Worcestershire Safeguarding Adults Board
Serious Case Review: The Care and Treatment of Adult TT whilst detained under the Mental Health Act

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1. Introduction

1.1 TT is a young man with a diagnosis of a learning disability and autistic spectrum disorder, with challenging behaviours. In April 2012 he was admitted to Greenways Assessment and Treatment Centre in Cheshire East under the Mental Health Act 1983 and subsequently detained there subject to Section 3 of that Act.

1.2 In July 2013, he was placed in Wast Hills Independent Hospital in Worcestershire. The hospital placement was commissioned by the NHS Vale Royal Clinical Commissioning Group in Cheshire where TT's family reside.

1.3 When TT's hospital placement at Wast Hills commenced, the provider of care and treatment at the hospital was Castlebeck Care in Administration. Castlebeck Care had gone into administration in March 2013. The viability of Castlebeck Care as a company had been adversely affected by the abuse revealed at their Winterbourne View Hospital in 2011. Danshell became the service provider at Wast Hills from September 2013.

1.4 At the time TT was placed, and throughout the entirety of his hospital placement, Wast Hills Hospital was subject to Large Scale Investigation procedures by Worcestershire County Council (WCC) due to significant concerns about the quality of care and treatment provided. Neither the commissioners of TT's hospital placement nor the parents of TT were aware of the Large Scale Investigation at the time TT was placed at Wast Hills. TT's parents say that it is extremely troubling that the Large Scale Investigation was not disclosed to them.

1.5 TT's hospital placement at Wast Hills completely broke down on 3rd March 2014. TT's challenging behaviour led to almost continual restraint involving large numbers of staff. The situation was one of significant risk to TT, the Wast Hills Staff and other service users at Wast Hills. Rapid tranquilisation had been attempted, but TT's agitation continued.

1.6 The police were summoned on the morning of 3rd March 2014 and declined to provide assistance on the basis that TT was already detained under the Mental Health Act. When contacted again in the early evening of the same day, the police arrested TT. Although this is contested, the police state that on this second visit to Wast Hills, they were advised by staff that TT had the mental capacity to be held accountable for injuries sustained by staff whilst attempting to restrain him. TT was then conveyed in restraints to Kidderminster Police Station. After obtaining medical advice that TT was not fit to be detained, he was returned to Wast Hills at around 4am on 4th March 2014 in the absence of any psychiatric beds.

1.7 It did not prove possible to find an alternative hospital placement for TT until 6th March 2014 when he was transferred to Recovery First in Widnes, Cheshire. During the period following his return from police cells on 4th March until his transfer from Wast Hills two days later, TT's extremely challenging behaviour and the lengthy periods of restraint continued.

1.8 On the first day of the crisis, 3rd March 2014, TT's responsible clinician – WH Consultant Psychiatrist - decided to remove his diagnosis of learning disability and autism spectrum disorder. The process by which TT's diagnosis was removed had begun earlier but the report which formalised the decision was written on 3rd March 2014.

1.9 It is undoubtedly an understatement to say that the events briefly described above caused significant distress to TT and his family.

1.10 A number of concerns were raised as a result of the breakdown of TT's hospital placement at Wast Hills. With the exception of allegations of assault made by and against TT, which were investigated as criminal matters by the police, the concerns arising from the case were initially dealt with under WCC Adult Protection procedures.

1.11 However on 23rd September 2014, the chair of the Adult Protection process - WCC Advanced Professional for Adult Protection -referred TT's case for consideration of a Serious Case Review (SCR) by Worcestershire Safeguarding Adults Board (WSAB) on grounds which included the appropriateness of TT's hospital placement at Wast Hills, lack of action taken by the placing authority until the crisis occurred, the removal of TT's diagnosis, the difficulty in finding TT an alternative hospital placement and information sharing about findings from other relevant investigations. She took the view that many of the issues raised fell outside the remit of the Adult Protection process.

1.12 Also in September 2014 Cheshire West and Chester (CW&C) Safeguarding Adults Board referred TT's case for consideration of a review at a lower level than a SCR by WSAB, specifically raising concerns about "cross borough" multi-agency working.

1.13 On 16th January 2015 the Independent Chair of WSAB wrote to TT's mother stating that whilst "the level of care TT received at Wast Hills was unacceptably poor" and that "clearly there were serious failings", she concluded that the criteria for undertaking a SCR had not been met.

1.14 On 15th February 2015 the CW&C Council Strategic Director of Adult Social Care and Health made a "formal re-referral" to WSAB for consideration of an SCR on the grounds of removal of TT's diagnosis and consequent treatment by the police of TT as an adult with capacity, concerns arising from the WCC Large Scale Investigation not being shared with the placing authority or family by the provider (then Castlebeck in Administration), and as WCC "had made no new hospital placements" then Wast Hills should have been suspending all new hospital placements.

1.15 On 17th March 2015 Irwin Mitchell Solicitors, instructed by TT's mother, who is also TT's litigation friend, wrote to WCC to advise that they intended to seek judicial review of the decision taken by WSAB not to conduct a SCR.

1.16 On 26th March 2015 WCC wrote to Irwin Mitchell to advise them that WSAB would review the decision not to hold a SCR and would establish a new SCR Sub Group for that purpose.

1.17 On 31st March 2015 WSAB decided to commission a SCR. As the Care Act 2014, which put Safeguarding Adult Boards on a statutory basis for the first time and provided statutory guidance on Safeguarding Adults Reviews, did not come into force until 1st April 2015, this SCR was therefore conducted in accordance with the WSAB SCR protocol which preceded the Care Act 2014. The process by which the SCR was conducted is shown at Appendix A.

1.18 In May 2015 WSAB commissioned David Mellor to be the independent author of the SCR overview report and independent chair of the SCR Panel established to oversee the preparation of the SCR overview report. (Membership of the SCR Panel is shown at Appendix B) David Mellor has never been employed by any agency in Worcestershire or Cheshire West and Chester. He is a retired chief police officer and currently is an independent chair of a safeguarding children board and a safeguarding adults board in the North West of England.

2. Terms of Reference

2.1 An SCR Panel was appointed to oversee the completion of the SCR. At the first Panel meeting on 11th May 2015 the scope of the SCR and terms of reference were drafted. TT's parents and their legal advisors were consulted on both the scope and the terms of reference prior to their finalisation.

2.2 At the second meeting of the Panel on 11th July 2015, it was decided to extend the terms of reference to include the period TT was detained under the Mental Health Act at Greenways Assessment and Treatment Centre in Macclesfield. Again the parents of TT were fully consulted.

Scope:

The scope of the SCR will be from April 2012. This is the month in which TT was first detained under the Mental Health Act at Greenways Assessment and Treatment Unit.

The critical incident involving TT concluded on 6th March 2014. The scope of the SCR will therefore conclude on 6th March 2014 although the progress and outcome of all investigations of events which took place during TT's stay at Wast Hills, or which formed part of the critical incident, will be within scope of the SCR.

Terms of Reference

1. The decision to detain TT under the Mental Health Act and place him in Greenways Assessment and Treatment Unit in Macclesfield. What led to the decision to detain TT under the Mental Health Act? How appropriate was the assessment, treatment and care of TT whilst TT was placed at Greenways?

2. The decision to commission a place for TT at Wast Hills: Was the hospital placement appropriate? How was the decision taken? Was all relevant information shared with all parties? Were sufficient efforts made to source an in-county hospital placement for TT including a bespoke package of individualised care? If no such efforts were made - why not? If any efforts were made, were they appropriate?

3. Worcestershire County Council's "Large Scale Investigation" of Wast Hills: When did this begin? What prompted it? What was the outcome? Is there a report on the investigation? Was there a point at which hospital placements to Wast Hills were suspended? If so, when was any suspension lifted? Were the commissioners of TT's hospital placement made aware of the Large Scale Investigation when TT was placed at Wast Hills or at any time during his hospital placement at Wast Hills? How was the suspension communicated to commissioners both locally and nationally?

4. How effectively was TT's hospital placement monitored and reviewed by the placing authority? How did the placing authority respond to any concerns raised by Wast Hills that TT's placement at the hospital was breaking down?

5. How appropriate was the assessment and treatment received by TT whilst at Wast Hills? Were any effective steps taken to monitor and assess the effectiveness of the therapy and treatment that TT was receiving?

6. How appropriate was the decision to move TT from the Lodge to the main hospital building at Wast Hills in December 2013?

7. The diagnosis of TT: Autism and Learning Disability diagnoses were "removed" whilst TT was placed in Wast Hills. What was the justification for this decision? Should this have triggered a review of detention under Section 3 of the Mental Health Act?

