safeguarding decisions.

- Clarity on who made key decisions regarding Bella's care and discharge, and whether these decisions were documented and followed best practices.
- If there were any policy gaps that impacted on this case or on the action taken by organisations and agencies involved.
- Whether there are any equality and diversity issues in relation to this case.
- > If there were any culture, status or reputation issues that impacted on this case.

In addition, the following Key Lines of Enquiry are required to be examined by the identified agencies.

- o Assessments by each organisation
- Mental Capacity
- Safeguarding Processes
- Information sharing
- o Risk assessment
- o Policies and Processes for Self-Neglect cases
- Supervision and support to Practitioners
- Professional Curiosity

Learning and Recommendations:

- Identifying lessons learned from this case regarding safeguarding adults with complex needs, particularly those receiving 24/7 support.
- Providing recommendations for improving interagency safeguarding practices, risk assessment, and decision-making processes, to prevent similar incidents from occurring in the future.

5. Individual Management Reports

The following agencies are invited and politely requested to contribute to the SAR by submitting Individual Management Reports (IMRs):

- British Transport Police (BTP)
- Cheshire Police
- Greater Manchester Police (GMP)
- Pennine Care NHS Foundation Trust
- Care Agency provider
- Cheshire East Adult Social Care
- Care Quality Commission (CQC)
- Stockport Mental Health Services (Stepping Hill Hospital)
- Nottingham Priory
- Cheshire and Wirral Partnership NHS Foundation Trust (CWP)
- Any other relevant agencies involved in Bella's care.
- **5.1** The IMRs should be carried out by someone who was not directly concerned with Bella or her family, or the immediate line manager of the practitioner/s involved and are not Panel members of this SAR.
- **5.2** IMRs/ Chronologies should be completed in the format provided.
- **5.3** All IMRs must include a full chronology of significant events in the format provided.
- **5.4** It is important that all IMRs / Chronologies also capture good practice to enable sharing for the purpose of learning and implementing evidenced based practice.

6. Timetable

- **6.1** The main timeline for this SAR will cover the 12 month period up to and including the first and second incident.
- **6.2** All IMRs and chronologies must be submitted to Cheshire East Safeguarding Adults Business Team electronically by: **31:10:2024**
- **6.3** Information will be collated from the Individual Management Reports (IMRs) from the agencies listed in point 5 where they will be analysed by the Panel and Overview Report Author.
- **6.4** All agencies submitting an IMR and chronology will have the opportunity to present their findings to The Panel on **05:12:2024**
- **6.5** The Panel will, having considered the IMR's and chronologies and taking account of the agencies presentations, agree the SAR outcomes and final publication issues at a meeting on **14:01:2025**
- **6.6** The Draft Report will be available for all agencies to comment on inaccuracies week commencing **04:02:2025.** All agencies will have 7 working days to notify of any inaccuracies or concerns. The independent chair/author may amend the report or will detail the concerns raised and reasons why the report has not been amended.
- **6.7** The Serious Case Group will meet on **20:02:2025** to agree the final Overview Report and Executive Summary.
- **6.8** The Final Overview Report will be circulated to an Extraordinary Cheshire East Safeguarding Adults Board Members before week commencing **24:02:2025**. Bella and where appropriate and applicable Bella's family will also be notified of the key findings.
- **6.9** The Independent Chair of the Safeguarding Adults Board will identify a SAB meeting to receive and discuss the Overview Report and Executive Summary, which will be presented by the independent chair/author, and the agreed recommendations. This may be an extraordinary meeting. This should be no later than **06:03:2025**
- 6.10 Practitioner Event: 27:11:2024

Once the report has been presented to Cheshire East Safeguarding Adults Board: All agencies involved with the SAR will take the Overview Report and Executive Summary through their own governance and accountability routes.

- All agencies involved with the SAR will debrief their staff.
- The Communication plan will be initiated.
- The action plan will be monitored by the Safeguarding Adults Board until it is completed.
- 7. Cross Border Collaboration- At the time of agreeing these Terms of Reference there are no other Safeguarding Adults Boards with an interest in the case that this SAR is based on. However given the complexity of Bella's care across different geographic and healthcare jurisdictions, a review of cross-border communication and collaboration between the different health trusts (e.g., Stockport, Cheshire East, Nottingham) will be essential to understanding the decision-making process and ensuring future improvements.

