



Safeguarding Adult Review 'Jane'

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Foreword Contributed by Jane's Family

'Jane'

A much-loved daughter, sister and auntie. Jane was fiercely independent sporty and clever; she excelled at sports representing her school at county level in both hockey and netball. After leaving school she trained as a PE teacher and spent some happy years teaching in private girls' schools. Jane was happiest outdoors and being at one with nature. She loved to walk and climb in the Lake District. She loved all animals and in particular her rescue dog Holly who gave her much comfort. Although Jane struggled in her later years as her mental health declined, she took great interest in her family, it was her desire to return to the North East to be closer to her loved ones.

We choose to remember Jane with deep affection. We think of her big beaming smile and her love of life.

Jane – missed forever

1967 - 2025

1.0 Introduction

1.1 Jane was a white British woman who was 57 years old when she was found deceased in a field near to her home on the 11th of January 2025. Jane's last contact with outside agencies supporting her following her discharge from a mental health hospital ward in December 2024 was 7 days earlier on the 4th of January 2025.

1.2 In September of 2024 Jane was seen by a Mental Health Practitioner from the Primary Care Network¹ (PCN) team, which later came under the Living Well Team from December 2024. At this consultation Jane reported feeling very socially isolated, depressed with very intensive suicidal thoughts, feeling like she had hit 'rock bottom'. Jane disclosed that she was staying in bed for prolonged periods of time and wasn't going out, but she wanted company. She also reported that she had experienced a panic attack when she had recently tried to go to a bus stop. She stated she didn't like where she was living and wanted to move to help her feel less isolated. It was also agreed with Jane that this information would be shared with ASC and that a referral for a package of care would be made. When ASC discussed Jane with the PCN practitioner it was agreed that Jane would be referred again when her mental health had improved after she had agreed to be admitted to hospital.

1.3 From the 22nd of September 2024 to the 5th of December 2024 Jane was admitted to the North ward which is a female mental health ward within the Irwell Unit² on an informal basis³. During her stay Jane was part of weekly Multi-Disciplinary Team (MDT) meetings where her care and treatment were discussed which would be expected practice for someone in hospital on an informal admission. Her discharge home was arranged after a 12-week admission with a care package funded by ASC, she was also referred to the Bury Home Treatment Team⁴ (BH TT) which comes under Pennine Care Foundation Trust (PCFT) for a follow up review on discharge as per process.

1.4 The BH TT saw Jane within 72 hours of discharge from hospital, during this visit she denied any thoughts or plans for self-harm/suicide. As a care package had been agreed by ASC safety planning was discussed and she was provided with support numbers and discharged from the BH TT and transferred back to the care of her GP.

1.5 The concerns for Jane during her informal admission had been listed as being:

- Self - neglect
- Suicidal thoughts
- Anxiety
- Significant depression

¹ PCN team have mental health practitioners who are based in GP practices

² The Irwell Unit is a purpose built adult mental health unit under the management of Pennine Care NHS Foundation Trust

³ An informal admission to a mental health facility means that a person has chosen to enter the facility for treatment of their mental health condition, with their full consent and understanding, and is not being held against their will. <https://www.mind.org.uk>

⁴⁴ The Home Treatment Team provides monitoring the effects of medication, ongoing risk assessment and a mental state examination at each visit. <https://www.penninecare.nhs.uk>

Jane was prescribed Vitamin B3 to treat a niacin deficiency⁵.

1.6 On the 25th of December 2024 North West Ambulance Service (NWAS) were called to Jane's home by Greater Manchester Fire and Rescue Service (GMFRS) following a call reporting that Jane was causing damage to her property, and that a fire had started there after Jane left a candle unattended. NWAS staff spoke with Jane, she was encouraged to speak to the PCFT Helpline about how she was feeling after stating that she was struggling with her mental health. She didn't wish to be taken to the Emergency Department (ED) and was assessed as being low risk for self-harm and suicide by NWAS staff.

1.7 On the 4th of January 2025 Jane's carer met with her at her home address, and they went for a walk together returning to Jane's home address. When they attempted to visit Jane the following day they got no response at her home address, the same outcome happened when the carer called on the 6th and 7th of January 2025. On the 7th the carer rang the Police late morning to raise their concerns and were advised that under the protocol Right Care Right Person⁶ (RCRP) they needed to make further enquiries to find out where Jane might be and were advised to contact the ambulance service. They were also advised that they could contact the Police again if required.

1.8 NWAS attended and requested support from GMFRS to gain access to Jane's property later the same day, she was not at home. The Police were contacted again at 18:19 to inform them that Jane could not be located, as a result a missing person investigation was opened.

1.9 A silver meeting⁷ was held by the Police on the 9th of January 2025, where appropriate discussions were held relating to how Jane might be traced considering the geographical area around her home and if there were places she was known to visit. It was not until the 11th of January 2025 that Jane was tragically found deceased in a field covered in snow, lying under an electric blanket with a bottle of alcohol approximately 2 miles from her home.

2.0 Commissioning of the Safeguarding Adult Review and Key Lines of Enquiry.

2.1 Bury Safeguarding Partnership (BSP) has a statutory duty under the Care Act 2014⁸ to arrange a Safeguarding Adult Review (SAR) involving an adult in its area with care and support needs (whether or not the local authority has been meeting any of those needs) if a – there is reasonable cause for concern about how the Safeguarding Partnership, members of it or other persons with relevant functions worked together to safeguard the adult and b – condition 1 or 2 is met.

- Condition 1 is met if:

⁵ Pellagra is a disease caused by a lack of the vitamin niacin, the most common symptom being inflamed skin <https://bestpractice.bmj.com>

⁶ Right Care Right Person is a nationally adopted operational model used by the Police and partner agencies to ensure that people of all ages who have health and/or social care needs are responded to by the right person, with the right skills, training and experience to best meet their needs <https://www.gov.uk>

⁷ A Police Silver meeting is a tactical command meeting to manage a tactical response to an incident <https://www.college.police.uk>

⁸ Care Act 2014 sections 44 (1), (2) and (3) <https://www.legislation.gov.uk> [Accessed October 2024]

a. the adult has died, and

b. the Safeguarding Partnership knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

2.2 SAR panel members must cooperate in and contribute to the review with a view to identifying the lessons to be learned and applying those lessons in the future. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work both independently and together, to help and protect adults with care and support needs who are at risk of abuse and/or neglect and are unable to protect themselves.

2.3 The initial SAR referral was submitted to Bury Council, by the Designated Nurse for Safeguarding Adults from NHS Greater Manchester Integrated Care Board (ICB) Bury locality on the 16th of January 2025. Screening took place on the 28th of January 2025 to review summaries of partner agencies involvement and to consider the referral. SAR panel members agreed that condition 1 was met and that a statutory SAR was required. The Independent Chair of the BSP agreed to progress the SAR on the 30th of January 2025. The first panel meeting was held on the 26th of March 2025 to discuss panel membership, the key lines of enquiry and methodology to be used.

The screening panel members agreed the following concerns identified as below:

- Care coordination following the hospital discharge decision including Jane's and family's participation.
- Clarity on who was the Lead Professional following the hospital discharge and the step down from mental health services 72 hours after Jane's discharge
- Care package reassessment by ASC
- Communication and information sharing between agencies
- The lack of use of professional curiosity
- The quality of risk assessments and the lack of escalation particularly in relation to non-statutory agencies
- Mental capacity assessments by NWAS, Mental Health Services and ASC
- Agency responses to the incident on the 25th of December 2024 in respect of risk assessment and potential need to escalate
- Agencies understanding of their role in respect of 'safe and well' checks as part of a commissioned care package
- Right Care Right Person and whether the initial contact was actioned in line with the national guidance

2.4 The above became the agreed key lines of enquiry for the SAR and evidence against these provided by agencies was reviewed and the analysis of the evidence was subsequently mapped against the six principles of adult safeguarding: empowerment, prevention, proportionality, protection, partnership and accountability⁹.

⁹ Six Principles of Adult Safeguarding <https://www.scie.org.uk>

2.5 A second panel meeting was held on the 21st of May 2025 to discuss the initial draft report with a practitioner learning event for practitioners and managers held on the 5th of June 2025. A third panel meeting to discuss the second version of the draft report was held on the 27th of June 2025. Final approval of the report by panel members was concluded on the 30th of June 2025.

3.0 Methodology

3.1 The methodology for the review was agreed as being the one most commonly used for SAR's. Agencies were asked to provide a chronology of their contacts with Jane from January 2024 until Jane's sad death in January 2025. Each agency was asked to provide an Individual Management Review (IMR) of their engagement addressing the areas of concern identified above. The IMR's were also required to identified single agency learning and consider multi-agency learning from their perspective as well as any good practice.

3.2 It was agreed that a practitioner learning event would be held face to face with those staff who had had direct contact with Jane to gain an understanding of how care was provided to her using a person-centred approach. Managers were also invited to the event following attendance by their staff to hear what information had been shared.

4.0 Panel Membership

Role	Agency involvement with Jane
Independent Author	
Board Manager	Bury Safeguarding Adults Partnership Board hosted by Bury Council
Assistant Team Manager	Adult Safeguarding Team Bury Council
Designated Nurse Safeguarding Adults	NHS Greater Manchester ICB Bury Locality
Detective Inspector	Serious Case Review Team Greater Manchester Police (GMP)
Safeguarding Practitioner	Northwest Ambulance Service
Prevention Manager	Greater Manchester Fire and Rescue Service (GMFRS)
Safeguarding Families Specialist Practitioner	Pennine Care NHS Foundation Trust (PCFT)
Safeguarding Families Lead	Greater Manchester Mental Health NHS Foundation Trust (GMMH)
Minute Taker	Bury Council

5.0 Equality and Diversity

5.1 Throughout this review process, the panel has considered the issues of equality and diversity. In particular, the 9 protected characteristics under the Equality Act 2010¹⁰. The independent author and panel members agreed that disability should be considered during the SAR process. Jane had recently been discharged from hospital following a voluntary admission to a mental health assessment ward and had a previous diagnosis of Dependent Personality Disorder¹¹. During her inpatient episode Jane also self-identified as a gay woman.

5.2 Jane had been in a stable relationship for approximately 20 years up to 2013 when the relationship became very strained as a result of her being diagnosed with cancer and having treatment for this, at which point the relationship broke down. The independent author and panel members do not find that there was any evidence of discriminatory behaviour by partner agencies in respect of their engagement with Jane and her sexual orientation for the purposes of the review.

6.0 Hindsight Bias

6.1 The independent author and panel members are highly cognisant that the death of Jane has caused distress to both her family and those involved in caring for her. As a panel we have attempted to view this case and its circumstances as it would have been seen by the individuals at the time. It would not be fair to recognise that a review of this type will undoubtedly lend itself to the application of hindsight. Hindsight always highlights what might have been done differently and this potential bias must be guarded against. There is further danger of 'outcome bias' and evaluating the quality of a decision when its outcome is already known. However, the panel and I have made every effort to avoid such an approach wherever possible.

7.0 The Lived Experience of Jane shared by her family and a neighbour in Bury

7.1 The independent author met in person with the 2 sisters of Jane on the 6th of March 2025 to gain an understanding of their sister's life and is very grateful for their input into this review. At this meeting she conveyed hers, and on behalf of the panel members and BSP members their sincere condolences in respect of how Jane had tragically died.

7.2 Jane was born in Gosforth in the North East of England and had 3 siblings, 2 sisters and 1 brother. Following their parents later divorce both parents went on to form other relationships resulting in Jane also having 2 half-brothers. Growing up the children's mother suffered from periods of depression which her sisters felt resulted in their mother not being able to give them the care and attention that might be expected as part of a mother's role when her mental health was poor. They felt that this resulted in Jane having a lasting desire to find someone who could fulfil her need to be 'mothered' into her adulthood.

¹⁰ The Equality Act 2010 <https://www.legislation.gov.uk/ukpga/2010/15/contents> [Accessed March 2025]

¹¹ Dependent personality disorder (DPD) is a long term condition characterized by an excessive need for others to take care of emotional and physical needs <https://www.ncbi.nlm.gov> [Accessed May 2025]

7.3 As a child Jane was a bright student who enjoyed sports, hockey and athletics being her favourites. She left school and went into further education in Bedford where she qualified as a Physical Education (PE) teacher. Jane successfully taught in a number of private girl's schools around the country for the next 10 years. Her sisters felt that following some lasting childhood trauma as a result of their mother's depressive episodes Jane never wanted to live alone. She sought accommodation with other people where she worked who could provide the support she felt she needed. It was during this time that Jane formed a long-term relationship with her female partner, the couple did not become parents themselves.