8. Was there compliance with the Mental Capacity Act? Did TT have capacity? Was this assessed?

9. How was TT's family involved in key decisions about the care of TT? How were concerns raised by TT's family and third parties (in particular in relation to the use of medication, the use of restraint, the decision to transfer TT to the main house and TT's segregation) addressed?

10. Did TT have access to an advocate whilst at Wast Hills? Why was access to Wast Hills denied to TT's Independent Social Worker who was employed by the family to monitor the effectiveness of TT's hospital placement?

11. The provider's escalation policies: How did the provider raise and escalate concerns which arose from the hospital placement of TT at Wast Hills? How effectively did the provider direct and support their staff in this regard?

12. The critical incident from 3rd – 6th March 2014: What appear to be the triggers for the critical incident? Was the use of restraint by the provider's staff at West Hills and by the police appropriate and in accordance with law and policy? Was the action taken by the police in response to requests for assistance from Wast Hills appropriate? How appropriate was the information provided to the police by Danshell as to TT's needs and diagnosis? Was action taken by the provider and the police in accordance with Mental Health Act protocols and procedures? Why was TT denied an appropriate adult whilst in police custody?

13. Attempts to find an alternative hospital placement for TT: What action was taken by the provider and the placing authority in an effort to find an alternative hospital placement? Were attempts to find an alternative hospital placement for TT affected by the change in his diagnosis referred to at 7 above? Is there sufficient availability of psychiatric beds to meet needs?

14. How appropriate was the transfer and handover of TT from Wast Hills to Recovery First? Were TT's comfort items transferred with him? If not – why not? Was it appropriate for TT to be transferred in a spit hood?

15. How effectively have agencies responded to and investigated allegations and concerns arising from TT's hospital placement at Wast Hills including the critical incident?

16. How appropriately were diversity issues in respect of TT addressed?

3. Synopsis

3.1 In 1999 TT was diagnosed with a Specific Development Disorder of Speech at the age of 5 years.

3.2 In 2003, aged 9 years, TT underwent an Autistic Spectrum Disorder (ASD) assessment which proved inconclusive on the grounds that he did not fulfil the diagnosis according to ICD -10 (World Health Organisation International Classification of Diseases) but did meet the criteria for ASD as outlined by Wing and Gould in 1979. Also TT did not meet the criteria for a diagnosis of Asperger Syndrome.

3.3 In 2005 TT attended a mainstream high school at the age of 11 and was described as a "loving, happy child who enjoyed school".

3.4 In 2009, changes in the behaviour of TT (now aged 15 years) were observed. He moved to a specialist school for children with autism and severe challenging behaviour (Kinsale School) where he settled for a period of 18 months before a gradual decline became evident. He began to exhibit challenging behaviour which included physical aggression to others including isolating staff, physical assaults and spitting; destroying environmental fixtures and fittings; inappropriately removing his own clothes, exposing and touching his genital areas; using clothing and other items as ligatures around his neck which were considered to be suicidal gestures and inducing vomiting.

3.5 In January 2012 TT commenced a new placement at an Individuals Making Autism Positive (IMAP) school in the CW&C Council area in which he resided with his parents and younger sibling. He had been due to commence a residential placement at the IMAP school in April 2012 but by this time he had attained the age of 18 which, under Ofsted regulations, precluded him from attending the IMAP school as a residential student.

3.6 On 10th April 2012 CW&C Social Worker advised NHS Cheshire and Wirral Partnership Trust (CWP) that no further funding was available for TT to return to Kinsale School as reservations had been expressed about Kinsale School's ability to meet TT's needs. CW&C Council state that cost was not a significant factor in the decision to rule out Kinsale School, observing that it was their strongly held view that the school had not been meeting TT's educational or care needs. TT's family say they were initially offered a placement at Kinsale School commencing on 16th April 2012 only for it to be withdrawn by CW&C Council. TT's family say they were not offered an alternative to Kinsale School.

3.7 On the same date a crisis situation arose in respect of TT, resulting in a home assessment by CWP Consultant Psychiatrist. Following the assessment he requested urgent input from the Community Nurse service to support TT's parents in his behaviour management, with consideration to be given to TT being admitted to hospital if managing him in the community did not prove possible. It was recognised that a Mental Health Act assessment would be required for in-patient admission. Initial discussions took place with Greenways Assessment and Treatment Centre in Macclesfield in order to identify accommodation and staffing to support the needs of TT should he be admitted.

3.8 TT's family point out that, prior to the assistance of the Community Nurse service being provided, they had been assessed as needing a budget for only 20 hours a week to employ support to care for TT at home. Given that TT required 2:1 support for community access and social inclusion, this equated at 10 hours a week which they considered to be inadequate. TT's family state that it was around this time they were introduced to the CW&C Council Adult Learning Disability Team with whom they had previously had no contact, nor even heard of their existence.

3.9 TT's family continued to struggle to cope with TT and on 13th April 2012, TT's mother visited Greenways.

3.10 On 16th April 2012 Children and Adolescent Mental Health Service (CAMHS) Consultant Psychiatrist agreed to continue involvement with TT until his 19th birthday to support transition, although CWP Consultant Psychiatrist was now TT's lead Responsible Medical Officer (RMO). It was agreed that CAMHS Consultant Psychiatrist would initially attend Care Programme Approach (CPA) meetings in respect of TT. It was also agreed that CWP Learning Disabilities team would take lead responsibility for TT's care. CAMHS Consultant Psychiatrist was of the view that TT's capacity to consent to admission to Greenways was reduced as a result of his high state of anxiety.

3.11 On 18th April 2012 TT's planned admission to Greenways was brought forward due to TT's mother being unable to continue to safely care for TT at home because of the severity of his behaviour. At that time he was attending IMAP school on a daily basis. CWP Consultant Psychiatrist was called out to the school to complete an urgent Mental Health Assessment and facilitate admission to Greenways.

3.12 Later that evening TT was admitted to Greenways. He was judged not to have capacity to consent to his admission in that he was inconsistent in his views about where he wanted to be and clearly did not have the ability to understand the issues, weigh the risks and benefits, and make a rational choice about admission to hospital. TT required admission for assessment and treatment and was therefore detained under Section 2 of the Mental Health Act. Specifically his admission was for medication review, behavioural management review and to support his autism diagnosis.

3.13 The Greenways IMR states that it was initially considered not possible to admit TT to Greenways that evening due to the staffing requirements. No other beds were available in the locality. However, staff were subsequently mobilised to ensure safe admission to Greenways that evening. TT's family offer a different perspective on the difficulties in admitting TT to Greenways on that evening. His mother states that she received a telephone call from a Consultant Psychiatrist to say that there was no bed available and asked if TT could return home for the night with some support. TT's mother adds that it took a complaint by CW&C Advanced Mental Health Practitioner to enable the decision not to admit TT that night to be over-ruled. TT's mother adds that either TT was detainable under the Mental Health Act that night or he wasn't. Greenways has responded to TT's mother's point to say that the Consultant Psychiatrist was exploring all the options including whether additional measures could be put in place that would mean that TT could be managed in the community if a bed was not available. The independent author has spoken to the CW&C Advanced Mental Health Practitioner who largely confirms the account provided by TT's parents. She states that it was decided that TT should be detained under the Mental Health Act and that Greenways was the appropriate place for TT to be admitted. She says that Greenways were able to offer a bed but did not have the staffing available. She says that, unbeknown to her, one of the Consultant Psychiatrist's rang TT's mother to ask if TT could be returned home with support for the night and TT admitted to Greenways the following day. The Advanced Mental Health Practitioner has said that she did not consider this course of action appropriate and insisted that the staffing issues were resolved in order for TT to be admitted to Greenways that night.

3.14 TT was originally admitted for a short period of assessment and the goal was to discharge TT to a more appropriate environment, which was defined as a 24 hour residential placement with staff skilled in supporting people who have a diagnosis of ASD. As TT had a history of fluctuating mental health and periods of challenging behaviour, such a hospital placement would need to be able to support TT through these difficult periods. NHS Vale Royal CCG IMR reports that TT's parents were keen to ensure that TT continued with his education. TT's comments at the time were recorded as "I would like to go home."

3.15 Following his admission TT continued to display a range of behavioural difficulties similar to those described prior to his admission, which varied in intensity and frequency. These included physical aggression to others, including hitting, punching, kicking; spitting; demanding speech i.e. telling others what they had to say e.g. "Call me sweetheart" or "Say a thousand apologies"; being destructive to property, e.g. damaging his mattress, pulling down and smashing light fittings, attempting to break windows, slamming doors, kicking doors (occasionally causing himself injury in the process);stripping clothes off (either; quickly undressing or redressing, or removing clothes and staying naked; touching his genitals and / or exposing his penis; tying his legs to furniture with items of his clothing; putting items of clothing or bedding down the toilet; pouring drinks over his head; throwing or spitting out food and drinks; self-injurious behaviour, e.g. hitting himself in the head, tying clothing or cords around his neck; urinating on the floor or on bedding and self-induced or spontaneous vomiting.