8. The Panel

8.1 Primary Involvement: The review process will prioritise the active involvement of Bella, ensuring that her voice is not only heard but meaningfully incorporated into the findings. It is widely recognised that individuals with learning disabilities have often been excluded from

decision-making processes that affect their lives, despite having a right to be fully engaged (Grove et al., 2019). Research shows that person-centered approaches are crucial to empowering individuals with learning disabilities, leading to outcomes that better reflect their needs and wishes (Department of Health, 2001; SCIE, 2018). This review will adopt such an approach, giving Bella a platform to express her experiences in a safe and supportive manner.

Where Bella consents, and where it is appropriate, her family and/or an advocate will also be engaged to ensure that Bella's broader support network is considered. Studies have highlighted the value of including family members, who can provide contextual understanding and ensure the individual's preferences are respected, especially when communication is complex (Tarleton, 2015). By integrating both Bella's perspective and those of her support network, the review will ensure a holistic approach to understanding her experience.

To facilitate this process, the panel will offer support services or advocate assistance to help Bella and her family understand the process and contribute effectively. This aligns with the recommendations of the Care Act 2014, which stresses the importance of advocacy to ensure people with learning disabilities can participate in reviews that impact them. Ensuring Bella's voice is heard in a meaningful way supports her rights to autonomy and empowerment, making her an active participant rather than a passive subject of the process

8.2 Cheshire East Safeguarding Adults Board has commissioned Frances Millar as the Independent Author of the Overview Report and Executive Summary and Independent Chair of the SAR Panel.

Frances Millar is independent of Cheshire East and all agencies involved in this case. The Panel will be made up of:

- Frances Millar Independent SAR Chair and Author
- Georgie Jones, T/DCI Cheshire Police
- > Sandra Murphy, Head of Adult Safeguarding, Cheshire East Council
- Katie Jones, Business Manager, Cheshire East Safeguarding Adults Board
- Katie Mills, Head of Safety Quality & Improvement, ICB
- Katy Endean, Deputy Designated Nurse for Safeguarding, ICB
- Lynne Turnbull, CEO, Disability Positive
- Racheal Elliott, Locality Manager, Cheshire East Council
- Katie Mowe, Serious Case Review Officer, Cheshire Police

9. Communications plan

- All public or media enquiries will be managed by Cheshire East Council's Communications team. All agencies, statutory, voluntary and independent, should re-direct any enquiries to the Cheshire East Communications Team.
- The action plan will identify how all agencies should report the SAR through their respective governance routes.

10. Additional Areas

10.1 Legal Advice

Cheshire East Safeguarding Adults Board and The Panel will take legal advice where it is required.

10.2 General Advice

General advice on Cheshire East's Safeguarding Adults Review procedure will be available from the SAB Business Manager.

10.3 The SAR Panel will review and amend these Terms of Reference as required during the SAR. Cheshire East Safeguarding Adults Board (CESAB) will be informed of any changes to the Terms of Reference.

11. Confidentiality:

All information shared as part of the SAR will be treated confidentially and used only for the purposes of the review. Agencies are expected to cooperate fully and transparently, sharing all relevant data and documentation.

12. Conclusion:

This SAR aims to provide a thorough review of the events leading to the incidents involving Bella, to ensure that all agencies involved in her care can learn from this case and improve their safeguarding practices for those adults who are at risk by definition of The Care Act 2014 in the future.

References

- The Care Act 2014
- The Care and Support Statutory Guidance issued under the Care Act 2014
- Cheshire East Safeguarding Adults Review Policy and Procedures
- SCIE Safeguarding Adult Reviews under the Care Act: implementation support.

These terms of reference have been agreed by Cheshire East Safeguarding Adult Review Panel and the CESAB Independent Chair and have been shared with Cheshire East Council Chief Executive and Cheshire East Council Director of Adult Social Services.