7.4 In her 30's Jane developed significant back pain and was medically retired from work receiving state benefits to support her everyday life. In 2005 she bought a shared ownership property in which she had a 75% interest, and a local housing association held the remaining 25%.

7.5 In 2013 Jane was diagnosed breast cancer, this diagnosis had a significant impact on both Jane's physical and mental health. On completion of a course of chemotherapy the strain on Jane's relationship with her partner became too much and the couple separated. This was the first time Jane had ever lived alone, and her sisters felt she found this incredibly difficult.

7.6 During her chemotherapy treatment in 2013 Jane found sleep particularly difficult, on one occasion she packed a suitcase and sleeping bag and drove her car up to the moors hoping for a better night's sleep aided by tablets and consumption of a small amount of alcohol. She was reported as a missing person to GMP and was eventually found by Police from West Yorkshire, Jane was conveyed by them to the Irwell Unit in Bury. As a result, she spent 8 weeks sectioned under the Mental Health Act (1983)¹².

7.7 In February 2014 GMP received an allegation of harassment naming Jane as the perpetrator. As a result, Jane was placed under arrest following her release from the Irwell Unit. The outcome of this arrest was that no further action was carried out and Jane was taken back to her home by the Police.

7.8 In 2014 Jane was reported as a missing person again and was located by Police from Cumbria Constabulary. She was transported to a mental health unit in Bury again where she spent a further 8 weeks sectioned under the MHA (1983).

7.9 At the start of the first Covid-19 lockdown on 23rd of March 2020 Jane was further isolated from social contact with others due to the government restrictions. When she was able to Jane joined a local Methodist church and sought pastoral support.

7.10 Jane's family noted that from the time of Covid-19 Jane began to talk in a different tone of voice and also in different languages which was not what they would describe as normal behaviour for their sister. They acknowledged that Jane could sometimes present as having challenging behaviours which some people found difficult to manage. For example, concerns

¹² The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder <https://legislation.gov.uk>

had been raised about Jane's behaviour at the Methodist church for which she received advice from the church's safeguarding officer in September 2021.

7.11 Little more is known by Jane's family of how Jane managed daily life from 2015 until the timeframe of the review, as previously explained family relationships with Jane were distant with little regular contact.

7.12 The independent author interviewed one of Jane's neighbours in Bury, whose contact number had been provided by Jane's family. The neighbour discussed her experience living near Jane, whom she had known since 2017. According to the neighbour, until the first COVID-19 lockdown in March 2020, Jane did not show signs of mental health issues or significant anxiety. The neighbour frequently saw Jane at the bus stop and inferred that Jane was making trips into Bury.

7.13 Jane's neighbour observed that national lockdowns from 2020 increased Jane's social isolation and her behaviour became more erratic. Concerned neighbours reported this to Bury Council's Anti-Social Behaviour team, who requested diaries of Jane's actions for assessment. The neighbour noted Jane often left her front door open at night and screamed for long periods. She also shared that neighbours were aware that Jane had no functioning boiler and that they had discussed collective funding to support Jane in having this replaced.

7.14 The neighbour shared that she was aware that one of the local councillors was also very proactive in trying to get Jane appropriate support in the community. Neighbours felt that Jane did have some mental health challenges but would minimise these to professionals. The independent author is grateful to Jane's neighbour for the reflections on Jane's presentation from 2017 until Jane's very sad death.

8.0 Background information known about Jane by agencies prior to the timeframe of the review.

8.1 PCFT

8.1.1 As identified in the lived experience of Jane at 7.6 and 7.8 Jane had two episodes of care with PCFT. Once in 2013 where Jane was seen by the Access and Crisis service which also became part of the Living Well Team from December 2024 and did not want any further advice or signposting for support. In 2014 a referral was received by the Mentally Vulnerable Offender Panel¹³ (MVOP) Jane had been charged with harassment and appeared in court as a first offence in December 2014. The records demonstrate that Jane engaged well having 24 sessions of Cognitive Behavioural Therapy¹⁴ (CBT) working on anxiety, assertiveness and anger. Her physical health had improved over the course of her therapy, and she was being supported by Macmillan nurses, probation, and her church; she was discharged back to the care of her GP in 2015.

¹³ MVOP is the formal process for information sharing in relation to mentally vulnerable offenders <https://www.gmp.police.gov.uk> [Accessed March 2025]

¹⁴ CBT is a talking therapy that can help people manage their problems by changing the way they think and behave, commonly used to treat anxiety and depression <https://www.nhs.uk> [accessed March 2025]

8.1.2 In March 2022 Jane had a brief involvement with the Bury Access and Crisis Team following a referral by the PCFT mental health practitioner on the joint response car unit God¹⁵.

8.2 Bury Adult Social Care

8.2.1 In May 2023 a local councillor emailed the director of adult care with concerns, a neighbour of Jane's had contacted them about Jane's mental health stating she was known to police for harassing a local shopkeeper, arguing with neighbours and screaming and banging at home during the night. Someone from the Connect and Direct¹⁶ (CAD) Hub within the Council visited Jane who denied and minimised all concerns stating she was fine; she declined support but accepted signposting information. A further visit was made in June 2023 where she was signposted to local groups and advised on how to obtain a bus pass. Jane again said she was fine; no further concerns were noted, and the referral was closed.

8.3 Greater Manchester Police

8.3.1 In 2014 GMP had 5 contacts with Jane following reports by family of her expressing suicidal ideation she denied these on contact sharing that she was struggling following the breakdown of her long-term relationship. In June 2024 Jane was found at a reservoir on 2 occasions the latter resulting in her being taken to hospital under Section 136 of the Mental Health Act (1983)¹⁷ and again in September 2014 following Jane being reported missing by Pennine Care, she had jumped into the same reservoir, was recovered by Police and returned to hospital.

8.3.2 In 2021 there were two further contacts with GMP, her brother contacted Police saying Jane wasn't making any sense when he spoke to her and a further contact reporting that Jane was causing harassment at a local church, an ambulance was called following the first contact and the second contact resulted in a referral to mental health. The referral was sent to the Access and Crisis team who arranged to see Jane, she was found not to be detainable under the MHA (1983) and the referral was subsequently closed.

8.3.3 In 2022 reports were received from Jane's neighbours that she was standing in the middle of the road and appeared to be in a mental health crisis. A Police officer and mental health practitioner attended, no immediate concerns were recorded following discussion with Jane, a referral was made to the Bury Access and Crisis Team as noted at 8.1.2.

9.0 Analysis of Agency Information against the Terms of Reference

¹⁵ The mental health joint response service involves a mental health practitioner and a police officer jointly attending incidents where the person is experiencing a mental health crisis. The incidents are passed to them by GMP call handlers, they respond in a dedicated police vehicle following which the person will be assessed.

¹⁶ CAD is the point of contact with Bury council for advice on Adult Care Services <https://www.theburydirectory.co.uk>

¹⁷ Section 136 is part of the Mental Health Act that gives Police emergency powers if they think you have a mental health disorder and you need immediate help. They can take you or keep you in a place of safety where your mental health will be assessed <https://www.legislation.gov.uk>

9.1. Communication and information sharing between agencies, was it in line with expected practice?

9.1.1 Within the scoping period GMP had eleven recorded incidents involving Jane. Of those ten incidents one was a medical episode, NWS were contacted which was in line with expected practice. Five care plans were submitted by response officers in relation to concerns about Jane's mental health. The care plans were then reviewed by specialist safeguarding officers within the district safeguarding team, as a result four of the care plans prompted referrals to ASC as staff felt the safeguarding threshold had been met.

9.1.2 Following the incident in January 2024 when Jane rang the Police to report unknown people had been entering her property for years and had installed cameras to "spy on her" no referral was made following the completion of a care plan as it was felt there was no immediate concern by the mental health practitioner also in attendance, she also refused consent to information sharing and support from mental health services. The safeguarding officer recorded a detailed rationale into why no referral was made which was in line with expected practice and this review has found no reason to challenge.

9.1.3 There were three incidents where a care plan should have been submitted by police officers following contact with Jane; in March 2024 when a referral was made via the EDT at ASC in June 2024 when neighbours reported concerns about Jane, and in December 2024 when the fire occurred in Jane's home.

9.1.4 GMP's Adult at Risk policy reflects that a care plan is to be submitted following an incident involving a vulnerable adult. Officers are required to use the Vulnerability Assessment Framework to record relevant information about the person and incident which then allows a specialist safeguarding officer to review the incident, assess the risk in consideration with previous reports to determine whether a referral to another agency is required. There is potential that some officers may have the mistaken belief that when another agency is involved, they assume responsibility for making a referral and that a care plan is not required.

9.1.5 ASC had multiple direct interactions with Jane during the review's scoping period. On February the 9th 2024, staff from the Connect and Direct (CAD) hub visited Jane due to concerns about her deteriorating mental health, which was believed to potentially lead to recurrent antisocial behaviour without intervention. Jane declined referrals to her GP and mental health services. While her refusal was respected, this represented a missed opportunity for information sharing and consultation with other professionals. Although Jane might not have engaged with the services if offered, sharing information could have facilitated better coordinated care.

9.1.6 The Access and Crisis Team referred Jane to the BHTT on the 16th of July 2024 due to a deterioration in her mental health, it was reported that she was neglecting herself and was deemed to be vulnerable. The CAD team were unable to contact Jane by telephone and so a letter was sent to her asking her to contact their service. Following this referral Jane was seen for regular home visits to undertake a mental health assessment by a Consultant Psychiatrist. The assessment determined that additional involvement from BHTT would offer social support

for Jane. Additionally, a referral to Women of Worth¹⁸ could facilitate social inclusion, as Jane expressed feelings of social isolation during her assessment. ASC were made aware of the outcome of the assessment and onward referrals as would be expected practice.

9.1.7 After a welfare check on Jane by the Police on the 21st of August 2024, where she reported sleeping poorly, eating and drinking little, not leaving her flat due to external stimuli, experiencing electrical sensations in her head, and wanting to be in hospital for mental protection, the care plan completed by the Police resulted in communication with the CAD hub staff. A safeguarding section 42 enquiry was opened due to evident self-neglect which was not being managed. ASC struggled to establish who was currently supporting Jane in the community and it became clear that there was no plan or lead agency with regards to Jane's mental health. Jane was discussed at a PCFT led living well huddle meeting on the 10th of September 2024 resulting in the CMHT agreeing that someone who knew Jane would call her for a 'check on her'. ASC were not advised on whether contact had been made with Jane and if so what the outcome was. There then followed a report shared with ASC by a practitioner from the Primary Care Network¹⁹ (PCN) team who visited Jane on the 16th of September 2024.

9.1.8 Jane was again referred to the BHTT on the 17th of September 2024 this time by an AMHP from the PCN after concerns about Jane were raised with the Integrated Neighbourhood Team (INT)²⁰. At this time Jane was presenting as being low in mood with very intense suicidal thoughts and evidence of self-neglect, she reported that she had no money for food. A prompt assessment concluded the need for an informal admission to North ward to consider Jane's suicidal thoughts and assess her mental state in a place of safety and to consider options for reducing Jane's self-neglect and to review her diagnosis of Dependent Personality Disorder²¹ (DPD). The assessment referenced that Jane was still socially isolated and had no support following earlier referrals made in July. Jane was being discussed at GP led INT MDT meetings at which the AMHP was present, updates are shared at the next scheduled meeting and not as a result of the meeting's conclusion therefore the social worker may not have been aware of Jane's admission to North ward.

9.1.9 Jane was referred to Women of Worth by the BHTT with wording in the referral that mentioned Bolton which placed her outside their Bury boundary. This postcode was correct but not checked by the Women of Worth who informed the BHTT that Jane was not within their boundary, this information was not corrected and so Jane was never given the opportunity to engage with this service.

9.1.10 On March the 1st 2024, when Jane was experiencing mental health challenges and denying entry to professionals including NWAS, the Police, and a mental health practitioner,

¹⁸ Women of Worth is a unique service in the local community of Bury for women only helping them to become emotionally resilient and more independent. <https://gmwsa.org> [Accessed May 2025]

¹⁹ Primary Care Networks are groups of GP surgeries that work together with other health and care providers to deliver a wide range of services to the local population <https://www.england.nhs.uk>

²⁰ Integrated Neighbourhood Team improves the co-ordination and communication between different health and social care services, ensuring people receive the right care at the right time and place.

²¹ Dependent personality disorder is defined as a very intense and overwhelming need to be cared for often accompanied by fears of being alone <https://www.psychologytoday.com> [Accessed May 2025]

those involved conducted clinical and environmental risk assessments. They agreed that using Section 135 of the MHA (1983)²² was the best approach to gain access and address Jane's mental health needs safely.

