Cheshire East Safeguarding Adults Board

Cheshire East SAR Bella

Final Report

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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.

Contents

01. Who is Bella ? 4
02. Introduction 5
03. Scope 6
04. Safeguarding Adults Board SAR Referral 7
05. Their Voice, Our Learning 8
06. Methodology 10
07. Key themes and lines of enquiry 11
08. Parallel investigations 13
09. Professionals involvements 13
10. Synopsis of events pertinent to the review 16
11. Practitioner engagement 19
12. Key messages from the event 21
13. Analysis of practice and findings (with theoretical foundations) 22
14. Summary of learning for the recommendations 29
15. System learning and recommendations 31
16. Conclusion 31

Appendices.

1. References 37
2. Terms of Reference 40
3. Glossary 46

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 2014[1] 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 injury[2].

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 blame[3]. 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 practices[4].

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 multi-agency communication.

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04. Safeguarding Adults Board SAR Referral

Cheshire East Safeguarding Adults Board (CESAB) has a statutory duty[5] 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-neglect[6].

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.

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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, person-centred 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.

📚 **Critical Learning: 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.

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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 [7]to 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.

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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.

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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.

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09. Professionals Involvements

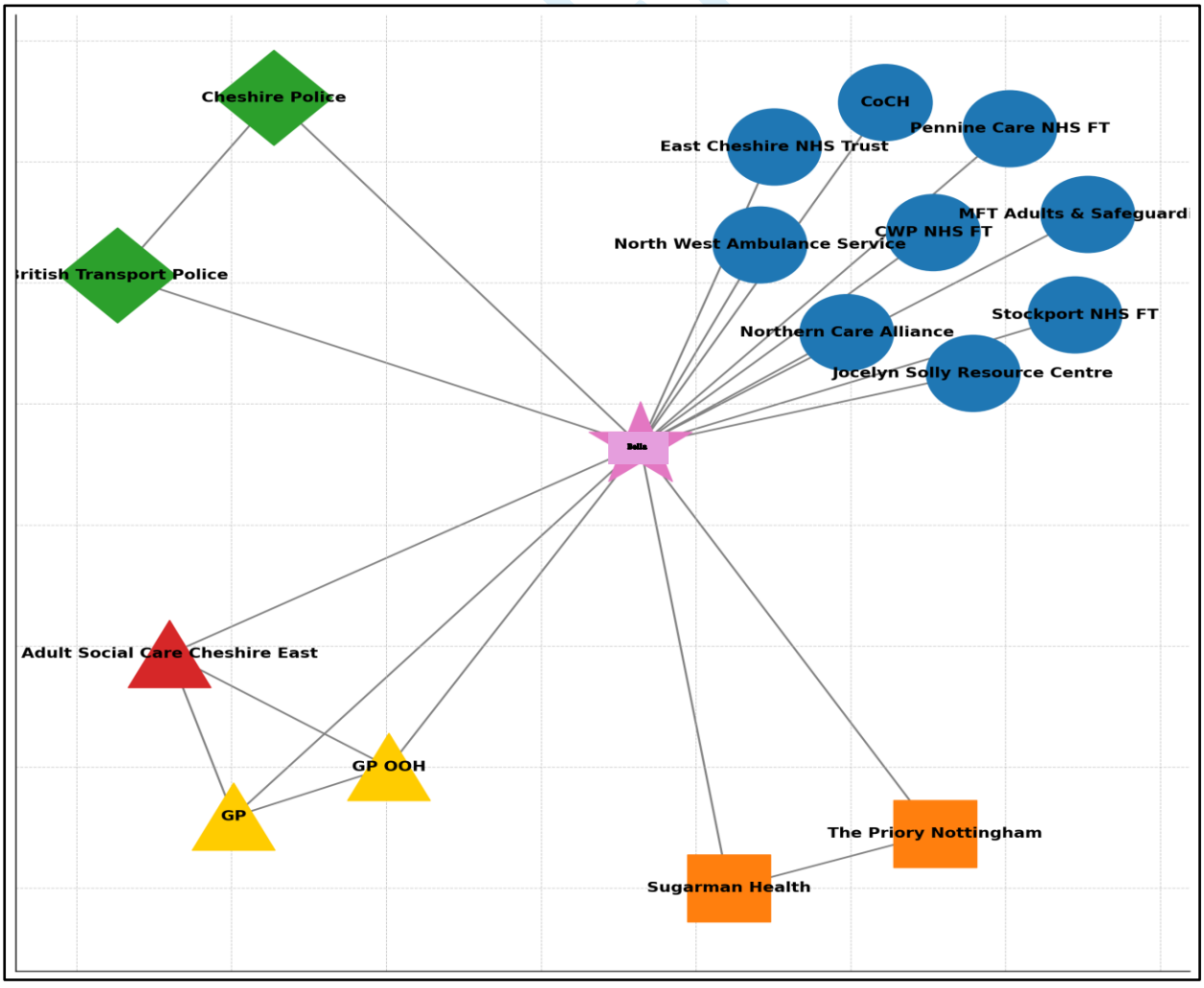
9.1 Involved agencies

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.

[Fig.1]



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.

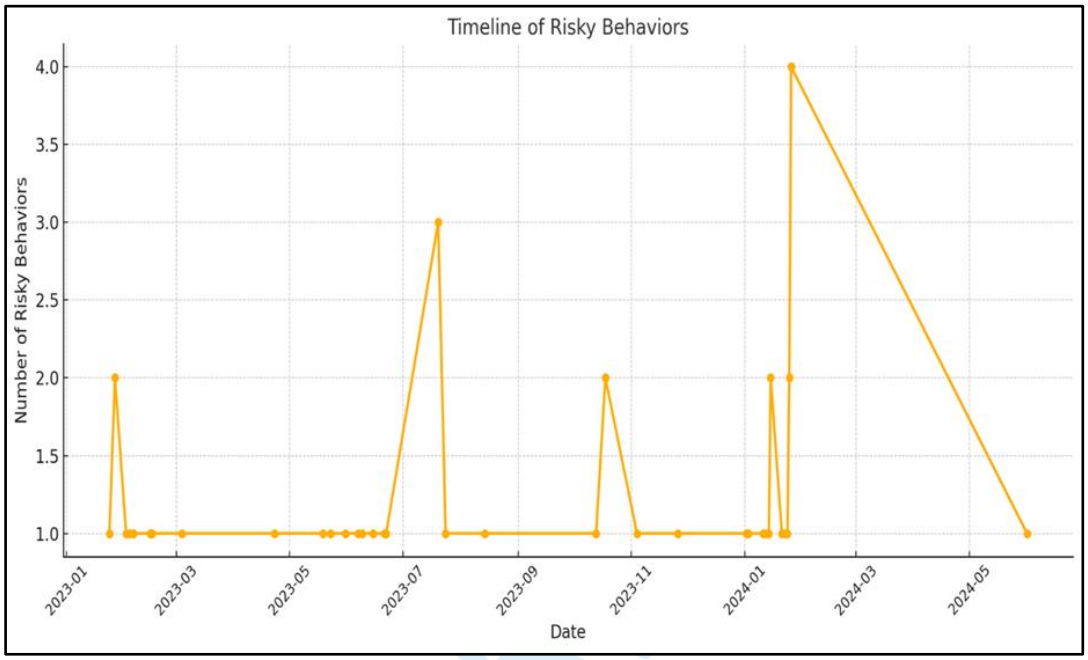
9.3.3 The importance of her dogs in her life has also been a source of difficulty in the past. There have been historical disputes with neighbours regarding the dogs, which have acted as a trigger for Bella, highlighting just how central they are to her sense of security and happiness. This connection 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, person-centered 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:**

📚 **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 person-centered 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:

i. **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.

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

SUMMARY

TABLE 1

Ref	Subject	Initial Findings
I	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 guidance[8] 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 [9]*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, person-centred 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 post-discharge 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	[redacted]
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.

- Assessments by each organisation
- Mental Capacity
- Safeguarding Processes
- Information sharing
- Risk assessment
- 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
BTP	British Transport Police
CESAB	Cheshire East Safeguarding Adults Board
CQC	Care Quality Commission
CoP	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