Appendix 3 – Glossary of Acronyms

Acronym	Full Term and/ or Description
A&E	Accident and Emergency
ВТР	British Transport Police
CESAB	Cheshire East Safeguarding Adults Board
cqc	Care Quality Commission
СоР	Court of Protection
DHSC	Department of Health and Social Care
DoLS	Deprivation of Liberty Safeguards
GP	General Practitioner
HRO	High Reliability Organisation
MCA	Mental Capacity Act
MDT	Multi-Disciplinary Team
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health
NEAD	Non-Epileptic Attack Disorder
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PBS	Positive Behavioural Support
SAB	Safeguarding Adults Board
SAR	Safeguarding Adults Review
Section 2	Provision under the Mental Health Act for the assessment of mental health conditions
SEND	Special Educational Needs and Disabilities
TIC	Trauma-Informed Care



No.	Recommendation	Action
1	Embedding Professional Curiosity and Assumption- Checking into Practice	During the next 12 months CESAB will run a Prevention Management & Learning (PML) Session focussing on Professional Curiosity CESAB to link with SCEP on recent DARDR Action around Professional Curiosity Q&A Sub-group to conduct a multi-agency audit on Professional Curiosity CESAB will ask partners to provide evidence of their Supervision Policy
No.	Recommendation	Action
2	Autism and Trauma- Informed Care Framework	CESAB will promote existing or emerging autism strategies within organisations which should be aligned to Autism Act 2009 and NICE guidelines. PML focussed session on neurodiversity (including communication) planned for May 2025 CESAB to request evidence of autism training from all partners. CESAB annual single agency report and annual frontline visits to focus on trauma informed practice. CESAB to produce a one minute guide (OMG) on understanding executive functioning and fluctuating capacity in autism.
3	Multi-Agency Risk Assessment and Discharge Planning	CESAB to promote best practice with regard to multi-agency risk assessments and discharge planning meetings for all individuals with complex needs and high-risk presentations. Q & A subgroup to conduct a multi-agency audit focussed on hospital discharge, questions to include evidence of risk assessment and MCA, including views, wishes and feelings of the person being discharged. Evidence of dissenting views being recorded. CESAB to ask partners to provide their 'Out of area' commissioning/ placement policies as part of the CESAB single agency report.



No.	Recommendation	Action
4	Documented Decision-	CESAB to seek assurance that partners have a Supervision policy, Record keeping policy and an audit
	Making and Governance Oversight	policy/procedure. Partners to evidence how their organisation ensures polices are complied with. CESAB to request confirmation from agencies on how they ensure all employees are aware of their governance procedures.
5	Strengthen Safeguarding	Continue to work closely with SCEP, promoting forums such as the Serious & Organised Crime Group and the Operation Expel process.
	Responses to Exploitation and	Ensure that the board is linked to the Pan-Cheshire overarching All Age Exploitation Strategy
	Complex Risk	Promotion of the Complex Safeguarding Forum – policies and procedures, plus referral process
		To ensure the themes of exploitation and complex risk are captured in the annual Complex Safeguarding Forum Report
No.	Recommendation	Action
6	Strengthen the application of the Legal Framework Use and Oversight (MCA, DoLS, CoP)	Following learning from previous SARS, work is ongoing in relation to professional use and application of the MCA. So, this review will focus on DiDs (Deprivation of Liberty in a domestic setting) and CoP (Court of Protection). The board will ensure the promotion of DiDs through its networks. CESAB to seek assurance that line managers have legal literacy and can offer appropriate advice and support regarding MCA, CoP and DiDs cases



7	Real-Time Learning	Require all agencies to self-audit during the SAR process to identify immediate actions and learning, rather							
	and Assurance during	nan waiting for the final report.							
	and after Reviews	CESAB to require real-time assurance reports from agencies on:							
		How learning is being embedded.							
		What immediate practice changes have been made.							
		How learning is being cascaded.							
		Partners to evidence this in Single Agency Report.							

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Safeguarding Adults Review about Bella



The Cheshire East Safeguarding Adults Board includes people from: - Cheshire East Council, Police, Health, Probation, Fire Service and many other organisations that help keep people safe.



The Board work together to make sure adults with care needs are kept safe from abuse and neglect.



In September 2024 Cheshire East Safeguarding Adults Board (CESAB) ordered a **Safeguarding Adults Review** about Bella.