9.1.11 The Access and Crisis Team's records reflect that Jane engaged well with this assessment, there was no evidence of any serious mental illness, Jane was able to communicate her understanding of why her neighbours were concerned and why they had called the Police. She could explain why it was dangerous to be in the road and was adamant that she did not want signposting to any other services, she was therefore informed that her GP would be notified of their contact with her, and that she was being handed back to the care of her GP. She was assessed as having the mental capacity to make the decision not to be referred on to other services.

9.1.12 On December the 25th 2024, GMFRS and an NWS paramedic had direct contact with Jane following reports of a fire at her home by her neighbours. She had accidentally started a fire in a bedroom with candles and had caused damage to glass cabinets. Jane refused to go to the ED and seemed agitated. The paramedic contacted the mental health advisor helpline and asked the call handler to speak directly to Jane which they did. On conclusion of this conversation the call handler shared this information with Jane's GP in line with expected practice.

9.1.13 Following the fire at Jane's home on Christmas Day GMFRS policy would be to report any safeguarding concern through their own internal system and then share the referral with ASC. The safeguarding referral threshold was not considered to be met at this time, the concern shared by practitioners was that this was not a safeguarding issue but a concern about Jane's mental health and contact with the mental health services had been made, therefore policy was followed as per expected practice.

9.1.14 Further evidence of appropriate information sharing was provided by NWS who shared information with ASC about Jane's issues with her home environment, following this consultation an early help referral was not felt necessary as the issue with Jane's broken boiler could have been addressed through housing or a social prescribing pathway.

9.1.15 Jane's GP record reflects multiple conversations with her both at face-to-face appointments at the practice and as part of MDT meetings. A review of these demonstrates that information sharing with other agencies where it might have been appropriate to do so wasn't always evident. Examples of this would include when agencies were planning Jane's discharge from hospital and when there were concerns about Jane's presentation over the Christmas and New Year period. Practitioners reflected that it was not standard practice to invite GP's to MDT meetings held by PCFT for inpatients. The hospital discharge summary was typed on the 9th of December 2024, 2 working days after Jane's discharge and sent to the GP which included the follow up plan highlighting the potential risk for self-neglect.

²² Section 135 of the MHA 1983 allows Police to enter a private place like a person's home to allow for an assessment of their mental health.

9.1.16 During her inpatient stay on North ward from September to December 2024 the appropriate teams undertook the required assessments which had triggered Jane's admission. The occupational therapist (OT) completed community reviews of her home environment, functional community living skills – accessing community venues, budgeting skills, social interaction skills, and road safety skills, she was also seen by a physiotherapist. A referral was made to ASC and a social worker allocated to Jane. PCFT staff also contacted the housing and welfare staff at the council to see what support they could offer in relation to a review of Jane's benefits and debt management. Jane was also offered the input from a psychologist but declined this. Contact was made with Jane's siblings in the North East and an aunt and cousin in London.

9.1.17 From October 2024 when Jane was an inpatient on North ward there was good involvement from the OT and the INT social worker when discharge planning was being considered. Jane was visited in person by the social worker while she was on the ward, the social worker attended as many of the MDT meetings as they were able to that were held to plan her discharge. There was professional challenge in an attempt to arrange the most suitable support for Jane when the CMHT felt their input was not required. The social worker felt that Jane should have transferred to the CMHT on discharge from hospital due to her diagnosis of DPD.

9.1.18 The social worker allocated to Jane was not informed of the change in plan by the ward team relating to the support Jane would be offered on discharge, the original plan was that Jane would be supported by the BHTT for 2 weeks post discharge. At some point this was changed to the BHTT providing a single 72-hour home visit which resulted in Jane being discharged from their service with contact information provided. Practitioners from the BHTT reflected that they should have been included in the ward MDT meetings to gain a greater understanding of Jane's presentation and her views.

9.1.19 Jane was referred again to the PCFT Access and Crisis Team three days after her discharge by the Intermediate Care at Home Team²³, the referral was screened and accepted by the PCFT Living Well Team, previously the Access and Crisis Team. As a result, a Senior Mental Health Practitioner (SMHP) contacted the referrer for further information, a telephone screening call was arranged with Jane for the 23rd of December 2024.

9.1.20 The SMHP contacted Jane as agreed on the 23rd of December 2024 and introduced herself and the reason for the referral and telephone call, however Jane stated that she felt unwell and disconnected the call. The practitioner attempted three more calls with Jane that day of which all went to voicemail. A message was left asking Jane to contact the office and book a further appointment for the New Year. This message was followed up by an NHS text message that acknowledged that the call had been discontinued and gave Jane details of helpline contacts. The practitioner tried to speak with Jane over the telephone the following day, but this call also went to voicemail. A letter was also sent advising of helpline contacts

²³ The Intermediate Care at Home Team across Bury provides short term support to help people recover and regain independence after hospital stays or illness, support is offered to assist in activities of daily living

and to repeat the request for Jane to contact the office to book a further appointment all of which would be expected practice. Jane's GP was informed of Jane's lack of engagement with the service which again would have been expected practice. However, the SMHP did not inform Jane's social worker which would be expected by the Trust's information sharing protocol.

9.1.21 Jane's social worker, care provider, and the EDT were not informed of the fire at Jane's home on Christmas Day by any of the agencies that attended at the time. This may have been because one agency thought the other would communicate this information when in fact nobody did. This was a missed opportunity to share important information about how Jane was feeling and if further support could be offered by ASC in increasing the care package with Jane's consent.

9.2 Was the use of professional curiosity evidenced in agencies engagement with Jane? If not, what more could agencies do to embed the value of this?

9.2.1 The review of the care plans submitted by GMP for Jane evidenced that the officers who completed them recorded a large amount of detail regarding Jane's vulnerabilities and mental health struggles. The amount of detail demonstrates that officers spent time engaging with Jane and asking her appropriate questions. Following submission of the care plans to the point of triage by the safeguarding officers there is further evidence that these officers have completed research around what information was held about Jane on police systems from previous incidents to inform their decision making around referral submissions to ASC. This demonstrates officers utilising their professional curiosity at both stages in the interaction relating to Jane; in initial discussions with her and then subsequent searches on police databases.

9.2.2 Jane only had one GP consultation during the scoping period of the review, at this appointment there is evidence of what was a lengthy discussion with Jane regarding her current presentation both physically and mentally, and what may have been contributing to her feeling lonely and isolated. With Jane's informed consent the GP made appropriate referrals to other agencies with a view to obtaining support for her in the community. One of the challenges across primary care is that contact with patients sometimes isn't frequent as in Jane's case, and seeing the same GP at each appointment to build up a better understanding of the person and their history isn't always as achievable in the current climate.

9.2.3 When NWS had contact with Jane there was evidence in the records of their engagement with her that professional curiosity had been applied in both see and treat episodes of care and in face-to-face contacts with Jane. There was evidence that see and treat clinicians within the clinical hub at NWS provided a more in-depth triage with Jane following contacts from Police and prior to dispatch of an ambulance resource. They explored her mental health presentation and her thoughts with her as well as her risk of harm both to herself and to others.

9.2.4 On Christmas Day 2024 documentation supports that attending paramedics explored in detail with Jane her mental health history, her current mood and reasoning for her behaviours.

The information she shared was further discussed with a member of staff on the mental health advisor helpline. Jane engaged well with all the professionals at her home and gave her consent to referrals to supporting services. The electronic patient report form which is completed for every patient contact is detailed around Jane's responses to questions, risks and the response from the specialist mental health services.

9.2.5 Following the review of ASC records it was felt that there were missed opportunities for additional professional curiosity when Jane was minimising the impact her poor mental health was having on her behaviours and manage her home for example in February 2024. What she was saying did not correspond with what information her neighbours were reporting. Her responses could have been challenged further by staff when they had direct contact with her and if they had been aware of her financial struggles. Jane could have been referred to the Staying Well Team within ASC for prevention work in line with the Care Act (2014).

9.2.6 Some missed opportunities were identified in applying further professional curiosity relating Jane declining support with her finances and benefit entitlement as well as support to get her boiler fixed both by the OT at PCFT and the social worker. Jane's reasoning wasn't documented initially in her ASC record and there is no evidence to support her decision making was challenged or discussed with health professionals when it was recorded that she was presenting with unusual behaviours. It is noted however that the social worker did persist in working with Jane to eventually get her boiler repaired 2 weeks later.

9.2.7 During Jane's inpatient episode, one of her sisters mentioned that other family members had been diagnosed with autism, leading to questions about whether Jane might also have autism. This information was duly considered as part of the assessment and formulation process prior to her discharge. The clinician responsible for managing Jane's care evaluated this possibility against her presentation during her inpatient stay and concluded that there were no indications of behaviours suggesting that Jane had autism.

9.2.8 There was evidence in Jane's medical record at PCFT that professional curiosity had been applied to other aspects of Jane's care and treatment. In discussing her sense of social isolation, it was understood that Jane wanted to have closer contact with her family whilst acknowledging that this had been difficult for many years. Staff contacted Jane's sister to try and get a better understanding of why this was and if there was an option for them to agree to supporting Jane to be nearer to them.

9.2.9 As part of her inpatient stay physical health checks were made on Jane which may have been impacting on her health. It was concluded after assessment of Jane that her diagnosis of DPD was evidenced by her struggles with her ability to cope alone at home causing her significant anxiety. Despite these clinicians felt she did not have a psychotic disorder or mental illness that required a formal detention under the MHA (1983). Jane was not willing to be prescribed medication to address her anxiety and demonstrated no reason for staff to question her ability to make this decision.

9.2.10 During her assessments and reviews Jane spoke to staff about feeling worse and that she felt desperate in trying to make sense of her life. She informed staff that she did not want to stay in hospital and that she did not want to go home. Her main concern was that of

loneliness, feeling like she needed company to help her in life and support in making decisions regarding basic household tasks. Despite continued reports from Jane that there were no improvements in her presentation during her hospital stay staff had observed that Jane was eating and sleeping well, appeared to regularly address her personal care needs and engaged socially with others on the ward. When staff attempted to probe with Jane her ability to be capable of more than she thought she could do these were difficult conversations to have with her, she would often decline to engage with any exploration by staff around the reason for this.

9.2.11 Jane was consistent throughout her inpatient episode that she could not cope on her own which was evident on admission from the level of self-neglect she presented with and her anxiety levels. Throughout her stay Jane refused to engage with the ward psychologist on working on reducing her anxiety levels. On ward rounds she was consistent in stating that she had no hope for her future. She refused to complete her OT assessment, however the OT noted that while working with Jane during her stay on North ward she did not appear to have significant deficits in her practical ability, more a lack of confidence in her own abilities, this information was shared with the social worker as part of the discharge planning process. The OT team offered to support Jane in acquiring a new boiler for her home, but she was dismissive of the offer at the time.

9.2.12 The wards housing and welfare lead reviewed Jane's entitlement to benefits, calculating that she should be able to claim more universal credit and could also apply for the Personal Independence Payment (PIP) allowance benefit on discharge. The staff member also supported an application to provide Jane with debt management, however Jane refused to attend the job centre to implement this as she did not feel it was important. Her decision was respected with no evidence of professional curiosity being applied into why Jane did not feel this was important when some of her anxiety was acknowledged as being around her inability to manage her finances.

9.2.13 Jane explained to her social worker on the 6th of December 2024 that she had declined to have the boiler repaired before she was discharged as she felt overwhelmed in hospital and she had declined support with her benefits because she was in receipt of both housing benefit and universal credit. She was able to demonstrate a reasonable rationale for her decision making at that time. The lack of heating in Jane's home was addressed as far as was possible by the social worker who provided a portable heater to allow discharge to go ahead. Following the social workers continued engagement in building up a working relationship with Jane in the following days she eventually agreed to have the boiler repaired which was completed on the 18th of December 2024.

9.3 Risk Assessments, were these completed as expected when there was contact with Jane by agencies? In particular in relation to the incident on Christmas Day and the period of time in January 2025 when Jane was not answering her door or telephone calls?

9.3.1 In September 2024 when Jane was admitted to North ward the PCFT risk assessment tool is completed by all practitioners at initial assessment, subsequent reviews and if new risks

present. The 4-domain tool sits within a wider mental health assessment document alongside additional service review specific templates. These direct practitioners to consider risk factors and compile a risk and safety plan directly with the patient using language that the person would understand. There is evidence that Jane's electronic records that these assessments were applied as part of this process during interview and when she was seen and assessed by the different practitioners within PCFT.

9.3.2 The initial plan for discharge was going to be in November 2024 but was extended as Jane's care package was not in place as a Care Act Assessment had yet to be completed by ASC. Jane's clinical records did not identify a lead professional, North ward staff assumed that her social worker would have taken on this responsibility as she had been involved in her discharge planning, and it was communicated that there was no need for CMHT involvement on discharge.