3.16 On 19th April 2012 – TT's first full day at Greenways – an incident involving restraint of TT was the subject of a safeguarding referral to Cheshire East Council after TT stated that staff had hurt him. This was the first of fifteen safeguarding referrals to Cheshire East Council made during TT's hospital placement at Greenways. (Cheshire East Council was not requested to contribute to this SCR) TT's parents say they were unaware of all 15 safeguarding referrals and specifically were unaware that there had been an incident which necessitated a safeguarding referral on TT's first full day at Greenways. Greenways responds by saying that there was discussion with TTs family as to when they should be contacted as it was distressing for them to be called by phone following every incident. Greenways add that referrals to the Local Authority and incidents that had occurred on the ward were discussed at patient review meetings which were often attended by TT's mother.

3.17 The first patient review meeting in respect of TT was held on 25th April 2012 where is was noted that during TT's first week at Greenways, Management of Violence and Aggression (MVA) techniques were used in response to TT's behaviours, usually in the form of wrist holds and verbal de-escalation. A senior management review of restraint incidents concluded that an appropriate level of restraint had been used on TT.

3.18 On 25th April 2012 the Greenways Multi-Disciplinary Team (MDT) held the initial CPA meeting in respect of TT. A behavioural plan and strategies for TT were to be further developed. In respect of TT's accommodation needs, it appears that discussions continued to take place with Ofsted over IMAP registration. IMAP was reported to be looking at other options for TT also. TT's leisure needs were considered and a timetable of activities was developed and his continuing educational needs were discussed. TT's speech and language assessment was continuing.

3.19 On 2nd May 2012 TT's patient review meeting, which was attended by TT's mother, noted a generally good sleep pattern over the week. At mealtimes it was noted that TT had heightened anxiety. His behaviour continued to be monitored in response to changes in medication.

3.20 At the next patient review meeting on 9th May 2012 it was decided that TT should not attend these meetings. This decision was agreed by the MDT and TT's mother. It was agreed that TT would complete his patient review paperwork prior to the meetings and that a member of the clinical staff would speak to him following the meetings. TT continued to focus on wanting to leave. He continued with 2:1 staff support.

3.21 On 10th May 2012 the CPA meeting was advised that two residential options provided by IMAP had been considered but the NHS Vale Royal CCG IMR records family concern that the nature of behaviour that TT could engage in might make him vulnerable in hospital placements within or near a community setting. Other residential options were also discussed at this time and arrangements were made for CW&C Social Worker, CWP Care Co-ordinator and TT's parents to visit them. TT's parents were also to be engaged in drawing up a person specification for TT to assist in making judgements about the suitability of hospital placements.

3.22 On 11th May 2012 TT was detained under Section 3 of the Mental Health Act at Greenways on the basis that he would need to stay in a hospital environment for longer term assessment and support due to the nature of his challenging behaviour. He was also to receive treatment for his mental disorder and it was considered not to be possible to provide that on an informal basis.

3.23 On 22nd May 2012 an incident in which it was alleged that TT had assaulted a member of Greenways staff was reported to the police. There were a number of assaults on staff during TT's placement which staff reported to the police who provided them with a reference number for the incident. Discussions apparently took place regarding TT's capacity and it was considered that TT did not have the capacity to be interviewed. (Cheshire Constabulary has not been requested to submit an IMR to this SCR)

3.24 At the 30th May 2012 patient review meeting TT's parents expressed the view that some of TTs frustrations arose because he couldn't get off the unit enough and exercise sufficiently. A discussion took place regarding the safety of the public if TT was taken off the unit. It was agreed that a risk assessment would be completed prior to each outing and there would be liaison with the police. TT's parents expressed concerns at matters being reported to the police. TT's Independent Mental Health Advocate (IMHA) had begun attending the patient review meetings in respect of TT.

3.25 On 31st May 2012 TT sustained an injury to his teeth during MVA when he "took himself to the floor" when physical intervention began. A safeguarding referral was made to Cheshire East Council. On the same date Greenways made a referral to a Psychiatric Intensive Care Unit (PICU) to request an opinion on the care being provided to TT including his behavioural plan and medication. The feedback from PICU suggested that the introduction of different medicines to control TT's aggression may be appropriate. TT's parents say, that in their experience, TT had "never taken himself to the floor". Members of staff interviewed for the Greenways IMR have stated that this was in relation to TT's interest in the tale of Gullivers Travels when Gulliver was tied down. Staff describe that TT wanted to be treated like Gulliver. TT's parents also say that they were unaware of the PICU referral. Greenways respond by saying that the PICU referral was reported at the Patient Review Meeting on 13th June 2012 which was attended by TT's mother.

3.26 On 18th June 2012 a peer review meeting was held in order to review the behavioural approaches adopted to manage TT's behaviour. The meeting was chaired by a Senior Nurse and attended by an external Autism Specialist Nurse amongst others. Restraint was reviewed by an MVA trainer.

3.27 By the time of the next CPA meeting on 20th June 2012, several potential placements had been viewed. TT's parents had expressed a preference for a lodge within the grounds of the IMAP centre. However refurbishment of the lodge would take up to 3 months to complete. Discussions also took place about Deprivation of Liberty issues which could arise as a result of the level of restriction TT may require in this placement. Whether or not TT should remain at Greenways until new accommodation was ready was also discussed and it was agreed that there wasn't a better option for him at that time. Consideration was also given to whether TT required formal cognitive assessment to determine which service he should receive support and care from. However it was decided that it would not be possible to complete this with TT at that time and that he should continue to receive a service from the CWP Learning Disability team as this was felt to be appropriate to meet his needs.

3.28 At the patient review meeting held on 4th July 2012 TT was reported to be receiving regular visits from IMAP to support his education. Learning from incidents apparently revealed that TT was less aggressive when staff adopted a more collaborative, as opposed to controlling, approach.

3.29 On 3rd July 2012 Greenways staff visited IMAP school to discuss the care package for TT's potential residential placement there. Relevant documentation was shared with IMAP staff and the possibility of the aforementioned lodge being used to house TT was discussed.

3.30 The next CPA meeting for TT took place on 25th July 2012. There appeared to be a strong focus on the IMAP lodge option. Ofsted had approved the provision of registered accommodation for TT separate from the on-site children's home. IMAP were also in discussion with the Care Quality Commission (CQC) over registration of the lodge based on TT requiring assistance with personal care and some nursing input.

3.31 The patient review meeting held on 26th July 2012 heard that TT had verbally insulted members of the public whilst out on Section 17 leave (the section of the Mental Health Act which allows the Responsible Clinician to grant a detained patient leave of absence from hospital).

3.32 On 27th July 2012 the CPA meeting noted that the person specification for TT's accommodation needs had been completed. The staffing requirements for the IMAP lodge option were considered. The Greenways clinical team felt that TT needed a large team of staff to work with him, with capacity to facilitate regular rotation of staff. IMAP circulated information regarding the proposed package of care for TT which also contained suggested timescales for his placement to begin. TT's parents had expressed some concerns about the space available to TT should he move into the lodge. In response, IMAP had suggested the possibility of TT moving into a two classroom conversion. However, until a definite placement with IMAP was confirmed, it was agreed that consideration of alternative placements should continue with a preference for local providers in the first instance. TT's parents wish to point out that the "lodge" under consideration on the IMAP site was in fact a static caravan. They add that they were concerned that TT might find the accommodation a little tight as he was 6' 2" in height.

3.33 At the patient review meeting held on 29th August 2012, TT's challenging behaviours were noted to be more isolated and infrequent than previously and that episodes of physical restraint had reduced.

3.34 At the 26th September 2012 patient review meeting TT's parents expressed concern about the slurred speech of their son and asked if this was a side effect of his medication. Changes to medication since admission were discussed following which TT's parents agreed to a therapeutic trial dose of methylphenidate. TT's parents say that they first raised the issue of TT's slurred speech with Greenways in July 2012.

3.35 A CPA meeting on 25th September 2012 considered four further placement options, which included Wast Hills Hospital for the first time. TT's father expressed reservations about Wast Hills as it was run by Castlebeck, the company which had been responsible for Winterbourne View Hospital where serious abuse of patients had been exposed. At this stage it was anticipated that CW&C Council Education Department would fund 25% of the cost of TT's care until July 2013 with Health and Social Care splitting the remaining 75% of the cost equally. (Despite further enquiries of the organisations involved, it has not been possible to establish why IMAP was no longer considered a viable option for TT by this time. However, there is a reference in meeting notes to IMAP expressing concern about how they would be able to provide the necessary staffing to care for TT out of hours and at weekends.)