A Safeguarding Adults Reviews (SAR) is carried out by the Board where an adult has died or has been badly hurt from abuse or neglect. The reviews look at how well people and organisations worked together to protect the adult.



This is an easy read summary of the report from the Safeguarding Adults Review.

This Report has some **information** about a young woman getting **seriously hurt.**

About Bella:



Bella is aged 26.

Bella likes art, keeping fit and looking after her dogs.

Bella likes her teddy bear called Chester.



Bella is autistic, has epilepsy and a brain injury.

Bella also struggles with her mental health.



Bella lives in supportive living accommodation and has carers that support her every day.



A lot of other partners also help Bella such as the doctor, the council, the mental health service, housing and local hospitals.



In January 2024 Bella's carers and family were worried about Bella's depression and mental health.



On January 27th, 2024, Bella was feeling very sad and was seen upset on the train tracks at a railway station. Sadly, Bella was hit by a train.



Bella was seriously hurt and needed to stay in hospital for a long time. She is at home now but is still getting better.

What we learnt from the Bella Review -



Staff need to listen to people and ask questions to find out what is important to people.



Staff need to understand how to help people that are autistic.



All agencies need to work together when they tell a person they can leave hospital. This includes managing **risks**.

Risks mean something that might harm or danger a person.



Staff need to make sure they write clear records.

Managers need to check that records are up to date with the right information.



Staff need to think about how some people might need more support due to their **complex needs**.

Complex needs are when a person has many different needs such as disability and mental health. They might need a high level of support and need help from different services.



Staff need to know how different laws like the **mental capacity act** can help people.

Mental Capacity Act is about making sure that people have the support they need to make as many decisions as possible.



Staff need to learn from safeguarding adult reviews. These reviews should happen quickly to make sure that services are better in the future.

What happens now?



The Cheshire East Safeguarding Adults Board will make sure the learning from Bella's review is shared with all partners that keep people safe.



The Board will check with partners that they have made changes from the safeguarding adults review learning.



The report will be available on the Board's website

www.stopadultabuse.org.uk

Who helped with this report?



The Board thank Bella and her mum for sharing their experiences. This will help agencies learn and make things better.







Easy Read summary of the Safeguarding Adults Review of Bella

Published by Cheshire East Safeguarding Adults Board, April 2025

www.stopadultabuse.org.uk

Page 125 Minute SAR Briefing – Bella

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Background:

Bella is 26 years old. She is a very creative person who also has a love for animals and keeping fit. Bella has epilepsy, a brain injury, complex mental health needs and is autistic. Bella lives in supportive living accommodation with 24hour support. She is very close to her family, especially her mother. Bella has received support from several organisations within Cheshire East including the local authority, mental health, housing, GP, hospital trusts, police and ambulance service. Plus, services out of area including mental health trusts, hospital trusts, a Private Health setting and British Transport Police. Bella's complex case includes incidents of self-harm, mental health crisis, risk taking behaviours and challenges associated with cross-border care provision. Bella's mental health declined in 2023 and in January 2024, she was missing from home on different occasions, each time, she was found near to train tracks. Sadly, in January 2024, Bella sustained life changing injuries when she was struck by a train. A Safeguarding Adults Review (SAR) was initiated under Section 44 of the Care Act 2014 following this incident involving Bella, who meets the definition of an adult at risk under the Care Act 2014. The purpose of the SAR was to identify lessons for multi-agency working to enhance future safeguarding practice. Bella and her mother were involved throughout this review, this ensured their views, opinions and concerns informed the SAR.

Resources and further information:

Safeguarding Adult Reviews in Cheshire East

Diagnostic overshadowing and how it impacts on people wit learning disability and autistic people | Local Government A

Commissioning self-advocacy as a basis for effective co-produced local Government Association

Best practice and insights report on improving housing choice for people with a learning disability | Local Government Association

What is professional curiosity? | Research in Practice

<u>Professional curiosity in safeguarding adults: Strategic Briefing (2020)</u> Research in Practice

http://www.stopadultabuse.org.uk/pdf/one-minute-guides/omg-professional-curiosity-final.pdf

Implementing change:

Discuss the themes with your team or service and consider how they may affect your practice. Determine what you or your team could do to act on these and implement any necessary changes.