9.3.3 A referral was made by the ward team to the BHTT this was to conduct a 72-hour post discharge review as per the discharge process, this team were familiar with Jane's needs as they had supported her at home prior to this hospital admission.

9.3.4 Jane's social worker could not attend her final discharge meeting on the 4th of December 2024 but sent an e-mail to the team on North ward confirming that she would attend Jane's home on the 6th of December 2024 with a form of heating and a food parcel following Jane's discharge home on the 5th. Jane's clinical record confirms that her discharge plan was discussed with her, and that there was no reason to question her capacity to understand that her care package would commence on the 6th of December 2024. She also demonstrated an understanding that the BHTT would be supporting her after discharge.

9.3.5 Jane and her sister challenged the professionals at the MDT meetings about Jane's discharge plan, expressing concerns over the perceived risks. They were assured that Jane would not be discharged without support. During telephone contact with Jane's cousin, she also shared the view that Jane should be moved to a placement that provided 24hr support. It was confirmed with family that ASC would provide a daily carer, whose effectiveness would be evaluated once Jane returned home.

9.3.6 GMP are required to complete risk assessments on each contact with a person, on each of the eleven contacts with Jane a risk assessment was completed. These were in the form of THRIVE assessments²⁴ on the logs of contact as well as a grading of the Care Plans (low, medium or high). The missing person report in January 2025 was also risk assessed with the grading reflecting the risk as being high which warranted and received an immediate response in police attendance.

9.3.7 BARDOC²⁵ had contact about Jane on Christmas Day and shared the outcome of this in a consultation letter to the GP surgery. The GP was not aware of the challenges practitioners were having in engaging with Jane in January until after she had been reported missing on the

²⁴ The THRIVE model is a risk assessment framework used by the Police to determine the appropriate police response to a call for service focussing on the level of threat, harm, risk, investigation, vulnerability and engagement

²⁵ BARDOC is the out of hours GP service that covers Bury

7th of January 2025. As a result, they were not part of any risk assessment discussions in the few days leading up to the missing person report. GP surgeries across Bury do not have generic risk assessment tools that they use. They would assess risk to an individual as part of the consultation process and record actions taken as a result.

9.3.8 Jane's last contact with her carer was on the 4th of January 2025, GMP were not contacted until the 7th of January by the carers to report concerns for Jane's safety. This initial call was correctly closed under the RCRP procedure, the caller was advised to attempt to contact neighbours or family who might have heard from Jane and know of her whereabouts. The caller was correctly advised to call again if there was still no further information know about where Jane might be. When the Police were contacted again to inform them that following the Fire Service gaining entry into Jane's home and she was not there a missing persons investigation commenced, this was less than 7 hours from the initial call and prioritised correctly.

9.3.9 The independent author is aware that a multi- agency risk assessment tool has been discussed previously as part of SAR's commissioned in Bury and is being considered following a different review commissioned by Bury. The use of risk assessment tools already in place by individual agencies should clearly detail what the risks are and necessary actions to be taken. The appropriate use of individual risk assessment tools should also allow practitioners who don't have regular contact with people to follow up where actions have been taken and if further action or escalation is needed.

9.3.10 As Jane had accidentally caused a fire at her home on Christmas Day 2024 when lit candles caught clothing in a bedroom GMFRS were present as well as NWAS and the Police. Jane was able to explain to those attending her that the damage she had also caused to glass cabinets in her home was as a result of her frustrations at the lack of contact with her family and that she had chosen to smash the glass as a mechanism to alleviate her negative thoughts rather than by screaming and shouting which she acknowledged would cause alarm to her neighbours. The paramedic called the mental health advisor helpline to seek advice.

9.3.11 The helpline caller advised the paramedic that it was their responsibility to assess the risk Jane posed to both herself and others and indicated that contact with ASC via the Emergency Duty Team (EDT) should be made passing on the telephone number. The call was logged as per the helpline advisor protocol. Those attending Jane concluded that the risk to herself and others was low and that she was able to demonstrate that she had insight into her emotions and the consequence of certain actions. It was agreed by those present with Jane at the time that she did not require sectioning under section 2 of the MHA (1983).²⁶ There was consideration of submitting a safeguarding referral to ASC for Jane following this incident as practitioners at the learning event felt the threshold had not been met, Jane was not being abused by another party, her social isolation resulting in her poor mental health was the priority.

²⁶ Section 2 of the MHA 1983 allows for a person to be admitted to hospital for up to 28 days to assess whether they are suffering from a mental disorder. Ibid

9.3.12 During each phase of all patient contacts NWAS frontline clinicians complete Dynamic Operational Risk Assessments²⁷ (DORA). The risk assessment is continuous and changes as circumstances present. Action is taken to mitigate the identified risk with monitoring and review. On Christmas Day the identified risk was documented as Jane's mental health including low mood which prompted the referral to the mental health crisis team and the conclusion that she did not require further mental health support.

9.3.13 When Jane was discharged from North ward the social worker used the 'Trusted Assessor' pathway by West INT which does not include a dedicated risk assessment. The document used by the social worker does include identification of some of the risks to Jane following decisions she had made during her inpatient stay. These included the risk that she might become homeless as a result of her not managing her finances and not being in receipt of her full benefit entitlement. She was also being discharged home in December with no access to central heating and hot water in her home. The provision of an oil fuelled heater would have provided some warmth however how she was to manage her hygiene needs with no hot water was unresolved due to Jane's inability to agree to support with obtaining a new boiler.

9.3.14 A collaborative risk assessment contributed to by all the MDT members would have evidenced each risk to Jane at point of discharge, what mitigations were able to be put in place and who was responsible for monitoring each of the risks identified. All agencies having a copy of the risk assessment including Jane herself could have assisted in supporting her after discharge from hospital.

9.3.15 Information not known about or discussed as part of the MDT meetings was in relation to Jane's previous history of going missing or the reasonably foreseeable circumstances of Jane not answering her door to carers, as a result this was not factored into the support planning with the care agency who were commissioned to support Jane once she was discharged.

9.3.16 As identified earlier Bury ASC were not contacted by any agency to inform them of the fire at Jane's home on Christmas Day 2024, this was a missed opportunity to come together again as an MDT to assess the current situation, review her care package and identify any new risks to put in place safety plans.

9.3.17 The care agency did not inform ASC about their inability to engage with Jane on the 5th and 6th of January 2025, they did however make attempts to contact her and did call the Police to report their concerns for her safety on the 7th of January when initial advice was to speak to relatives and contact NWAS. When these attempts failed and the fire service managed to gain access to Jane's home confirming she was not there the missing person protocol was applied. The social worker attended Jane's home and spoke with a neighbour to establish

²⁷ DORA used by NWAS involves a continuous process of identifying, assessing and mitigating operational hazards and risks when changing circumstances are evident. It is a proactive approach to ensure safety by adapting to an unfolding situation.

when they had last seen Jane. Throughout this day there were frequent communications between agencies and an acknowledgment of the potential risk to Jane's safety.

9.4 Care co-ordination in discharge planning, was it in line with relevant policies and procedures, was a lead professional identified?

9.4.1 Jane was not under the Care Programme Approach for mental health co-ordination. The INT social worker became her lead professional after the ward and CMHT informed ASC that Jane's increased anxiety was due to loneliness, isolation from her family, and inability to manage her home, rather than specialist mental health needs.

9.4.2 The independent author and panel members were advised that it is not typical for a generic adult social worker to lead on an acute mental health discharge, since they typically fall under secondary mental health services such as CMHT if agreed appropriate. The INT social worker identified that they felt the discharge should be led by CMHT and made a number of attempts to refer Jane to them only for it to be declined for the reasons stated above. There was INT management oversight of this conclusion, it was felt that nothing further could be done to have PCFT act as lead professionals.

9.4.3 In preparation for discharge usual practice would be for a social worker to complete a Care Act assessment when considering a person's needs. Jane's social worker completed a Trusted Assessor pathway instead. This may have been because the social worker allocated to Jane had previously worked in an acute hospital, the Trusted Assessor pathway would have been the one used in this scenario.

9.4.4 Upon reviewing the Trusted Assessor document, it is evident that the social worker adopted a comprehensive approach to Jane's needs. Furthermore, completing a Care Act assessment would not have changed the conclusions reached through the Trusted Assessor pathway, as certain parts of the Care Act assessment would have needed to be completed after Jane had returned home.

9.4.5 Following the social workers challenge that Jane should be under the care of the CMHT and this being rejected the social worker became the lead professional co-ordinating Jane's care. Practitioners across health and social care had mixed views on whether this was appropriate and if lead professional is clearly acknowledged in discharge planning and following discharge when different teams are trying to support an individual.

9.4.6 As a result of the social workers assessment of Jane's needs a care agency were commissioned by ASC to provide Jane with one care call a day mid-morning for one hour to prompt her to engage with washing, dressing, preparing meals and managing her home.

9.4.7 The GP surgery was communicated with by PCFT as part of the discharge planning arrangements. Although as previously noted there is no record of the MDT meeting minutes having been shared with the GP and what the discharge plan had been agreed as being to allow them to understand any risks identified and what agreed actions should be taken in response to a risk becoming 'live'.

9.5 Hospital discharge plans from North ward, was there appropriate involvement of Jane's family, was the discharge plan person centred?

9.5.1 There is clear evidence in the records of both PCFT and ASC that Jane was involved in discussions about her discharge plans and was invited to contribute to the MDT meeting discussions. There is also reference to one of Jane's sisters joining 2 of the MDT meetings over Microsoft Teams. As part of the discharge planning process, it was acknowledged that further assessment of Jane would be needed once she was back at home as at 9.4.4.

9.5.2 During the discharge planning process Jane was informed that she could stay on the ward for further assessment or that she could return home following the assessment of her needs by ASC concluding she could go home with a support package which would be subject to review.

9.5.3 Jane reported being dissatisfied with either the option of remaining on the ward or going home requesting that she needed a third option and asked to live closer to her family. Professionals attending the MDT were aware that Jane had no family members who lived close to her in Bury, she stated that she would like to move back to the North East where she had family. It was explained to Jane the ward could not facilitate this as it was a housing issue and one that they could not arrange as part of her care and treatment. Contact was made with a cousin in London who agreed to come to Bury to support Jane for 2 days in her home after her discharge but due to unanticipated family circumstances the cousin had to retract this offer.

19.5.4 Both Jane and her sister who attended the MDT meetings remotely continued to express their views that Jane would not cope well at home with the support package being proposed, and with the home environment. Jane acknowledged that being on North ward was not the right environment for her and asked at the MDT meeting again if a third option for her discharge could be offered.

9.5.5 Both PCFT and the social worker were aware that Jane was attempting to telephone her family frequently during her inpatient episode, when her calls went unanswered, she made further attempts to call them using other people's telephones in the hope that they would answer the call. The sister who attended the MDT meetings was aware of Jane's expressed desire to return to the North East to be with her family however her family felt unable to offer this option due to the pressure it would put on themselves. Instead, her family actively encouraged Jane to engage with the support offered to her in the Bury area.

9.5.6 The sister who attended two of the MDT meetings requested to be kept informed of further meetings, with her last attendance being on the 20th of November 2024. Despite regular attempts by staff to contact Jane's family, these calls were not always answered. The sister stated she was unaware of Jane's discharge home until a week later when Jane contacted her using a carer's mobile phone. Records held at PCFT indicate that the family was informed of the discharge date. The family also had an expectation that the broken boiler would be repaired before Jane's discharge. Although staff attempted to assist Jane in resolving this issue, she felt unable to manage the repair work prior to her discharge.

9.5.7 As planning for Jane's discharge progressed, she no longer required an inpatient acute psychiatric admission and while she remained anxious, she was able to communicate her views which included that she denied any thoughts of self-harm or suicide and no thoughts of harm to others. There was an acknowledgement of the risk of self-neglect considering Jane's history and anxiety levels but that this would be mitigated against by the care package provided by ASC.

9.5.8 A review of the Trusted Assessor document by ASC concluded that the care package commissioned was not inappropriate given that Jane's support needs appeared minimal, she had required only minimal prompting by ward staff to attend to her self-care and the OT assessment had concluded that support required was also minimal. The assessment reflected that she was also expressing no thoughts of self-harm or suicide. Any increase in the need for support could have been addressed promptly after discharge with support increasing to up to four calls a day if felt necessary.

9.5.9 Jane's GP, social worker, and family were informed about the discharge plan, which identified her needs as being more socially focused in accordance with PCFT policy and procedures. However, Jane's sister was not notified by hospital staff of her discharge from North Ward on December 5th; she only became aware nearly a week later when contacted by the carer.