3.36 The next CPA meeting took place on 8th October 2012 at which it was agreed that a decision over TT's future placement would need to have been taken by the end of that month. The meeting noted that TT was to start home visits following risk assessment. TT's parents ask why it took six months for TT to have his first home visit from Greenways? They say that the lack of a home visit for so long caused TT a great deal of upset. Greenways say that prior to TT accessing Section 17 leave, a full assessment was required as he was detained under the Mental Health Act. This involved risk-assessment and careful planning to build up to a visit home. Greenways say they were not preventing access home and facilitated other activities for TT. The independent author takes the view that it is regrettable that Greenways has chosen to defend the lack of home leave for TT for six months. It seems reasonable to assume that this prolonged period without home leave would have had an adverse effect on TT's wellbeing.

3.37 At the patient review meeting held on 24th October 2012 it was noted that TT appeared happier in himself, continued to participate in a full and varied activity programme and was tolerating the rotation of six staff members. The detention of TT under Section 3 of the Mental Health Act was due to expire on 10th November 2012. A best interest decision was made not to inform TT of the renewal of his detention under Section 3 due to the deterioration in his presentation when Section 2 was previously converted to Section 3. There were no dissenting opinions to this course of action.

3.38 By the time of the next CPA meeting on 12th November 2012 a suitable placement had still not been found. Wast Hills appeared to be rejected at this meeting on the grounds that whilst TT may have required this level of service when he was first admitted to Greenways, he no longer required it. It was noted that some of the placements under consideration were not on the Learning Disability Framework which had been introduced recently in order to ensure placements met required standards.

3.39 At the 4th December 2012 CPA meeting six placements were under consideration. It was noted that there had been a slight increase in incidents which required physical restraint. This was attributed to the disruption caused by building work being undertaken on the unit and the approach of Christmas.

3.40 On Christmas day 2012 TT was injured when a member of staff punched him on the nose whilst he was being bathed. Safeguarding processes were followed to ensure TT's safety and treatment for his injury. A safeguarding referral was made to Cheshire East Council and internal disciplinary action taken in respect of the member of staff.

3.41TT's parents were immediately informed of the incident, and have said they were shocked and traumatised to spend Christmas evening in the emergency room of a local hospital whilst TT was treated for his injuries.

3.42 At the patient review meeting held on 16th January 2013 an incident which resulted in TT being escorted back to Greenways by police, due to his agitated behaviour whilst out in the community, was discussed. TT's family take the view that this incident (on 13th January 2013) occurred because TT was treated very unprofessionally by a member of Greenways staff who accompanied TT, his mother and his sibling to a local garden centre. TT's sibling described how the member of Greenways staff became increasingly angry with TT and when he made a remark about "playing with his dick", she allegedly shoved a block of cheese violently into his mouth before summoning the police. This was treated as a safeguarding referral.

3.43 At a patient review meeting on 13th March 2013, risks associated with TT's behaviour whilst off the unit were considered. There was a re-evaluation of the places it was safe for him to visit. TT's family described attending this meeting at which a lead nurse expressed strong concern about TT's behaviour whilst off-site. TT's family state that she was challenged by the Consultant Psychiatrist to produce evidence if TT was to be denied social inclusion. Despite the intervention of the Consultant Psychiatrist, TT's family say that after this meeting he was excluded from public places and treated like a "danger to society". Greenways respond by saying that staff were free to share their views at the Patient Review Meetings as part of the multi-disciplinary approach and as a way of ensuring all risks were explored and considered. They add that at times this would include challenge from colleagues as to how TTs behavioural management was being approached.

3.44 The search for a suitable placement for TT continued. TT's parents continued to visit potential placements with CWP Specialist Healthcare Co-ordinator. The MDT overseeing TT's case at Greenways decided to focus on a specialised autism unit with the ability to help TT to transition to the least restrictive environment after a period of stability and reduction in the presentation of his behaviours.

3.45 At the patient review meeting held on 10th April 2013, TT's behaviours over the previous 4 week period were reviewed including an inappropriate 999 call, 119 incidents of TT exposing himself, 76 recorded episodes of clothes removal, 21 episodes of damage to property and 31 incidents of physical aggression. The property damage to TT's bedroom had necessitated a best interest meeting to discuss if his behaviour caused his bedroom to become unfit for purpose, the safe care unit (a segregated area which was similar in many ways to a secure unit, including anti-ligature features) would be utilised, which in fact it was.

3.46 It is apparent that at least one potential specialist autism provider was deterred by the manner in which TT was presenting at Greenways at that time. They stated that they could not meet TT's needs because the current risk he presented to staff would be "unmanageable". Staff caring for TT rotated on a half hourly basis due to the challenging nature of his behaviour. Staff had apparently experienced burn out, trauma and significant injuries whilst caring for TT. The potential provider was also concerned about the likely frequency of safeguarding alerts, which local safeguarding teams might consider to be unacceptable in a residential environment. TT's parents say that a "monster profile" was created for TT which may well have deterred potential providers.

3.47 By April 2013 the choice of placement for TT had been narrowed down to two, one of which was Wast Hills. Both Wast Hills and the alternative providers assessed TT. Ultimately Wast Hills was chosen. The alternative provider was deemed to be unsuitable because they would have needed to develop a suitable environment into which to admit TT. Additionally Wast Hills offered to place TT in a lodge away from the main hospital building which appealed to TT's parents.

3.48 According to the NHS Vale Royal CCG IMR, CW&C Social Worker liaised with Worcestershire County Council over any safeguarding concerns in respect of Wast Hills and was advised there were none. It is not known whether this conversation took place before or after Worcestershire County Council began their Large Scale Investigation of Wast Hills. It is understood that the process by which provider hospital placement assurance was obtained was managed by CW&C Social Worker.

3.49 By this time there appeared to be a certain amount of pressure to place TT without further delay as a result of both the high level of incidents and the high intensity of staffing required - which was 5 or 6:1 on occasions – at Greenways. Greenways add that it was only during episodes of restraint that a large number of staff were required to manage TTs behaviour, that he was usually cared for by 2 members of staff rotating and for visits out and activities this would be increased depending on the activity. TT's parents say they were never told that this level of staffing was required for TT. TT's parents also wonder whether the pressure to place TT at Wast Hills may have contributed to safeguarding checks in respect of Wast Hills not being done as thoroughly as they should have.

3.50 Around this time TT's parents requested a Mental Health Review tribunal to decide whether TT should continue to be detained under Section 3. On 15th April 2013 the tribunal upheld TT's detention under Section 3.

3.51 A high cost case funding application form in respect of TT was sent to the Clinical Projects Manager in NHS Vale Royal CCG who forwarded it to the Executive Director at NHS Vale Royal CCG who approved it on 31st May 2013. The application stated that "the level of restrictive practices needs a hospital setting and cannot be provided in a community setting". It went on to state that TT "needs to be detained under Section 3 of the Mental Health Act in order to receive hospital care for his safety, the safety of others and to prevent any deterioration in his mental state".

3.52 The application indicated that TT needed "to receive regular assessment of his mental state and behaviour by nurses, psychologists and psychiatrists. The future plan would be to continue to monitor his medication and positive behaviour management plan and make appropriate changes dependent on his mental state and behaviour".

3.53 The application added that TT "needs to access Section 17 leave to the local and wider community, as and when his behaviour was assessed as being safe to do so".

3.54 The application contained a number of recommendations:

- "that TT continues to be supported to engage in a variety of therapeutic and social activities by an Occupational Therapist in order to maintain and improve his interests and skills
- that TT's physical health needs continue to be monitored closely and appropriate care continues to be provided
- that Wast Hills Autism Specialist Hospital is an appropriate hospital placement to meet his needs".

3.55 The application anticipated a transition plan would be developed including a social story to inform and include TT in the process. Also noted in the application was that TT's parents had been fully involved with all decision making in respect of his future hospital placement and the requirement for his continued detention.

3.56 The application turned to the responsibilities of the provider Wast Hills, stating that they had identified that TT's future care pathway would have an agreed outcome of assessing if he could be managed within Wast Hills under Deprivation of Liberty Safeguards (DoLS) under The Mental Capacity Act 2005, as an alternative to his current detention under the Mental Health Act.

3.57 The application also stated that Wast Hills had identified that in his treatment pathway, strategies would be developed to engage TT in community based activities and create appropriate risk management plans to facilitate such activities.