Practice implications: Bella's complex mix of epilepsy, mental health problems, autistic spectrum condition and her use of risk-taking presented services with considerable challenges.

Staff have access to Legal Gateway Meetings/ Complex Safeguarding Meetings it is essential they utilise this if they need further advice/guidance. Information sharing and accurate record keeping is essential.

Professional curiosity is a term that describes the capacity and the skill to communication that allows a practitioner to explore and understand what is happening to a person or within a family rather than making assumptions or accepting things at face value. It requires practitioners to think 'outside the box', perhaps beyond their usual professional role, and to consider families' circumstances holistically.

The Purpose of a Safeguarding Adults Review:

- Establish the facts that led to the serious injury and whether there are any lessons to be learned from the case about how professionals and agencies worked together to safeguard Bella
- Highlight areas of good practice to be shared
- Identify how and within what timescales any actions will be acted on, and what is expected to change.
- Contribute to a better understanding of the nature of Adult Safeguarding
- Ensure that the experiences of Bella and her family are heard regarding their lived experiences and the impact of mental health and autism on young adults with complex needs

Key Themes:

Diagnosis of Autism and severe mental health – recognised that Bella's needs plus her risk-taking made Bella's case extremely complex.

Access to support – out of hours, out of area

Autism-informed care that recognises sensory, communication, and processing needs within all safeguarding and mental health responses.

Multi-agency collaboration that prioritises real-time information sharing, shared risk assessments, and collaborative care planning across agencies and regional boundaries.

Discharge planning processes that embed multiagency challenge, person-centred risk management, and clear post-discharge oversight.

A consistent and legally literate approach to capacity assessments, restrictive practices, and lawful deprivation of liberty.

STOP ADULT ABUSE #

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Recommendations:

The SAR made the following recommendations:

Embedding Professional Curiosity and Assumption-Checking into Practice

Promotion of Autism and Trauma-Informed Care Frameworks

Importance of Multi-Agency Risk Assessment and Discharge Planning

Importance of timely documented Decision-Making and Governance oversight

Strengthen Safeguarding Responses to Exploitation and Complex Risk

Strengthen Legal Framework Use and Oversight (MCA, DOLs, CoP)

The value of Real-Time Learning and Assurance during and after Reviews





OPEN

Scrutiny Committee

Thursday, 4 September 2025

Substantial Development or Variation of Service (SDV) - Stage 1 Process

Report of: Acting Governance, Compliance and Monitoring Officer

Report Reference No: SC/10/25-26

Ward(s) Affected: All

For Decision or Scrutiny: Decision

Purpose of Report

The purpose of this report is to seek the views of the committee in relation to streamlining the process for determining Substantial Developments or Variation of Service (SDV).

Executive Summary

- 2. NHS Cheshire and Merseyside Integrated Care Board (ICB) are currently reviewing numerous policies that may or may not impact residents of Cheshire East.
- 2.1 The ICB has a duty to engage with Local Authority Health and Overview Scrutiny Committees (HOSC) to seek confirmation as to whether the HOSC believes this proposal is a substantial change to NHS services.
- 2.2. As outlined within the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) regulations, and covered within the Cheshire and Merseyside protocol for the establishment of joint health scrutiny arrangements, where a proposal on changes to NHS services impact on more than one Local Authority area, it is for each individual authority to reach a view on whether the proposal is deemed to be a Substantial Development or Variation (SDV) for that Local Authority area, and where more than one Local Authority agrees that it does (for the same proposal) then regulations place a requirement on

- those local authorities to establish a joint overview and scrutiny committee for the purposes of considering the proposal.
- 2.3 The Cheshire and Merseyside protocol deals with the proposed operation of such arrangements for the Local Authorities of Cheshire and Merseyside. Details of the protocol are attached at Appendix 1 Cheshire and Merseyside Joint Health Scrutiny Arrangements
 Protocol.pdf.
- 2.4 Due to a review of a significant number of policies administered by Cheshire and Merseyside ICB, it is anticipated that a number of SDV considerations will be required by the Scrutiny Committee. To help deal with the SDV's in a timely manner, the committee are asked to consider streamlining 'Stage 1' (initial consultation phase) of the process.