9.5.10 The discharge plan for Jane did involve both her and a sister in the discussions, up to the point of her discharge while Jane disagreed that the level of support would be sufficient to allow her to cope she accepted that this was the only option being offered to her, and agreed to return home with BHTT providing a follow-up visit on discharge and her care package commissioned by ASC.

9.6 The decision to step down Jane from the BHTT, was this in line with policy? Is there any learning identified by PCFT?

9.6.1 Jane was discharged from North ward on the 5th of December 2024 and was followed up with a visit from the BHTT on the 7th of December, this was within the 72-hour window following discharge under the Department of Health and Social Care's statutory guidance: Discharge from mental health inpatient settings. She was not under the CMHT at the point of discharge for the reasons previously identified. The records from the visit on the 7th confirmed that Jane had no thoughts or plans of self-harm or suicide and that package of care was now in place commissioned by ASC, safety planning was discussed. Jane was provided with support numbers if experiencing a crisis along with a list of community services to consider helping reduce her feelings of social isolation. This was in line with the discharge policy and role of the BHTT.

9.6.2 Practitioners from the BHTT felt that they should have been invited to the MDT meetings to discuss Jane as she had been open to them previously. They felt that the ward decision to change the follow up by the BHTT from 2 weeks of support to a single 72-hour visit would have provided Jane with more support given the views about her discharge that she and her sister were expressing in the MDT meetings.

9.6.3 On the 8th of December 2024 the day after discharge from the BHTT Jane was referred to the PCFT Access and Crisis team by an OT from the Council's Intermediate Care Team who had been supporting delivery of her discharge package. The team screened and forwarded the referral to the Living Well Service in line with their single point of access process. The OT was concerned that Jane was struggling to cope with everyday tasks and had been finding it hard to go on with her life. From this date to the 18th of December ASC tried to obtain a microwave for Jane via a grant application. Jane maintained her view that although physically able to manage mentally she felt overwhelmed at home. She was offered an increase in her support package or alternative accommodation in supported living but informed staff that she "couldn't see the point" and "didn't want strangers around her". There was no indication in ASC records that staff felt that Jane lacked the mental capacity to understand the potential risk of further social isolation as a result of her unwillingness to engage with further offers of support.

9.6.4 Jane was screened to be seen by the living well teams SMHP to assess her mental health and social care needs. Fundamental to this role is the offer of early interventions to reduce referrals to secondary care services such as the CMHT and inpatient admissions and for those clients who do not meet thresholds for CMHT. Records show that the SMHP contacted the OT for further information and a telephone triage appointment was agreed with Jane for the 23rd of December 2024. Despite several attempts the SMHP was unable to engage Jane prior to her sad death.

9.6.5 When contact with Jane was unable to be established on the 23rd of December it is recognised that the living well team are not resourced to proactively undertake a face-to-face visit to establish whether Jane was safe and well. It is not clear from the records whether this service considered requesting a face-to-face check via Police, ASC or confirming with her care provider if she had been seen that day.

9.7 Right Care Right Person (RCRP) – was the agreed process followed? Is there any learning following how the missing person procedure was managed?

9.7.1 RCRP is a national initiative that aims to ensure that people with mental health crises receive the specialised care and support they need from health and social care professionals, rather than potentially facing an inappropriate or ineffective response from the Police.

9.7.2 The initial call to the Police was made at 11:52 am on the 7th of January 2025 by carers who raised concerns that they had not seen or heard from Jane since their last contact with her on the 4th of January 2025. The carers were advised to contact NWAS and to try to establish from family and friends of Jane if they had had any contact with her which is the expected first step of the RCRP pathway. As per procedure a THRIVE assessment was recorded on the Police log and reviewed by an appropriately trained member of staff under RCRP before the log was closed.

9.7.3 Following the call to NWAS on the 7th of January 2025 there is an expectation under the RCRP that NWAS should make telephone calls with known next of kin and hospitals to see if the person can be located. If these enquiries result in no information being established, then

the Police would be contacted to allow them to make the decision on whether a missing person alert is created.

9.7.4 The Concern for Welfare Guidelines have been produced in response to the Home Office Right Care Right Person National Partnership Agreement. These guidelines are applied when it is known or confirmed that someone is in a specified location or at a specified address. Under RCRP NWAS are unable to send a resource to an address without confirmation.

9.7.5 On the 7th of January at 14:46 during a further 999 call was made to GMP, care staff stated they had already made extensive efforts to contact Jane, which practitioners at the learning event confirmed. The carer believed Jane was home but unable or unwilling to answer the door. NWAS escalated the concern for welfare, GMFRS facilitated a forced entry into Jane's home, found her absent, this was then appropriately escalated to the Police, following the RCRP pathway.

9.7.6 The Missing Persons investigation that then commenced on the 7th of January 2025 was properly managed in accordance with GMP policy. A detailed update was provided by the officer submitting the report and this was then reviewed by a Sergeant. On being escalated to high risk a review by a detective from the Criminal Investigation Department (CID) was completed. Throughout the investigation several actions were identified and progressed with appropriate command oversight by a response Sergeant. In addition, 33 hours following the report a Silver Command Meeting²⁸ was held to ensure GMP District Senior Leadership and governance in the search for Jane.

9.7.7 Following carers being advised by the Police to make further attempts to contact Jane or see if any agency had had contact with her on the 5th and 6th of January the GP surgery were not contacted to confirm whether they had had any contact with Jane over the two days, neither were her family. When the practice was made aware on the 7th of January 2025 that Jane was formally recorded as a missing person they tried themselves to contact Jane to offer her an appointment for a review which went unanswered.

9.8 Care Act assessments of Jane and how this translated to her care package being commissioned, was her care plan person centred?

9.8.1 As previously noted a Care Act assessment was not completed by the social worker neither did Jane have a typical care plan under the act. The Trusted Assessor discharge process was followed, the support plan as a result of completing this assessment was shared with the care agency who were going to be supporting Jane outlining what tasks to complete when they visited.

9.8.2 A review of the support plan by ASC concluded that it was task orientated and did not appear to have been written in a way that suggested it was written in collaboration with Jane, therefore not person centred. It was written based on the evidence of her practical care needs

²⁸ A 'Silver Meeting' refers to a meeting within the Police command structure used when managing a major incident or operation, specifically at tactical level. <https://www.college.police.uk>

as determined by the ward staff and therapists with no formal consideration of her social or emotional needs.

9.8.3 When a Trusted Assessor discharge is arranged a Care Act assessment and support plan are then completed at a later date in the community. Sadly, in this instance this had not yet been completed by the time of Jane's death. The time frame set is within 6 to 8 weeks and as a result the review was not overdue at the time of Jane's death. The social worker initially attempted to arrange a reablement care package, the difference being that while providing care reablement staff are also assessing needs for equipment and working towards independence before determining the longer-term care package needed at the end of their six-week involvement.

9.8.4 The reablement team declined the referral multiple times due to there being no pathway in place for reablement to pick up acute mental health discharges, there were no rehabilitation needs from a physical perspective, Jane's needs were in relation to her levels of anxiety impacting on her mental health. Despite the level of anxiety was having on her mental health the Intermediate Care at Home Service agreed to put in place the support from the care agency as a step down from an acute hospital admission which had the added benefit of therapist follow up at home as in Jane's case an OT.

9.8.5 Unfortunately, when the OT did contact Jane when she was back at home, she appeared to be mentally unwell again and unable to participate in the therapy assessment. The therapist referred Jane back to mental health services on the 8th of December 2024. When the therapist visited Jane on the 13th of December 2024 Jane was still unable to engage and was erratic and repetitive in her comments and behaviours. The therapist felt unable to support Jane and that she needed input from her social worker and the mental health team.

9.8.6 Following a review of note of concern placed on Jane's social care record by the therapist her social worker spoke with Jane, and agencies for an update on the 16th of December and visited Jane on the 18th of December 2024. It was recorded that Jane was waiting to be reviewed by the SMHP from PCFT and therefore her care package remained unchanged. From this time until her death Jane was only being supported by the care agency and a non-mental health social worker. When she was contacted via telephone on the 23rd of December by the SMHP she was unable to participate in an assessment and had been unable to participate in the therapy assessment by the OT at her home on the 13th of December 2024.

9.9 Recording of capacity assessments – were these completed on a formal capacity template as per policy for your agency?

9.9.1 Jane was seen on one occasion during the scoping period of the review by a GP in August 2024. At this appointment the documentation clearly indicates that Jane appeared distressed. It is noted that she voiced numerous areas of concern relating to her housing situation including the risk of her being made homeless. She stated that she felt socially isolated, was struggling to manage her home and that her boiler was broken so she had no heating or hot water. She informed the GP that she was waiting on contact from the Women of Worth charity who she understood would offer her some support.

9.9.2 During this consultation Jane gave the GP no indication that she couldn't engage coherently in conversation about how she was feeling. The consultation did not require Jane to make any specific decisions about her care or referrals to other agencies for support, it was a review and conversation about her mental health. As a result of the consultation no changes were suggested to Jane about the current support she had, and no formal capacity assessment was felt necessary.

9.9.3 As a result of her inpatient stay on North ward PCFT records refer to Jane as having the mental capacity to engage in a meaningful way in relation to her assessments and discharge offer within her clinical care record. Staff are expected to use the Trust mental capacity assessment template for any decision that a patient's presentation might suggest that they have an impairment of the functioning of the brain identified of which there were none identified in this case. There was no indication that Jane's capacity levels were considered to fluctuate or that her executive functioning²⁹ in relation to her capacity were an issue.

9.9.4 When NWS clinicians attend a person who they believe may lack the mental capacity to make an informed decision about their care or treatment they also use a template to record their assessment of the individual within the electronic patient report form. The template prompts the clinician to record the steps they have taken to support the patient to make an informed decision as well as why there is reason to believe their capacity is in doubt such as evidence of an acquired brain injury, dementia or a significant learning disability.

9.9.5 Following an assessment of capacity if this is found to be lacking at the time the decision needs to be made the clinician is required to complete a best interest determination in parallel with what the options available are and if the person has any advance decision to refuse treatment or there is an LPA in place. Options available to NWS are to transport the patient to hospital, for the patient to remain at home or to place with community care. Clinicians are required to choose the option that is proportionate to the risk, and the least restrictive option. Following a review of Jane's record on the occasions that clinicians did engage face to face with Jane assessments of her mental capacity were recorded in line with NWS policy and procedures.

9.9.6 NWS also utilise an assessment tool called BASIC STEP which is embedded in the electronic patient report form which supports assessment of a person's mental health presentation alongside their physical health. This consists of a series of short questions around behaviour, appearance, speech, insight and cognition. The assessment moves on to review the patients' thoughts emotional state and perceptual disturbances all of which are recorded to ensure a holistic assessment is completed.

9.9.7 A review of Jane's record held by ASC does not evidence that Jane had any formal mental capacity assessments documented when staff had direct contact with her. There is no reference to staff recording anything in relation to Jane's capacity in relation to any decisions that she needed to make such as returning home when there was evidence in her record from the 11th of November 2024 that during these discussions Jane was unable to focus on the

²⁹ Executive functioning refers to the mental processes and cognitive skills that allow individuals to plan, execute, and monitor their thoughts and behaviours to achieve goals.

conversation, was speaking in what appeared to be a made up language and put herself in a squatting position on the floor. She was unable to give coherent responses to the questions she was being asked and was unable to expand her thoughts about returning home.

9.9.8 There is no evidence that Jane's capacity to manage her finances without support was assessed against a background of the potential for her to be made homeless if she couldn't manage her bills. It was known that she had no functioning boiler and therefore no access to heating and hot water in her property and she had lost a significant amount of weight prior to her admission which were all potential flags indicating someone's inability to care for themselves without a significant amount of support. Jane's responses to many of the questions she was asked was documented as 'Mmmm' despite the social workers attempts to obtain a more definitive response from Jane.

9.9.9 The above demonstrates that there was a missed opportunity to assess Jane's mental capacity in relation to discharge planning, and also her ability to manage her finances. There was no contact with Jane's family to check if they held any Lasting Power of Attorney (LPA) for Jane which would have involved them in decision making. The Council could also have applied for a Court Appointed Deputyship to manage Jane's finances or a Department of Work and Pensions (DWP) appointee as an interim measure with the potential to resolve some of Jane's stressors about her financial situation and her risk of homelessness. Practitioners reflected that the length of time both options take typically between 2-6 months meant that neither would have been in place prior to Jane's discharge from North ward.

9.10 What was the care provider required to do in respect of 'safe and well' checks following the care package being commissioned – is there any learning for ASC and the care provider?

9.10.1 Following the completion of the Trusted Assessor document this was sent to brokerage at Bury Council for them to source a care provider to support Jane following her discharge from North ward. The commissioned provider was to support Jane once a day for an hour at mid-morning using a single carer.