3.58 The application stated that CWP Healthcare Co-ordinator would take the lead role in monitoring and reviewing TT's commissioned service, negotiating a reduction in costings after a period of assessment and developing a discharge pathway when appropriate and ensuring that CW&C Council undertake their responsibility under Section 117 of the Mental Health Act. (duty to provide aftercare for patients detained under the Mental Health Act)

3.59 In order to achieve the goal of providing clinical and behavioural expertise to develop TT's community integration and effective risk management, which would incorporate positive behavioural management strategies, the application anticipated the following hospital placement outcomes:

- A reduction in serious incidents
- Increased community access with less restrictions
- Less restrictive practices in management and support plans.
- Changes to his detention level with a long term objective of management under the Mental Capacity Act 2005
- Over a longer term, to reduce the level of intensive staff support that he needs
- More control over TT's behaviours and his impulse control

TT's parents say they were unaware of these desired outcomes but fully support them. They say that they continually pressed Wast Hills to achieve these outcomes for TT but that they failed, whereas Recovery First has succeeded.

3.60 However the application was clear that, at that time, TT required a large staff team that were able to rotate regularly as he would target staff supporting him and staff rotation was proven to minimise the impact of this behaviour. Additionally the application stated that the environment needed to be robust as TT was at risk of self-harm and also could physically damage the environment, thus placing himself and others at risk. TT also needed an environment where safe controls could be implemented by the staff team, e.g. the ability to isolate water and electrics if he placed himself and/or others at risk. TT was noted to have required physical intervention on a regular basis to manage his presenting risks of harm to self and others. To this end the staff team were required to be trained in physical intervention techniques which needed to be British Institute of Learning Disability Accredited (BILD). And TT was stated to need a clinical team with knowledge and experience of working with individuals who have complex sensory integration needs due to their autism.

3.61 Finally the environment that would be conducive to TT's long term needs would be informed by this further period of assessment at Wast Hills.

3.62 On 13th June 2013 the final CPA meeting was held at Greenways. Preparation for TT's transfer to Wast Hills was discussed including the development of a social story to support transfer. Liaison with Wast Hills to facilitate TT's discharge was reported to be underway. It was decided not to tell TT about the move until the morning of his discharge in order to ensure the least anxiety on his part.

3.63 On 2nd July 2013 TT was transferred to Wast Hills Hospital.

3.64 On 23rd July 2013 a special case conference was organised by CW&C Council to address TT's family's complaints about his transition to adulthood and his treatment at Greenways. The family received a number of apologies from agencies represented at the meeting.

Wast Hills Hospital

3.65 Wast Hills is an independent hospital, consisting of three separate buildings on one site for adults who are on the autistic spectrum who are also living with a learning disability and complex needs. The service can also support people who may be detained under the Mental Health Act. However it is an open rehabilitative hospital which means that restrictions are limited and there are no formal facilities to seclude patients.

3.66 On 21st January 2013 a member of staff at Wast Hills notified the CQC of physical abuse of a service user by a member of staff. The member of staff concerned was suspended and a disciplinary investigation commenced. The CQC notified WCC Adult Safeguarding team.

3.67 On 28th January 2013 WCC Adult Safeguarding Team received the safeguarding alert from the CQC which was passed to the Redditch and Bromsgrove Community Social Work Team. Although there are case notes written by the Duty Social Worker indicating that Wast Hills would be investigating the matter pending the outcome of a police investigation, no strategy discussion was recorded, there was no protection plan, and no investigation episode completed recording the outcome.

3.68 It would appear that disciplinary action was taken against the staff member in respect of whom the allegation was made, and that they subsequently returned to work at Wast Hills where they were subject to an action plan.

3.69 On 6th March 2013 the CQC website noted that Castlebeck Care (Teesdale) Limited, the former provider of Winterbourne View, had gone into administration. The CQC went on to state that their "primary concern is the safety and welfare of people who use services". They added that they were working closely with local authorities and professional experts to make sure the people currently using Castlebeck's services were not adversely affected by any changes. The CQC's Director of Operations was quoted as saying that "our first concern is to make sure people who use Castlebeck's services continue to receive good quality care. So we'll be working with Castlebeck's management and commissioners to ensure that this is the case".

3.70 On 15th May 2013 the same member of Wast Hills Hospital staff who had made the earlier allegation (see Paragraph 3.66) contacted the CQC to make allegations of regular physical abuse across the whole service, emotional and psychological abuse and a lack of dignity and respect. Specifically the whistleblower alleged that "violence is met with violence" and restraints take place several times a day in the main house at Wast Hills. The CQC notified WCC Safeguarding team and decided to undertake a responsive inspection of Wast Hills as a result of information received.

3.71 On 17th May 2013, as a result of the whistleblower's call to the CQC, WCC began a "Large Scale Investigation" of standards of care and treatment at Wast Hills Hospital. The commissioners of all service users currently placed at Wast Hills were notified. At this stage no consideration was given to the suspension of new hospital placements or agreement made that Wast Hills would notify WCC of any proposed hospital placements.

3.72 19th June 2013 CW&C Social Worker emailed CWP Specialist Healthcare Co-ordinator seeking advice on any safeguarding issues at Wasthills. It is not known what enquiries CWP Specialist Healthcare Co-ordinator made in response to this email.

3.73 On 1st July 2013 CW&C Social Worker made contact with the WCC Complex Needs Reviewing Officer who was said to visit Wast Hills regularly. Apparently they agreed to maintain regular contact regarding any safeguarding concerns. The WCC Complex Needs Reviewing Officer has no record or recollection of this discussion.

3.74 On 2nd July 2013 TT's hospital placement began at Wast Hills.

3.75 On 25th July 2013 the CQC carried out the unannounced responsive inspection as a result of the concerns raised by the whistleblower on 15th May 2013. The inspection focussed on the outcomes of respecting and involving people who use services, consent to care and treatment, care and welfare of people who use services, safeguarding people who use services from abuse, management of medicines and supporting workers. Wast Hills was found to be compliant in each outcome.

3.76 As stated in paragraph 3.64, on 26th July 2013 a case conference took place in Cheshire West & Chester Council area at the request of TT's parents who raised concerns about their son's transition from children to adults services from February 2012 onwards. Specifically they were concerned about lack of consistency in social work support, no single service in overall control of TT's care plan, decisions not co-ordinated or shared with the family, confusion over TT's needs and future hospital placement requirements, lack of communication between professionals and a sense of "passing the buck" between services and professionals.

3.77 In response the Head of Service for Prevention and Wellbeing at CW&C Council proposed that a task and finish group be established in order to identify the changes required to process and protocols in order to ensure that future transition cases receive a better, more co-ordinated and seamless service. (As the issues considered by this task and finish group are outside the terms of reference of this Serious Case Review, any findings from the task and finish group have not bee shared with this review)

3.78 At the same meeting it was noted that TT had settled very well at Wast Hills, the care appeared to be meeting his needs and there had been no instances of him being physically restrained so far in contrast with Greenways. Additionally, TT's parents had confidence in CW&C Social Worker who was identified as TT's care co-ordinator and who would be the central point of contact for all professionals involved with TT. The commissioners of TT's hospital placement at Wast Hills, NHS Vale Royal CCG were not represented at this meeting. It is not known whether they agreed to CW&C Social Worker fulfilling this central point of contact role.

3.79 On 2nd August 2013 the CQC published a report on their responsive inspection of Wast Hills. The report made reference to the WCC investigation of the abuse alleged by the whistleblower and stated that it had not yet concluded. It is assumed that the "WCC investigation" referred to was the "Large Scale Investigation".

3.80 In September 2013 Danshell "bought out" Castlebeck Care acquiring around twenty new services at this time including Wast Hills Hospital. On 4th September 2013 Danshell became the provider of services at Wast Hills.

3.81 On 10th September 2013 an alert raised by a whistleblower was shared by WCC Safeguarding Team Manager with NHS Redditch and Bromsgrove CCG Quality Assurance Manager 1. The whisteblower reported that the culture in the main hospital building at Wast Hills significantly affected staff behaviour. It was described as a "macho culture" where the staff had to be "strong" on all accounts. It was reported at staff meetings that support workers were "dominant and manipulative". Additionally leadership was described as ineffectual, handovers were said to be poor and there was said to be a lack of staff to cover the requirements of residents. The whistle-blower said that he/she had been left alone caring for 7 residents.

3.82 On 1st October 2013 the initial CPA meeting took place following TT's admission to Wast Hills. TT was visited in the lodge and the view was expressed that he was making steady, positive progress. The level of incidents and the severity of his aggression was noted to be reducing. However it was noted that TT had displayed patterns of behaviour characterised by violence, aggression and self-injury which was considered to be in keeping with aspects of his known behaviours. TT was considered to continue to fulfil the criteria for detention in hospital under Section 3 of the Mental Health Act. However, it was noted that he went out into the community on a regular basis within limits. The next CPA meeting was planned for 16th April 2014. TT's parents state that the Wast Hills documentation for this CPA meeting make frequent references to TT's autism.