RECOMMENDATIONS

The Scrutiny Committee is recommended to:

1. Delegate authority to the Statutory Scrutiny Officer, in consultation with the Chair and Vice Chair of the Scrutiny Committee, to decide whether a proposal represents a "substantial" change.

Background

- Several proposals relating to health service developments or variations are expected in the coming months. Each proposal that could impact Cheshire East residents will require initial consideration by this Committee.
- 3.1 The Committee's role during the initial consultation phase is limited to determining whether the proposals constitute a "substantial" change for Cheshire East residents.
- 3.2 Where such proposals impact on more than one local authority area, each authority's health scrutiny arrangements must consider whether the proposals constitute a substantial development or variation or not. The regulations place a requirement on those local authorities that agree that a proposal is substantial to establish, in each instance, a joint overview and scrutiny committee for the purposes of considering it. This stage will remain unchanged.

- 3.4 It is acknowledged that due to the number and nature of service change proposals that are expected, there may be circumstances where the first phase, including the initial decision, may need to be expedited to allow for timely second stage and detailed consideration of the proposals by the place-based, or ad hoc joint health scrutiny committee in line with statutory health scrutiny requirements. To facilitate such cases, it is proposed that the Scrutiny Committee consider an option for streamlining its approach to the initial consideration of proposals where appropriate.
- 3.5 The Committee is recommended to delegate the decision on whether a proposal represents a "substantial" change to the Statutory Scrutiny Officer (or their representative), in consultation with the Chair and Vice Chair of the Scrutiny Committee.
- 3.6 In each case, the Statutory Scrutiny Officer, Chair, and Vice Chair may still decide convene the full committee to make this decision when deemed appropriate. When exercising delegated authority, they will report their decision back to the committee at the next available meeting, providing their reasoning for the determination of proposals as substantial, or not substantial.
- 3.7 This delegation will not affect the second phase of scrutiny for any proposals identified as substantial, which will continue to be examined in detail by either this Committee for proposals affecting only Cheshire East, or by a Joint Health Scrutiny Committee if the proposals affect two or more areas in Cheshire and Merseyside.

Consultation and Engagement

4. No consultation is necessary for this report.

Reasons for Recommendations

To ensure efficient and timely consideration of SDV proposals which will support the ongoing review of NHS Cheshire and Merseyside ICB policies.

Other Options Considered

Option	Impact	Risk	
Do nothing –	Potential delay in	Reputational damage	
continue with	providing response to	and increased	
current process	NHS consultations	pressure on partner	
		working	
		arrangements	

Implications and Comments

Monitoring Officer/Legal/Governance

6. The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) regulations place a requirement on relevant individual scrutiny arrangements to reach a view on whether they are satisfied that any proposal that is deemed to be a substantial development or variation is in the interests of the health service in that area. The proposed change to the process will delegate authority to the Statutory Officer, in consultation with the Chair and Vice Chair of the Scrutiny Committee, to make initial decisions on whether the proposal is substantial or not in order to expedite the process considering an expected influx of policy changes. Decisions will still be reached using the same criteria and will be reported back to Committee together with the reasoning behind those decisions, which provides assurance. This does represent a shift in decision making but with Member involvement remaining and is a means by which to ensure that decision are made in a timely and effective manner given NHS consultation deadlines and that scrutiny committee time is focused on substantial proposals which require individual or joint scrutiny committee attention.

Section 151 Officer/Finance

7. Streamlining the process for determining Substantial Developments or Variation of Service (SDV) will have no impact on the council budget or the MTFS however, it will avoid potential additional costs arising from any additional meetings needing to be arranged to enable a representative from the NHS to attend.

Human Resources

8. There are no implications to Human Resources.

Risk Management

9. There are no implications to Risk Management.

Impact on other Committees

10. There will be no impact to any other Committees.

Policy

11.