9.10.2 The tasks required of the carer were to ensure that Jane was safe and well, and gain insight into her personal functioning within her own home environment. The record does not expand on how this was to be done or what to do if Jane was not 'safe and well' on arrival. The carer was to encourage and support Jane with all aspects of personal care and dressing to ensure her appearance and hygiene needs were being met, encouraging her to make sure she had clean clothes to wear. In relation to addressing her weight loss the carer was required to promote Jane's independence and confidence with meeting and maintaining nutritional intake.

9.10.3 A review of the support plan as concluded at point 9.8.2 does not evidence that it was formulated with Jane and that she contributed to it, agreeing what support her required. There was no documented action that the carers were to take in contacting ASC if Jane was not engaging with her support plan or was not home when the carer attended.

9.10.4 There is no record to evidence that Jane was not engaging with the carer each day from the point of her discharge to the contact with the Police on the 7th of January 2025. Managers at the practitioner learning event reflected that they would not expect a care provider to contact them on each occasion that they had not been able to engage with a person they were commissioned to provide support to. It would be up to the care provider themselves to decide at what point they needed to inform ASC of any 'prolonged no contact', no protocol appears to have been in place.

9.10.5 The care agency could have alerted ASC to the fact that they had not been able to engage with Jane on the 5th and 6th of January 2025, the 5th was a Sunday there is an out of hours service at ASC that the carer could have notified. They could also have contacted the Police sooner than the 7th of January however the response would have been the same, that they should attempt to contact any friends and family known to the person and contact NWS as per the RCRP protocol.

9.10.6 The care agency staff could not have reasonably foreseen that Jane was at risk of something so tragic given the level of information that was shared with them about Jane's previous history.

10.0 Findings

10.1 Was Jane's hospital discharge aligned with the Department of Health and Social Care's statutory guidance: discharge from mental health inpatient settings?

10.1.1 On the 26th of January 2024, the Department of Health and Social Care published Statutory guidance: discharge from mental health inpatient settings.³⁰ The guidance provides eight key principles for how NHS bodies and councils should work together for effective discharge planning from all mental health inpatient services (Appendix 2). Principle 1 states that 'Individuals should be regarded as partners in their own care throughout the discharge process and their autonomy should be respected'.

10.1.2 The framework for achieving excellence in mental health discharge consists of three main components:

- Essential system partnerships
- Language and frameworks
- Pathways, based on the discharge to assess (D2A) model.

³⁰ <https://www.gov.uk/government/publications/discharge-from-mental-health-inpatient-settings/discharge-from-mental-health-inpatient-settings> [Accessed April 2025]

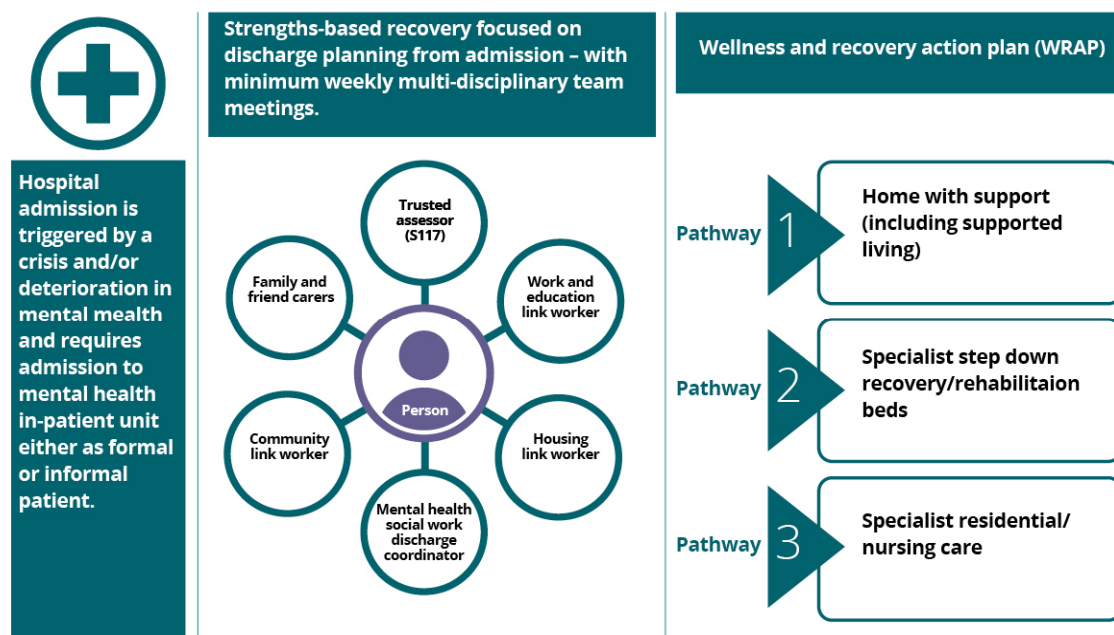


Figure 1. Local Government Association: A framework for achieving excellence in mental health discharge

10.1.3 Having correct system partners is essential to ensure excellence in discharge from mental health settings to evidence that the individual is receiving holistic support from correct partners and ensuring patient safety in risk management utilising effective communication and collaboration between partners. Collaborative working upholds ethical standards in patient care, ensuring that patients' rights and preferences are respected. Providing support networks through community partnerships enhances a person's ability to cope and thrive post discharge.

10.1. 4 Achieving excellence in person centred discharge from inpatient mental health settings requires practitioners to have a good understanding of both the legal and practice frameworks that need to be considered. These relate both to the process of discharge planning and the statutory considerations that are specific to the Mental Health Act 1983, the Mental Capacity Act 2005³¹ and the Care Act 2014.

10.1.5 It is not clear whether Jane had a discharge plan that would fulfil the requirement of a Wellness and Recovery Action Plan³² (WRAP). As part of her discharge planning process best practice is identified as being the person, families and relevant professionals given notice of a decision to discharge at least 48 hours prior to person's discharge from a mental health

³¹ MCA: Care planning, involvement and person centred care (SCIE)
<https://www.scie.org.uk/mca/practice/care-planning/person-centred-care> [Accessed April 2025]

³² What is WRAP? – Wellness Recovery Action Plan
<https://www.wellnessrecoveryactionplan.com/what-is-wrap> [Accessed April 2025]

setting. No follow up MDT was planned and the principles of personalised care and self - advocacy do not appear to have been fulfilled.

The completion of the WRAP which should have been completed with the person and those involved in their care and support in the community, and the WRAP risk assessment should be shared with the person, family/carer and relevant professionals including the GP. A follow-up meeting 72 hours post discharge with the person should also be scheduled. Jane was reviewed by the BHTT within this timeframe.

The five key concepts that are core of WRAP are defined as being:

- Hope: the belief that we can get well, stay well and go on to fulfil our dreams and goals
- Personal responsibility: it is up to each of us to act and do what needs to be done to stay well
- Education: learning all we can about what we are experiencing helps us make good decisions about all parts of our lives
- Self-advocacy: reaching out to others and expressing our needs helps us get what we need, want and deserve to support our wellness and recovery
- Support: receiving support from others, and giving support, will help us feel better and enhance our quality of life

Jane's hospital discharge followed pathway one in the earlier schematic, she was discharged home with a package of support. After being discharged concerns were raised about Jane's ability to cope with managing her care needs. Improved communication between agencies may have provided the opportunity to come together as an MDT to re-evaluate Jane's care and support needs prior to her sad death.

10.2. Findings following the Six Principles of Safeguarding aligned with Jane's care both in the community and in hospital from January 2024 to January 2025

10.2.1 Empowerment – Jane's voice was sought, but she was not supported effectively enough to act on her expressed wishes

The report finds that generally Jane's views were sought by those supporting her for the timeframe of the review. When staff were trying to establish how she was feeling, how this translated to her behaviours to inform risks to both her and to others there is evidence of conversations with her in records held by agencies engaged with Jane.

Prior to her admission to North ward Jane was seen by her GP and was actively involved in decisions about her ongoing care. When Police were called out to see her in 2024 following concerns being raised by people about her mental health, again appropriate conversations were had with Jane and onward referrals to other agencies made with her informed consent. When care plans were submitted these were subsequently reviewed by safeguarding professionals within the Police service and onward referrals made to other agencies.

Jane would demonstrate a willingness to support a referral, but this did not always translate to her subsequently engaging with the service when it was offered. Appropriate signposting, written and verbal information was shared with Jane to allow her to reflect on the service

provision offered and if she later felt she was able to engage with this she had the information she would need to contact these services. Of note is the referral to Women of Worth that Jane consented to to try and engage Jane in social activities, this is a female only service and was appropriate to offer to Jane given her sexuality in the hope that it would give her the confidence to engage with it. Sadly, as noted at point 9.1.9 the incorrect mention of Bolton was not actioned following the referral and so Women of Worth had no contact with Jane.

Jane's mental health was assessed in the community by appropriate mental health practitioners during contact with her in the community in 2024. There was no suggestion that during these contacts that Jane's mental health had deteriorated to such an extent that she required formal admission under section 2 of the MHA (1983). She stated her wish to remain in her own home and her decisions were respected.

During her inpatient stay on North ward she had numerous assessments completed by various clinicians including psychiatrist, OT and physiotherapist. She was taken to her own home by the OT to assess how she would be able to manage to care for herself on discharge. Jane was actively encouraged to participate in the assessment. The outcome of the assessment did not indicate a need for 24-hour care, on the ward Jane demonstrated to staff that she was able to address her own care needs and was able to prepare food and was eating and drinking better than when she had been at home. Her physiotherapy assessment did not identify that Jane required any mobility aids to support her return home, she was given exercises to do to support her ability to remain independent.

Assessment of her mental health acknowledged that she had a diagnosis of DPD however clinicians concluded that her mental health needs were not significant enough to require CMHT input for her discharge planning and future management in the community. The CMHT advised ASC that Jane's needs were social in nature and not as a result of severe and enduring mental health needs.

Discharge planning involved Jane and one of her sisters who supported her in expressing her view on her discharge from North ward, the report finds that Jane did not want to return home and requested a third option to return to the North East to be closer to her family, however this option was not in gift of the statutory agencies to achieve for her.

10.2.2 Prevention – Risk factors were known but systems failed to prevent deterioration after discharge

As noted earlier appropriate risk assessments and agreed management plans were put in place for Jane following concerns being raised about her behaviours which had the potential to pose risks to herself.

The social worker who completed the Trusted Assessor document prior to Jane's discharge from North ward was aware of the reasons for Jane's admission, self-neglect, weight loss, anxiety, significant depression and suicidal thoughts.

During the discharge planning process, the social worker did challenge the CMHT about their lack of involvement following Jane's discharge given the reason for admission being significant depression and suicidal thoughts and a diagnosis of DPD. The challenge was not accepted on

the basis that the CMHT's view was that Jane's presentation was down to her social stressors at home and her feelings of social isolation. As identified earlier the social worker was not informed by the ward team of the change in plan post discharge regarding the length of follow up by the BHTT.

Following completion of the Trusted Assessor form ASC commissioned a package of care for Jane as previously identified. It reflected that Jane had no physical care needs or physical rehabilitation potential. The care package would be reviewed once Jane had returned home and could have been stepped up quickly to additional calls a day if there was enough evidence that Jane was not managing with the support she had in place. ASC received no reports from the care agency alerting them to the fact that the support package was not sufficient in December 2024 prior to being informed that Jane could not be located by the carer on the 7th of January 2025.

It is recognised that Jane was discharged home in December 2024 to her home which had no central heating and no hot water due to her boiler not working. An attempt had been made by the OT when she was in hospital to support her in addressing this, however at the time Jane was unwilling to take up this opportunity. To mitigate this the social worker provided an oil filled radiator and a food package for Jane at home until her care package began and she received support with meal preparation.

Jane informed the ward team that she had no credit on her mobile phone and no landline at home, limiting her to receiving calls only. After discharge, she needed to contact services once they reached out to her, but she did not respond. This risk was not addressed before discharge, which practitioners noted as a missed opportunity, though there was uncertainty about who should have taken responsibility for addressing this.

10.2.3 Proportionality – Alternative options (e.g supported living) were not sufficiently explored based on Jane's circumstances

As part of the discharge planning process both Jane and her sister expressed their views repeatedly that Jane would not cope on her own at home with the level of support that was being suggested. Staff acknowledged Jane's request for a third option of moving back to the North East to be closer to her family but was advised that required communication with her family and their support to achieve.

The review has considered whether an alternative option of a step-down placement with 24hour support could have been offered to Jane. The majority of step-down placements in Bury are provided for people with intermediate care and/or physical rehabilitation and typically cater but not exclusively to the older population with problems such as recovery from fractures, major surgery or strokes. It would have been unlikely that Jane would have been accepted for such a placement given her level of assessed need. The current providers of such placements do not cover mental health provision. This was confirmed by managers attending the learning event.