3.83 On 7th October 2013 the further whistleblowing allegations about treatment and care at Wast Hills (see Paragraph 3.81 above) led to an agreement between WCC and Danshell, that new hospital placements to Wast Hills would be suspended. This suspension was not lifted until 11th August 2014.

3.84 During the evening of 4th November 2013 an unannounced quality assurance visit was carried out at Wast Hills by NHS Redditch and Bromsgrove and NHS Birmingham South CCGs and WCC. Feedback from this visit was subsequently shared with the Large Scale Investigation.

3.85 TT's situation appeared to deteriorate because at a professionals meeting on 19th November 2013 WH Consultant Psychiatrist advised CWP Specialist Healthcare Co-ordinator and CW&C Social Worker, who happened to be visiting TT at Wast Hills that day, that as a result of risks in TT's presentation and the impact on other patients in the lodge, staff felt TT would be better and more safely supported in the main hospital. WH Consultant Psychiatrist said she would be informing TT's parents of the decision and the rationale behind it. The C&WP Specialist Healthcare Co-ordinator and CW&C Social Worker agreed with the proposed move providing the parents agreed, a best interests decision was made and TT was properly informed about the move. They requested that Wast Hills put the decision in writing. At this stage no date for the move was suggested. TT's parents say they were not involved in any best interests meeting in respect of the move of TT from the lodge.

3.86 On 4th December 2013 TT was moved from the lodge to the main hospital. A management team member advised TT of the move by using a "social story". Initially TT was tearful and said he "liked the lodge" and would "miss the staff". Although reluctant he was reassured that members of the lodge staff would move to the main building with him. His transition to the main building was closely monitored until 12th December 2013 by which time he was described as calm after some periods of agitation and violence.

3.87 On 11th December 2013 CW&C Social Worker contacted WCC Adult Safeguarding Team Manager by phone to advise that TT had moved from the lodge to the main hospital building at Wast Hills. She also said that TT's Independent Social Worker had mentioned to her that restraint was being used to manage TT's behaviour. WCC Adult Safeguarding Team Manager informed her that there were no safeguarding alerts in relation to TT. CW&C Social Worker confirmed she would be visiting TT at Wast Hills and would contact the WCC Adult Protection Team if any concerns arose from her visit. (There is no record that WCC Adult Safeguarding Team Manager informed CW&C Social Worker of the Large Scale Investigation during this conversation.)

3.88 On 14th December 2013 a safeguarding alert was raised by a WH Staff Nurse 1 in respect of TT. It was alleged that TT had been hit by another Wast Hills resident. The alert was sent to the Redditch & Bromsgrove Community Learning Disabilities Team which contacted Wast Hills and decided that the threshold for action under safeguarding procedures was not met as there was no evidence of significant harm to TT. WCC Social Worker 1 did not notify the funding authority, NHS Vale Royal CCG or CW&C Social Worker of this alert to discuss and agree the decision taken. TT's parents say that they were not informed of this alert.

3.89 WH Clinical Nurse Lead at Wast Hills was informed that the police had been contacted on 15th December 2013 and that they were carrying out an investigation. She added that that TT alleged that the abuse happened on 14th December 2013 but did not report this until the following day. She said that TT had no signs of injury and that the funding authority had been informed by Wast Hills.

3.90 On 16th December 2013 WH Charge Nurse 1 reported that TT had informed him that WH Staff Member 1 had attempted to restrain him by pulling him onto the bed and in doing so had pulled his thumb back. TT also mentioned WH Member of Staff 2. WH Charge Nurse 1 confirmed that the staff involved had been suspended. This alert was referred by WCC Social Worker 1 to the WCC Adult Safeguarding Team but did not apparently notify CW&C Social Worker of this alert to discuss and agree the decision taken.

3.91 However CW&C Social Worker visited TT at Wast Hills and was present when TT was interviewed on 17th December 2013 by Police regarding his allegations against staff members.

3.92 WCC recorded in a Protection Plan that the three Wast Hills staff involved in the restraint of TT had been suspended whilst the police carried out their investigation, that TT would continue to be supported by Wast Hills staff in accordance with his care plan and CW&C Social Worker would support him through the investigation. TT was noted to have capacity to raise concerns and in respect of the Adult Protection process which would follow." No justification for the judgement that TT had capacity to raise concerns was recorded nor is there any record that a mental capacity assessment was carried out. There is no record of how TT's parents would be informed of the allegation made by their son or the action being taken in response to it.

3.93 On 22nd December 2013 TT's Independent Social Worker contacted the CQC to raise concerns that TT had been restrained on a number of occasions. He explained that he was monitoring TT's hospital placement at Wast Hills. CQC records say that he had not witnessed the restraints but had been told about them on his visits to Wast Hills. It appears that the independent social worker was advised to discuss his concerns with the WCC safeguarding team.

3.94 On 6th January 2014, CW&C Social Worker advised WCC that on reviewing the papers in respect of the 14th December 2013 allegation by TT, she noticed that TT had been restrained on 13th December 2013 using a "hook technique" which caused reddening to his shoulders. She requested that Wast Hills make a separate safeguarding alert in respect of this incident. This further safeguarding alert was recorded on 20th January 2014. TT's parents say they were not made aware of this alert.

3.95 On 9th January 2014 the police investigation of the 14th December 2013 allegation concluded that Wast Hills staff had not acted unlawfully or maliciously in the restraint of TT. As a result no report was forwarded to the Crown Prosecution Service (CPS) and the matter was filed pending any further information coming to light.

3.96 On 28th January 2014 a WCC Large Scale Investigation meeting considered TT for the first time. The meeting was updated on the investigation of the safeguarding alert in respect of alleged inappropriate restraint on 14th December 2013 and the more recent safeguarding alert in respect of a reddening to TT's shoulders following restraint on 13th December 2013. In respect of the 13th December 2013 incident, the Large Scale Investigation concluded that the threshold for progress through adult safeguarding procedures was not met. There is no record of how TT and his family were engaged in respect of this latter decision. TT's parents state they were not made aware that TT was discussed by the Large Scale Investigation.

3.97 During January 2014 a person who knew TT saw him in a shop near his parent's home whilst he was on a home visit from Wast Hills. She was deeply disturbed by TT's presentation and very concerned by his apparent deterioration. She said "he appeared to be heavily drugged (and) was dribbling down his clothes terribly". She added that she called his name several times but got no response from him. At the time he was supported by two or three care staff. She subsequently expressed her concerns to CW&C Council in what she described as a formal complaint. TT's parents feel that this was a missed opportunity for those involved in monitoring TT's placement at Wast Hills to question the care and treatment he was receiving there.

3.98 On 7th February 2014 WH Consultant Clinical Psychologist prepared a report in which she noted that whilst TT's self-injurious behaviour had decreased, the frequency and severity of his aggressive/destructive behaviour had increased. She described the latter development as a "concerning trend which required further investigation". The report went on to question whether the difficulties TT experienced could be attributable to a diagnosis of ASD or "whether there were other factors which are impacting on TT's presentation".

3.99 On 11th February 2014, TT's parents were invited to a "formulation" meeting at Wast Hills, the purpose of which was to explore the underlying causes of TT's behaviour and develop a working hypothesis in relation to his treatment. It was during this meeting that TT's parents were advised that TT's diagnosis was being reviewed. TT's Independent Social Worker had also been invited to this meeting but was excluded from the meeting by Danshell whilst apparent confusion over his status was clarified. He was asked to wait in a separate room where TT's parents could access his advice as required. He declined this arrangement and left Wast Hills Hospital. He never visited TT in Wast Hills thereafter.

3.100 On 26th February 2014, Wast Hills completed their internal investigation of the 14th December 2013 incident and concluded that physical intervention in the form of a "supine T" on TT's bed had been used. WH Charge Nurse 1 had identified that this was incorrect and intervened himself. However the investigation report concluded that the restraint on TT's bed was nonetheless a reasonable decision by the staff involved as there was broken glass on the floor of the bedroom and TT was exhibiting increased aggression at that time. However the report considered that staff could have used a "corridor supine position" as an alternative as this would not have placed any undue pressure or force on TT's arms. The report concluded that it was unclear how TT's thumb was hyper flexed during the incident, or indeed whether his thumb was actually injured at all. The report added that the restraint used on TT on this occasion had the potential to cause him significant harm.