Commitment 2: Improving health and wellbeing	Commitment 3: An effective and enabling council

Equality, Diversity and Inclusion

12. There are no Equality, Diversity or Inclusions implications of this report.

Other Implications

13. There are no implications relating to Rural Communities, Children and Young People, Public Health or Climate Change.

Consultation

Name of Consultee	Post held	Date sent	Date returned	
Statutory Officer (or deputy) :				
Ashley Hughes	S151 Officer	20/08/25	27/08/25	
Janet Witkowski	Acting Monitoring Officer	20/08/25	20/08/25	
Legal and Finance				
Julie Gregory	Head of Legal Services	06/08/25	11/08/25	
Nick Finnan	Principal Accountant			

Other Consultees: Directors			
Name	Job title	Click or tap to enter a date	Click or tap to enter a date

Access to Informa	ation
Contact Officer:	Jennifer Ashley, Katie Small
	jennifer.ashley@cheshireeast.gov.uk, katie.small@cheshireeast.gov.uk
Appendices:	Appendix 1 - Cheshire and Merseyside Joint Health Scrutiny Arrangements Protocol.pdf
Background Papers:	Section 244 - National Health Service Act 2006 Scrutiny Committee - December 2024 - Proposed SDV Gluten Free Prescribing Scrutiny Committee - June 2025 - Proposed SDV Fertility Treatments

Scrutiny Committee Work Programme 2025/2026

Report Reference	Scrutiny Committee	Title	Purpose of Report	Lead Officer	Consultation	Equality Impact Assessment	Cheshire East Plan Commitment	Part of Budget & Policy Framework	Exempt Item
SC/04/2025- 26	04/09/25	Domestic Homicide Report - EMMA	The purpose of the Report is to share the Learning from the Domestic Homicide Review relating to EMMA.	BROOMHALL, Jill	N/A	No	Improving health and wellbeing	No	No
AH/42/2025- 26 & SC/07/2025- 26	04/09/25	Safeguarding Adults Review - BELLA	The purpose of the Report is to scrutinise relevant learning from a Safeguarding Adults Review involving a young woman with Autism who was hit by a train	BROOMHALL, Jill	No	No	Improving health and wellbeing; Unlocking prosperity for all	No	No
SC/19/24-25	04/09/25	Suicide Prevention and Mental Health Community Support	At the request of Scrutiny Committee, to provide information about the services and interventions available to support people's mental	KILMINSTER, Guy	N/A	No	Improving health and wellbeing	No	No

			health and prevent self-harm and suicide in the community.						
SC/10/25-26	04/09/25	Substantial Development or Variation of Service (SDV) - Stage 1 Process	To consider proposals for Stage 1 of a potential SDV, to be considered by the Statutory Scrutiny Officer, Chair and Vice Chair, outside of a formal scrutiny committee meeting.	SMALL, Katie	No	No	Effective and enabling council	No	No
SC/10/24-25	11/12/25	Primary Care / Community Services	To receive an update on the Primary Care Estates Programme from East Cheshire NHS Trust and potential changes to community services across the borough		No	No	Improving Health and Wellbeing	No	No
SC/16/24-25	11/12/25	Cheshire & Merseyside Health Partnership	Following the setting of a number of objectives, how is the partnership meeting the 2		N/A	No	Improving Health and Wellbeing	No	No

			objectives of 'improving population health and health care', and 'tackling health inequalities', — have they been achieved, and what is being done to achieve them?						
SC/17/24-25	11/12/25	Domestic Abuse Related Deaths and Inquests at Coroners Courts	The committee to scrutinise why it can take a significant amount of time for an inquest to be undertaken.	BROOMHALL, Jill	N/A	No	Improving Health and Wellbeing	No	No
SC/06/25-26	11/12/25	Safer Cheshire East Partnership Action Plan / Annual Report	To scrutinise the SCEP Action Plan and Annual Report	CHRISTOPHERSON, Richard	N/A	No	Unlocking prosperity for all	No	No
SC/14/24-25	To be agreed	Right Care, Right Person	Following its implementation, review a year on, the impact it has had on residents and policing across the Cheshire East area.	BROOMHALL, Jill	N/A	No	Improving Health and Wellbeing	No	No
SC/08/2025- 26	To be agreed	Leighton Hospital Expansion	To receive an update on progress and		No	No	Improving health and wellbeing	No	No

		Programme - A&E update from implementation of new	details of new systems implemented in A&E providing online waiting					
SC09/2025- 26	To be agreed	Housing Partners	times To provide details of support provided to residents by Housing Partners on Anti Social Behaviour	No	No	Improving health and wellbeing	No	TBC