Bury also provides supported schemes that typically support those over the age of sixty-five, these are single occupancy properties with warden support available but not twenty-four

hours a day. There are mental health supported living residential care providers in Bury however the threshold for this type of accommodation was not felt to be met by Jane by either the social worker or PCFT staff. The assessment of Jane was that she required some support, she had a home to return to and would be reviewed by agencies following her discharge home.

10.2.4 Protection – Systems failed to re-engage Jane despite early warning signs post discharge

As identified in the earlier headings Jane was offered support according to the assessments undertaken with her over the time frame of the review. Her family were involved in discussions about her care and treatment and represented her view about her discharge home during the MDT meetings that they were able to join.

There had been discussions with Jane and a cousin who had initially agreed to stay with Jane and support her initial discharge home, the cousin however had to step away from this offer due to an unforeseen family commitment that prevented them from staying in Bury with Jane. ASC were never made aware of this potential plan by a relative to support Jane on discharge.

Staff attending the practitioner learning event discussed the missed opportunity to come together as an MDT following the discharge of Jane from the BHTT 72 hours after discharge and the intermediate care OT raising their concerns in relation to Jane's inability to cope at home less than a week after her discharge from North ward. The lack of leadership in convening an MDT was in part felt to be the pressures on staff due to the demand for services and a lack of understanding of who the lead professional was.

10.2.5 Partnership – Multi-agency contacts were made but lacked coordinated oversight or follow-up

The review has demonstrated that a number of agencies reported their concerns about Jane to appropriate professionals. Security staff in Rochdale reported their concerns to the Police about Jane in July 2024 following concerns about her behaviours to themselves and members of the public.

The INT and PCN staff alerted professionals to their concerns about Jane in September 2024 when she informed the INT that she had no money for food and demonstrated evidence of self-neglect. It was this alert that resulted in Jane's informal admission to North ward.

There were a variety of difference commissioned services and teams supporting Jane during the timeframe of the review. Her ability to engage with them was inconsistent and difficult for staff to manage. Jane would not always answer her mobile telephone or had no credit on it to be able to contact support services and statutory agencies potentially at times when she may have been better able to use the support in a meaningful way. Attempts had been made to support Jane with managing her finances and receiving all the benefits she was entitled to allowing her to live a more comfortable life and manage some of the stressors lack of money was causing her. Jane declined these opportunities of support and there is no evidence shared for the purposes of the review that staff felt that Jane did not have the mental capacity to

make what to others may seem to be an 'unwise decision' under the MCA (2005).³³ It was only following the social workers engagement with Jane and building up trust after her discharge from North ward that she consented to support with having the boiler repaired and applying for further financial support.

10.2.6 Accountability – Referrals were made but no agency took ownership of the growing risk picture

There were a number of referrals made to ASC by the Police following the submission of care plans following checks by the forces safeguarding officers. None of these led to formal section 42 enquiries under safeguarding procedures as they were in relation to Jane's behaviours and her mental health with no indication of unmet care needs or self-neglect. The concerns were noted appropriately and closed on the understanding that Jane had arranged support in place provided by suitable agencies. The first care plan from the Police that indicated evidence of self-neglect was received on the 20th of August 2024 responded to appropriately by ASC who liaised with mental health services.

11.0 Good Practice

11.1 Bury ASC

11.1 The social worker allocated to Jane was an experienced member of staff who managed to work with Jane in supporting her to have a replacement boiler enabling her to have the ability to heat her home and have hot water in December 2024.

11.2 The social worker used her professional judgement in raising a challenge to PCFT in respect of the lack of CMHT involvement with Jane during her discharge planning from North ward in December 2024. While it is acknowledged that this challenge was rejected on the basis that Jane's needs were social and linked to her levels of anxiety about her ability to manage at home it was appropriate for the social worker to have challenged this given that she had a diagnosis of DPD which the social worker had been made aware of.

11.3 The social worker sought agreement with PCFT to delay the discharge of Jane from North ward until further assessment of her needs could be made and a support package put in place.

11.4 The referrals made to ASC by the Police were actioned to alternative agencies appropriately to provide Jane with suitable support to meet her needs and explore presenting behaviours.

11.2 GMFRS

11.2.1 A fire safety assessment was undertaken at Jane's home on Christmas Day, an additional smoke alarm was fitted to the hallway of her property and other smoke alarms were checked.

11.3 NWAS

³³ Principle 3 of the MCA (2005) Making a decision that others could disagree with does not mean the person lacks the capacity to make their own decision. <https://www.scie.org.uk>

11.3.1 NWAS staff followed their MCA policy correctly in their contacts with Jane.

11.4 PCFT

11.4.1 In July 2024 the BHTT offered Jane social support which is not a routine offer but one that was felt would support Jane whilst other referrals were being actioned.

11.4.2 Jane's mental capacity was assessed informally in September 2024, confirming she could consent to an informal admission to North ward as the least restrictive option. The MCA policy was correctly applied.

11.4.3 On the 8th of December when the referral was received by PCFT further information was sought from the referring agency to aid the assessment of Jane later that month.

11.4.4 On Christmas Day 2024 the PCFT Mental Health Advisor Helpline staff were called by NWAS following Jane causing damage to her home and appearing to be struggling with her mental health. The call handler spoke directly to Jane which was outside of the expected remit of this service when calls are made to it by professionals, there is a separate number for clients to contact.

12.0 Learning as a result of this Safeguarding Adult Review

12.1 Bury Council

12.1.1 Since their engagement with Jane Bury Council have newly recruited a Head of Learning Disabilities, Mental Health and Autism Lead. This post has created stronger links for teams to raise concerns if they feel someone has mental health needs, but they are not being effectively managed. The Council also recognises that further training relating to embedding professional curiosity would benefit practice. Further training dates have been planned to commence in April 2025.

12.1.2 Commissioning contracts with care agencies lacked guidelines on missed visits, relying on unmonitored agency policies. After a contract review prompted by this SAR, the Commissioning Team will now require customized policies for individual needs, verified during quality reviews. This example will be discussed at a future forum for learning.

12.1.3 The BSP Manager provided Women of Worth with the link to the government postcode mapper, advising them to verify the postcode on referrals. This was correct on the referral made to the service by BHTT, despite the referral mentioning Bolton rather than Bury.

12.2 GMP

12.2.1 The Adult at Risk Policy is available across the Force intranet. Communication around the requirement to submit a care plan where a person presents with mental health related concerns has been circulated via Chief Constable orders. In the December 2024 Vulnerability Practice Board meeting district Superintendents were reminded about the necessity to submit care plans for vulnerable adult incidents. In addition, the Strategic Mental Health Lead for GMP has been consulted with, and the non-compliance with the referral policy of care plans is being addressed with local SLT's to offer guidance to the districts on best practice. Training

around reviewing care plans and the submission of appropriate referrals to safeguarding agencies is undertaken on a regular basis to support officers new to the safeguarding teams.

12.2.2 When Police had contact with Jane in September 2024 following Jane ringing to speak to an officer the call handler on this occasion did not complete research on Jane's history which may have changed the THRIVE risk assessment. Since this time RCRP has been implemented across GMP and within the policy it notes that research is completed as part of the procedure. GMP recognises that RCRP is still a new process about which communication to Force staff continues to be circulated.

12.2.3 GMP recognises the importance of professional curiosity in their daily work, within the Force Organisational Learning further training on professional curiosity was circulated on the 3rd of March 2025, this information provided a number of training dates that staff could book onto.

13.0 Conclusions

13.1 Following a survey in 2017 undertaken by Mind highlighting mental health discharge planning problems came as 'no surprise'³⁴ Mind's chief executive stated that "Leaving hospital and coming home can be daunting - you need to feel prepared and confident that you will cope". Jane supported by her sister repeatedly stated to staff that she would not cope when she was discharged home.

13.2 More locally an independent review of Greater Manchester Mental Health NHS Foundation Trust³⁵ in January 2024 found that patient centred care was defined as the provision of care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions. The NHS Long Term Plan³⁶ commits to making personalised care 'business as usual'

13.3 The report finds that Jane was provided with assurances that she would not be returning to the same situation she had been in when she was admitted, ASC had agreed to fund support for her when she went home. The review finds that the support of one hour once a day was not sufficient to prevent Jane's mental health from declining and her anxiety increasing evidenced by the episode three days after discharge when she was referred to the PCFT Access and Crisis Team following discharge from the BHTT the day before. There was no communication between the BHTT and the Access and Crisis Team or consideration of agencies coming together as part of an MDT to establish what more if anything could be done to support and engage Jane. The referral was screened and an appointment made to speak to Jane two weeks later.

13.3 Maintaining contact with Jane was difficult for practitioners, Jane only had a mobile telephone which due to her poor management of finances she often did not have credit on. This resulted in her being able to answer calls if she felt able to, but not always make calls for

³⁴<https://www.communitycare.co.uk/2017/12/08/survey-highlighting-mental-health-discharge-planning-problems-surprise-experts-say/>

³⁵<https://www.england.nhs.uk>

³⁶<https://www.longtermplan.nhs.uk>

support when she might have felt more able to do so. As a result, agencies were left with no option but to write to Jane offering her the opportunity to contact them. Practitioners discussed whether it was possible to provide free phone lines to key public sector services such as social care and mental health for people in similar circumstances to Jane.

13.4 At the practitioner learning event staff attending felt that agencies have to rely on telephone contact with people and aren't resourced to seek face to face contact. There is heavy reliance on a person being able to contact support services once a telephone message is left for them or a letter from an agency is received. Practitioners felt that this is sometimes unrealistic for vulnerable people as in Jane's case and the default if no contact is made is to refer back to the persons' GP. Limitations on what agencies could provide was acknowledged.

13.5 Staff attending the practitioner learning event from the BHTT picked up the above point and felt that had there been a professionals meeting convened prior to Jane's discharge from North ward this potentially could have resulted in better post discharge co-ordination. Their team are resourced to provide follow up visits and had they been made aware of the concerns by the INT staff in the days post Jane's discharge they could have gone out and sought to review how she was managing. The ward team changed the plan to refer to the BHTT for 2 weeks support to a 72-hour follow-up visit again this would have provided greater support to Jane as this service is funded for proactive case management.

13.6 Despite Jane being referred to and discussed by multiple teams e.g. CAD, INT, BHTT, Access and Crisis and the Living Well Team there was no clear lead professional, or agency held responsible for overseeing the increasing risk of further breakdown in Jane's mental health and her care co-ordination.

13.6 The Local Government Association set out in its 'A framework for achieving excellence in mental health discharge document' the national context stating:

'Across the country the challenges with mental health discharge processes are multifaceted and can be attributed to several systemic issues. These issues were clearly defined during December 2022 to March 2023 as a result of NHS England Discharge Challenge for Mental Health and Community Service'³⁷ The key themes emerging were summarised as:

- Increased demand/acuity
- Lack of suitable housing or accommodation
- More patients being admitted at point of crisis
- High staff turnover and vacancies#
- A culture of risk aversion
- Community capacity/increasing caseloads
- Inconsistent discharge planning processes
- Funding disputes between NHS and councils
- Information and data

³⁷ <https://www.england.nhs.uk/long-read/discharge-challenge-for-mental-health-and-community-services-providers> [Accessed May 2025]

13.7 While the report does not find that all of these factors had an impact on the care Jane received the plans for her discharge could have been more patient centred with a strengthening of the evidence of her mental capacity to make decisions. When trying to work with Jane it was difficult to get her to focus for long enough on conversations to allow staff to assess her capacity but there is a lack of evidence to suggest that this was attempted. The long-promised reform to the Mental Health Act aims to give people detained under it as much involvement as possible in their own discharge planning.

13.8 The Parliamentary and Health Service Ombudsman in the foreword of their report Discharge from mental health care: making it safe and patient-centred³⁸ published in February 2024 stated that *'It is right that we recognise and pay tribute to the overwhelming majority of hard working professionals who are committed to delivering care for those who most need it on a daily basis in spite of huge pressures. The failings we see in my Office's mental health casework are symptomatic of services that have lacked the necessary political prioritisation and real will for change. The lack of traction in bringing about reform to the Mental Health Act is a testament to this. It is something the Government must address as a priority if it wants to prove it is committed to making vast improvements for people using mental health services.'*

13.9 The BSP members should consider whether the findings from this SAR provide a satisfactory level of assurance that Jane's care and treatment was in line with the DHSC's statutory hospital discharge and community support guidance and where improvements can be made develops and action plan to address this.

13.10 The BSP members should consider whether the findings from this SAR provide satisfactory level of assurance that Jane's care and treatment demonstrates good practice against the six principles of adult safeguarding.