3.101 The actions arising from the investigation were that the three Wast Hills staff returned to work, repeated MAYBO (a nationally accredited suite of qualifications in conflict management and physical intervention) training and were to be taken through the investigation report in order to reflect on how their intervention could have been more serious. Advice was also to be sought from Wast Hills MAYBO trainer in order to develop a detailed physical intervention plan for TT to deal with his high levels of violence and aggression.

3.102 Also on 26th February 2014, WCC's Adult Protection Team recorded the safeguarding referral in respect of the restraint of TT on 14th December 2013, as "partially substantiated" on the grounds that whilst TT had been restrained in an inappropriate way, there were mitigating circumstances as to why staff did not use a standard restraint technique.

3.103 On 27th February 2014 TT was visited at Wast Hills by his mother and solicitor. It is believed that during this meeting TT gained the impression that he would be able to move back to the lodge.

The Critical Incident

3.104 From Wast Hills incident reports it is clear that TT became increasingly agitated from Thursday 27th February and throughout the weekend which followed. Wast Hills staff describe repeated physical violence towards staff and spitting. At times TT was reported to appear to be upset and tearful. Wast Hills staff reported TT making repeated references to being able to have anbesol (an antiseptic which provide pain relief from mouth ulcers which TT regarded as a "comfort item") and return to the lodge over this period. TT's parents note that TT regarded his anbesol as a "comfort item" which he had previously carried around with him in his rucksack. They say it had been removed from him on the instructions of WH Consultant Psychiatrist.

3.105 On at least one occasion TT was reported to have said that the solicitor who accompanied his mother to the 27th February 2014 meeting had told him he could return to the lodge and have anbesol. Wast Hills staff therefore made a link between TT's increasingly agitated behaviour and the earlier visit to TT by his mother and a solicitor. Wast Hills staff discussed this with TT's mother during a phone call over this period and she is reported to have told Wast Hills staff that the solicitor asked TT to write down his concerns and had then responded by saying that she would see what could be done about those concerns.

3.106 Over the weekend of 1st and 2nd March 2014, TT was reported to be very aggressive and repeatedly trying to punch staff. Restraints were increasingly being used on TT.

Monday 3rd March 2014

3.107 At 8.35 am on 3rd March a member of staff from Wast Hills telephoned the police to state that they were are unable to cope with TT's behaviour and requested police assistance. The police arrived at 9.20am and concluded that they could not arrest TT and detain him in custody as he was already detained under the Mental Health Act.

3.108 The Danshell IMR states that throughout 3rd March Wast Hills staff attempted to disengage from restraint of TT, but he was unresponsive to all strategies they tried and his level of aggression remained very high. Up to 9 staff were needed to restrain him at times. Wast Hills contacted NHS Vale Royal CCG to advise that TT's placement was no longer tenable and that an alternative bed in a PICU was required.

3.109 At 4.14pm on the same date WH Clinical Nurse Lead contacted the WCC Advanced Professional for Adult Protection to inform her that TT was presenting with extremely physically aggressive behaviour, that he has been restrained by up to 9 people for the majority of the day due to concerns about his safety and the safety of others and that he had received the maximum dose of PRN medication. (Medication administered when required) She also advised that Wast Hills did not provide rapid tranquilisation. The WCC Advanced Professional suggested that the sudden change in TT's presentation may indicate a deterioration in his mental health and advised contact with the local mental health team to request reassessment under the Mental Health Act. (The Mental Health Act advisor to the SCR Panel advises that it would have been appropriate for TT's mental health to be reassessed, but it would not have been necessary to do this under the Mental Health Act as TT was already detained under the Mental Health Act.)

3.110 Also on 3rd March WH Consultant Psychiatrist completed a Psychiatric Summary Report in respect of TT which stated that whilst at Wast Hills Hospital, clinical assessments had revealed that TT did not fulfil the criteria for Learning Disability and that evidence supporting a diagnosis of Childhood Autism had not been confirmed and that this was corroborated by pre-existing assessments.

3.111 In the report WH Consultant Psychiatrist went on to state that "over the past 72 hours, TT's violence and aggression has increased to a severity which is above the threshold at which it can safely be managed at Wast Hills." The report concluded with a single recommendation that a Psychiatric Intensive Care Unit (PICU) that can "currently meet TT's needs" be identified. The report included no recommendation that TT's diagnoses of Learning Disability and Childhood Autism be removed although the first page of the report identified TT's "specified diagnoses" to be Adult ADHD and "Behaviour Problems". (A version of the report apparently completed the following morning contained an amended single recommendation which read " To urgently identify an environment that can provide the level of security and emergency intervention required to minimise the identified risk of harm to TT and others. This is not currently available at Wast Hills".)

3.112 At 5.29pm on the same date, on the instructions of WH Regional Operations Director, staff at Wast Hills again telephoned the police. They stated that two members of staff had been assaulted by TT whilst restraining him. When the police attended at 5.51pm they state they were informed by Wast Hills staff that TT was fully aware of his actions and should be dealt with appropriately. The police arrested TT for assault and transported him to Kidderminster Police Station. A member of staff from Wast Hills followed the police to the station to stay with TT but apparently left when the Police said she wasn't required.

3.113 TT arrived at Kidderminster Police Station at 7.20pm the same evening. For most of his period in custody, TT remained under constant watch by two officers due to his violent behaviour. He was handcuffed with his hands behind his back for most of this period and on occasions wore a mesh spit hood to prevent him spitting at the custody staff. He was also placed in Emergency Response belts.

3.114 Custody staff determined that police custody was not in TT's best interests and a Force Medical Examiner (FME) was called to the police station to examine TT at 8.20pm the same evening. The FME decided that TT was not fit to be detained in custody and that he should be transferred back to Wast Hills where he could remain until a suitable alternative hospital placement was obtained. The FME recommended that TT be physically supervised in close proximity at all times whilst in police custody.

3.115 During the evening WHCT Approved Mental Health Professional made contact with staff at Wast Hills and the police and made enquiries about the availability of a PICU bed. (Apparently a PICU bed would have been available the following morning)

3.116 During the evening a senior manager at CW&C Council contacted TT's Independent Social Worker to advise him that TT had been arrested and to seek any help he could provide as he lived not far away from Wast Hills. As TT's Independent Social Worker was in Harrogate attending a conference, he arranged for the Director of Autism Inclusion to go to Kidderminster Police Station on his behalf.

3.117 Later that evening the Director of Autism Inclusion visited Kidderminster Police Station but was not allowed access to TT because of his agitated state.

3.118 At 10.47pm the same evening the Police Custody Sergeant recorded on TT's custody record that the police were aware that the FME had stated TT was not fit to be detained. However as a Section 3 mental health patient, he could only be released to a mental health establishment. The Sergeant raised his concern that TT remained in custody with the duty Police Inspector who decided that he should return to Wast Hills Hospital.

Tuesday 4th March 2014

3.119 At 2.15am on 4th March 2014 the WHCT Approved Mental Health Professional visited TT in Kidderminster Police Station. Although restraints remained in place, he was able to engage in a conversation with TT, who attempted to kick him in a 'half-hearted' manner and appeared limited in his ability to explain what had preceded his removal into police custody. A second conversation took place at 4.01am in which WHCT Approved Mental Health Professional described TT as calm, no longer hostile and a discussion about going to bed on his return to Wast Hills was described as "problem free" and agreed. The WHCT Approved mental health professional said TT 'seemed relieved' to be returning to Wast Hills.

3.120 TT was released from Police custody at 4.06am the same morning and conveyed by the police to Wast Hills.

3.121 During 4th March TT was described in the Danshell IMR to be "extremely dangerous and unpredictable". Discussions continued with NHS Vale Royal CCG who asked wast Hills to keep TT for a further 24 hours. Although TT continued to be "in crisis", physical intervention began to be intermittent rather than continual. By the evening of that day TT was reported to be more settled and manageable.

3.122 Later that day TT's Independent Social Worker was asked by the CW&C Senior Manager who had contacted him the previous evening to assist in finding TT an alternative hospital placement. TT's Independent Social Worker was still attending the conference in Harrogate where he met a manager of Recovery First who happened to be attending the same conference. After a conversation between the two, TT's Independent Social Worker concluded that Recovery First could be a suitable hospital placement for TT and advised CW&C Council accordingly.

3.123 Later on 4th March 2014, CWP Commissioning referred TT to Recovery First. Attached to the referral was a copy of the Psychiatric Summary Report first referred to in Paragraph 3.105 and an email from WH Clinical Nurse Lead. The email stated that TT had been taken into police custody following a significant increase in violence towards staff. It also stated that Wast Hills was not a secure service and therefore did not have the facilities to safely manage the situation. The email stated that TT needed a PICU bed. (Whilst Recovery First is not a PICU it does provide a service for men with ASD and challenging behaviours in a locked rehabilitation setting.)