14.0 Questions to the BSP

1. Should the delays to the publication of the reforms to the Mental Health Act be something that the BSP chair discusses with the National Network for Chairs of Adult Safeguarding Boards to agree if there is any leverage they can bring to bear on government to advance the legislation?
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2. How will the BSP receive assurance that the DHSC statutory hospital discharge and community support guidance is being embedded across health and social care in Bury?
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3. There were some missed opportunities to formally record Jane's mental capacity to make decisions when practitioners were engaging with her when she was behaving in a way that suggested she lacked capacity. Principle 1 the presumption of capacity was relied upon rather than being tested. How can agencies provide assurance that capacity is being tested when it would be appropriate to do so?
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³⁸ <https://www.ombudsman.org.uk> [Accessed May 2025]

4. Are the BSP members assured that the care and treatment Jane received was aligned with the six principles of safeguarding, if not how will this be addressed via an action plan?
5. Practitioners at the learning event acknowledged that there are multiple teams working across Bury to support people with their mental health, practitioners at the learning event felt that clearer information is required. What steps can be taken to assure the BSP that staff working across Bury know which team to refer to and who would be a lead professional for someone's care if more than one team were supporting?
6. There were opportunities for practitioners to have requested an MDT when Jane was discharged from North ward and was being referred back into support services. How does the BSP encourage its partner agencies to promote the value of MDT's to bring practitioners together to share concerns?
7. There were some occasions when practitioners did not make referrals for Jane to other agencies possibly on the basis that they presumed other partners would make the referral. How can agencies provide assurances to the BSP this finding will be addressed accepting that 2 referrals for the same concern are preferable to no referral?

Appendix 1

Abridged Combined Chronology from January 2024 to 11th January 2025

Date and Agency	Contact	Outcome
08.01.2024 GP	Letter from GMMH relapse of paranoia about people being in her house.	Discussed with MH nurse, had mental capacity, advised to refer back to Access and Crisis team.
20.01.2024 Police, GMMH and NWAS	Police report Jane believed to be having a mental health episode. Stated people had put cameras up in her home and there were listening devices.	Police and MH worker attended home address and could find no evidence of any devices. No thoughts of self-harm identified, Jane stated she did not want a referral to MH services, stated she was lonely and had no contact with her family. A Care Plan was submitted as medium risk due to history. Call triaged as category 3 response. Clinician attempted to contact Jane on 3 occasions. Contact made with GMP who advised that Jane had been seen by a MH Nurse and GP was to refer to Access and Crisis team.
09.02.2024 CAD Bury ASC	Visit by CAD worker following referral from councillor after neighbour complaints	Jane declined onward referrals to mental health and to see her GP.
16.02.2024 GMP and NWAS	Jane had contacted the Police to report her home was being bugged and items stolen. Police contacted NWAS with concern for welfare and mental health.	Call triaged appropriately, Jane was spoken to directly, no suicidal ideation or intent to self-harm. Ambulance response stood down appropriately.
26.02.2024 GMP	Neighbour reported to Police that Jane was threatening to kill residents.	Jane spoken to directly, she reported that the neighbours made a lot of noise which had a negative impact on her mental health. Spoken to by a MH Nurse, referral made to MH team. Crime recorded as no further action as neighbour did not support further action. Care plan submitted
01.03.2024 GMP, GMMH and NWAS	Neighbour reported Jane was playing loud music and smashing up her home and walking into the road.	Police and MH Nurse attended, followed by NWAS Jane stated her home was bugged, nurse made a MH referral. It was agreed that a MHA assessment was required but this was not urgent as she wasn't a risk to others or herself.

02.06.2024 GMP	Neighbour reported to Police that Jane was playing loud music and shouting overnight.	Police attended and spoke to Jane who identified no concerns about her mental health, no further action taken.
06.07.2024 GMP	Police contacted by security staff in Rochdale informing them Jane was being aggressive towards members of the public and to them.	Police attended and spoke with Jane she explained she was working for spirits and was a voice for God. No concerns were raised that Jane was a risk to herself or others, she was taken home by police officers and a care plan was submitted and triaged by a specialist safeguarding officer who made a referral to ASC
08.07.2024 GMP and NWAS	Neighbour of Jane rung the police reporting that she was shouting in slamming about in her property they could hear her state pretend to be dead or I'll kill you. Jane had put stickers on her window about being bugged and said she was a donkey.	NWAS were called and attended Jane's home and attempted to speak with Jane directly due to mental health concerns but these were unsuccessful. Neighbour advised that they didn't think Jane would respond but might do in the morning. A care plan was submitted and triaged by specialist safeguarding officers and a referral was made to ASC.
09.07.2024 NWAS and ASC	ASC received referral and NWAS and Police attended Jane's home.	ASC contacted Access and Crisis team who confirmed they had sent Jane an appointment for the 14 th . Police and NWAS felt that there was insufficient justification to force entry when Jane did not answer the door but could be heard in the property.
10.07.2024 Irwell Valley	Contact made with housing to report antisocial behaviour reports about Jane and the lack of functioning boiler, resulting in no heating or hot water for 6 months.	Housing advised that the boiler repair was the responsibility of the homeowner under the shared ownership scheme.
12.07.2024 GMP	Police attended Jane after reports that she was walking around waving a stick saying she was a faith healer.	Police took Jane home a mental health practitioner was contacted who confirmed Jane had an appointment with the service for the following day. A care plan was submitted and triaged by specialist safeguarding officers a further referral was made to ASC.
16.07.2024 BHTT and ASC	Referred to the service by the Access and Crisis team due to a deterioration in her mental health.	Jane had regular visits by the team and was discharged on the 28th of July 2024. She was agreeable to further referrals for some social support on discharge from the service Jane denied any thoughts or plans of suicide. It was noted she failed to attend her appointment with the Access and Crisis team

		on the 14 th July. During the intervention by the home treatment team ASC were informed of the BHTT involvement and closed the referral made to them.
24.07.2024 ASC	BHTT contacted ASC to request a social care assessment, Jane was struggling with day-to-day tasks and managing finances.	Staff attempted to contact Jane 4 times with no response to voicemails, a letter was sent out to ask her to contact them for assessment.
20.08.2024 GMP, CMHT and ASC	Call made to Police about Jane struggling with caring for herself and her poor mental health.	Jane was spoken to directly and shared that she was worried she may lose her home as her benefits had been stopped. A care plan was submitted, referrals were made to ASC and MH services. CMHT visited and referred back to the BHTT. ASC asked to support with tenancy related issues.
27.08.2024 GP	Seen by GP, Jane reported poor sleeping, struggling to manage her home, boiler broken resulting in cold showers, at risk of being made homeless, awaiting contact from Women of Worth for issues with social isolation.	Needs a social care assessment, Jane not clinically depressed or suicidal, note she has been discharged from the BHTT. Has had sleeping tablets in the past, advised to take no more than 4/5 a week. GP advised that the referral to the staying well support officer was declined as Jane was open to CAD. They would refer if they felt their team could support once CAD involvement ends.
05.09.2024 GP, ASC, BHTT	MDT meeting called to discuss concerns about Jane made by neighbours, safeguarding referral logged relating to self-neglect.	Jane not thought to be psychotic but suffering from loneliness which is presenting as behavioural problems. Jane agreed to admission on a voluntary basis to North Ward to assess her mental health. Safeguarding enquiry closed, BHTT confirmed they would support on discharge. Jane informed to contact ASC when medically fit for care act assessment if required.
11.09.2024 GP CMHT	Jane reviewed by AMHP from the CMHT	Issues with bus pass and universal credit addressed by AMHP. Issues of loneliness and unable to manage her home discussed again. Plan for a joint home visit to assess mental health needs, and possible assessment by ASC. Social prescribing discussed but Jane felt she needed support to access this and would not attend on her own.
13.09.2024 ASC	Councillor emailed the EDT after receiving an e-mail from Jane's neighbour raising concerns about her	EDT checked their records and concerns were already noted from the 11 th of September. CAD hub notified.

	not eating, losing weight, no fridge as she thinks it is bugged, boiler is broken and she seems mentally unwell.	
16.09.2024 AMHP and GP	Home visit took place	Refer to BHTT due to risks to self of harm and vulnerability. Reviewed by the BHTT the next day and request made for inpatient bed.
22.09.2024	Jane admitted to North Ward under the care of PCFT.	Discharged from the BHTT while an inpatient. Remained on North Ward until discharged home on the 5 th of December 2024. MDT meetings had been part of Jane's management plan reablement care package applied for but rejected 4 times. Step down care package of 1 call a day agreed with intermediate care therapy to support to ensure safe and well, encourage personal care, dietary intake and management of laundry and cleaning the property. Aim to observe how Jane manages at home. Occupational therapist visited Jane's home during her inpatient episode referral made to intermediate care occupational therapist on discharge. Oil radiator and food package provided on discharge. Jane declined boiler being fixed or benefits review.
07.12.2024	Jane seen by the BHTT following discharge from North Ward	Jane denied any thoughts or plans of self-harm/suicide. It was confirmed that ASC had provided a package of care and safety planning was discussed with telephone numbers provided.
11.12.2024 Irwell Valley Housing	Telephone call from Jane to request help with an internal leak in her property and to fix the broken boiler	Jane advised that the company do not cover these repairs under the shared ownership agreement, it is her responsibility to manage.
17.12.2024 Primary Care MH practitioner and Bury Living Well Team	Jane was referred to the Primary Care MH practitioner. The Bury Intermediate Care at Home team referred Jane to PCFT access team who screened the referral and passed her to the PCFT Living Well team.	Contact was made with Jane via telephone to explain their service, during the call Jane stated she felt unwell and disconnected the call. The practitioner made 3 repeat attempts to call Jane back all went to voicemail. A message was left asking her to book a face-to-face appointment. The practitioner rang the following day and again got no response and left a message. A letter was also posted out advising on helpline contacts and to ring the office to book a further appointment. GP made aware.

25.12.2024 GMP, GMFRS and NWS	Fire service called out to a fire at Jane's home following clothing in a bedroom accidentally catching fire after candles had been lit.	Fire service completed a fire safety check and fitted a smoke alarm to the hallway, other areas already had working smoke alarms fitted. Police and NWS contacted due to person inside the property at the time and reports of the mental distress of Jane resulting in her causing other damage to her home. Fire not thought to be deliberate, no accelerants found within the property. NWS completed a MCA assessment and felt Jane had capacity to understand the risks of her actions. Referral made to ASC and the mental health crisis team after Jane stated she wanted to remain at home.
07.01.2025 ASC and Irwell Valley Housing NWS, GMFRS and GMP	ASC contacted Irwell Valley Housing to report there had been no contact with Jane and were unable to gain access to the property.	ASC advised to contact the Police. ASC contacted Police and NWS, NWS unable to gain entry so GMFRS contacted. Access to the property established, Jane not at home. Evidence of the fire damage from Christmas Day being partially tidied. Carers hadn't been able to make contact with Jane since the 4 th of January.
08.01.2025 ASC	Safeguarding Team at Bury west received a safeguarding referral from the care agency reporting that Jane was missing and what subsequent actions had been taken.	The referral was not about self-neglect or abuse of Jane so no further screening required by the team. The commissioning team could have been informed due to the delay in the carers not being able to see or contact Jane since the 4 th of January.

Appendix 2

Statutory Mental Health Hospital Discharge Guidance

On 26 January 2024, the Department of Health and Social Care published [Statutory guidance: discharge from mental health inpatient settings](#). The guidance provides eight key principles for how NHS bodies (including NHS trusts, NHS foundation trusts and integrated care boards (ICBs)) and councils should work together for effective discharge planning from all mental health inpatient services:

- **Principle 1: Individuals should be regarded as partners in their own care throughout the discharge process and their choice and autonomy should be respected.**
- **Principle 2: Carers should be involved in the discharge process as early as possible.**
- **Principle 3: Discharge planning should start on admission or before and should take place throughout the time the person is in hospital.**
- **Principle 4: Health and council social care partners should support people to be discharged in a timely and safe way as soon as they are clinically ready to leave hospital.**
- **Principle 5: There should be ongoing communication between hospital teams and community services involved in onward care during the admission and post-discharge.**
- **Principle 6: Information should be shared effectively across relevant health and care teams and organisations across the system to support the best outcomes for the person.**
- **Principle 7: Local areas should build an infrastructure that supports safe and timely discharge, ensuring the right individualised support can be provided post-discharge.**
- **Principle 8: Funding mechanisms for discharge should be agreed to achieve the best outcomes for people and their chosen carers and should align with existing statutory duties.**

These eight key principles are woven throughout the framework for achieving excellence in mental health discharge. <https://www.gov.uk/government/publications/discharge-from-mental-health-inpatient-settings>