3.124 At 5.15pm the same day WCC Safeguarding Adults Team Manager emailed the police to advise them that staff at Wast Hills had contacted her with concerns over managing TT. She requested police assistance for Wast Hills if required. Following this the police made contact with Wast Hills and advised them to call them on the 999 system should an emergency arise in which the police were required to prevent a breach of the peace or protect persons from harm.

3.125 TT was visited by his parents and the Director of Autism Inclusion during the course of the day. When they saw TT they said he was traumatised. They said he really cried and said how horrible it had been at the police station. He told them that the staff at Wast Hills had threatened to call the police again.

3.126 A secure copy of the assessment of TT completed by WHCT Approved Mental Health Professional in the early hours of that morning was sent to NHS Vale Royal CCG that evening.

Wednesday 5th March 2014

3.127 On 5th March the Danshell IMR reported TT to be "extremely agitated" necessitating periods of further physical intervention.

3.128 During the morning of 5th March 2014 Wast Hills staff contacted a locum GP at the GP practice which provided an "enhanced service" to Wast Hill service users to request a visit to TT, but he declined to do so after making a clinical judgement that this was a non-urgent matter and he was dealing with an emergency with another patient. In a subsequent telephone conversation between Wast Hills staff and the GP Surgery practice manager, Wast Hills staff said that TT was in "crisis". The practice manager is stated to have responded by saying that if that was the case, GP intervention would not have been appropriate anyway.

3.129 Later that day Recovery First responded to the urgent referral by sending two assessors - RF Social Worker and RF Deputy Ward Manager - to Wast Hills to review the case and meet with TT. On arrival, the Recovery First assessing team were informed that they could not meet with TT as he was being restrained as a result of a violent incident. However the team were able to meet with a number of staff from Wast Hills including WH Consultant Psychiatrist and nursing staff. The Recovery First assessing team state that they were informed that, in the opinion of TT's current MDT, being placed in an autism-specific service, with clear structure, boundaries and routine, had actually exacerbated some of TT's difficult behaviours. Wast Hills staff added that a hospital placement in any similar service would not be helpful as TT was not on the autism spectrum.

3.130 Following the meeting with the Wast Hills MDT, the assessing team were met by CW&C Social Worker who was also visiting Wast Hills. This was a chance meeting and had not been arranged. The information provided by CW&C Social Worker contrasted with the information provided by the Wast Hills MDT, in that she advised the team that the opinion that TT did not suffer from an ASD was a recent one and that prior to this, services had worked with TT on the basis that he clearly was autistic. CW&C Social Worker strongly advised the assessing team to obtain further information from other sources prior to making any decision about whether TT should or should not be transferred to another ASD service.

3.131 The Recovery First assessing team formed the opinion that the information with which they had been provided was not adequate for the purpose of the assessment. Also noting the difference of opinion they had heard, they recommended that TT was not transferred to Recovery First until further information was obtained, particularly given the fact that they were not able to see TT. This recommendation was communicated to the Recovery First Hospital Director. However, partly as a result of the urgency of the situation, senior staff at Recovery First decided to offer a hospital placement for TT.

6th March 2014

3.132 At 8.45am on 6th March 2014 TT was conveyed from Wast Hills to Recovery First arriving at 10.45am. Transport was by secure private ambulance. The provider of this service decided that TT should travel in the celled area of the vehicle. WH Nurse 1 sat in a chair just outside the celled area. She was well known to TT and engaged him in conversation during the journey. At 10.20am the driver of the ambulance decided to activate the vehicle's blue lights in order to progress through heavy traffic more quickly as TT was becoming increasingly agitated. TT's parents observe that activating the blue lights on the secure ambulance would have been a "major sensory overload" for TT.

3.133 The secure ambulance staff remained with TT whilst initial admission processes took place at Recovery First until noon. The Recovery First IMR states that it had been agreed that TT would be transferred to Recovery First at 12 noon. TT's arrival at 10.45am meant that the ward staff were not fully prepared for his arrival which led to a delay in TT's admission. During this period it was decided that TT should wear a spit hood as he had started to spit at staff.

3.134 The secure ambulance was then driven to the company's base at London Gatwick, having dropped off the Wast Hills staff en route. The ambulance arrived at 4.50pm that day. Whilst the vehicle was being cleaned out a box containing TT's property was found. (It is presumed that this box contained his comfort items.) This box was posted to Wast Hills the following morning by first class post. It would appear there was considerable delay before this box containing TT's comfort items was finally sent to Recovery First, whose nursing staff state they were advised by Wast Hills that the box had been posted to them. When the box did not arrive, Recovery First nursing staff state that they again requested Wast Hills to send it without result. The Recovery First IMR states that TT's mother brought replacement comfort items to the ward. It has not yet been possible to establish whether TT's box of comfort items ever arrived at Recovery First.

3.135 On 6th March, following the critical incident, a safeguarding alert was raised by a Director at Danshell regarding the management of TT's behaviour and use of restraint at Wast Hills and Kidderminster Police Station from 3rd to 5th March 2014.

3.136 On 11th March 2014 the matter was recorded as a safeguarding alert. A safeguarding strategy was recorded. At this time it was recorded that the view of the acting Manager of Wast Hills was that TT had capacity when calm, but that this was limited during incidents of challenging behaviour. A body map recording the minor physical injuries and bruising sustained by TT and incident reports were provided by Wast Hills, who advised that they would be carrying out an internal investigation.

3.137 The outcome of the safeguarding strategy was that the case would not proceed to investigation as TT had been moved to an alternative hospital placement and that his safety and that of other service users had been assured. The final status of the allegation was recorded as "not substantiated" and it was stated that TT had been repeatedly restrained due to concerns about his safety and the safety of others. This resulted in bruising and grazes. Staff involved also sustained injuries. TT was transferred to a secure hospital placement as a result of an acute deterioration of his mental health. Physical intervention used by staff to minimise the risk posed by TT's expressive behaviour was considered to be proportionate to the potential risk to self and others.

3.138 There is no record that this conclusion was agreed with CW&C Social Worker.

3.139 On 11th August 2014 Worcestershire County Council concluded their Large Scale Investigation of standards of care and treatment at Wast Hills Hospital following multi-agency agreement that the risk of harm was reduced and that Wast Hills Hospital was operating safely.

3.140 The police decided not to pursue their investigation of the allegations of assault on Wast Hills staff allegedly perpetrated by TT on the grounds that they considered that TT lacked mental capacity.

4. Analysis

1. The decision to detain TT under the Mental Health Act and place him in Greenways Assessment and Treatment Unit in Macclesfield. What led to the decision to detain TT under the Mental Health Act? How appropriate was the assessment, treatment and care of TT whilst TT was placed at Greenways?

4.1 Paragraphs 3.6 to 3.14 describe the sequence of events which led to TT being detained at Greenways under the Mental Health Act. This decision appears appropriate given the circumstances which prevailed at the time. Greenways was a relatively local facility which appeared well placed to achieve the objectives set in respect of TT at the time of his admission.

4.2 However, had TT's transition to adult services been better co-ordinated and had his intended placement at IMAP school gone ahead as originally planned, then it is possible that the crisis in TT's life may have been less pronounced. And had TT's family received greater support in managing TT's needs at home, it seems possible that his detention under the Mental Health Act could have been avoided.

4.3 In the event the lack of co-ordination of TT's transition to adult services and consequent absence of a plan for his future care and treatment, resulted in TT being "parked" in Greenways for almost 15 months. He remained there for so much longer than was originally intended. TT's anxieties about his future must have been all-consuming. It is therefore completely unsurprising that his anxieties manifested themselves in the violent and destructive manner described earlier in this report.

4.4 The Greenways IMR author states that it was anticipated that the assessment and treatment of TT would likely be for a short period of time prior to the securing of a suitable future residential placement. It was certainly not anticipated on his admission that he would be an in-patient for 15 months. This is longer than most of the placements for patients in Greenways (currently the average stay is 5 – 6 months). The Greenways IMR states that it is usual for a discharge plan to be in place whilst an individual is an inpatient on the unit and that the lack of a discharge plan had a significant impact on both TT and his parents.

4.5 TT's care and treatment was managed by regular patient review meetings which were attended by members of the multi-disciplinary team involved in the care of TT, including TT's IMHA, Social Worker, Unit Manager, Staff Grade Psychiatrist, Consultant, Clinical Psychologist, Care Co-ordinator, Learning Disability team leader and TT's parents. CPA meetings were also held regularly and initial meetings included CAMHS as part of the transition of TT from children to adult services. This meeting developed and monitored the risk assessment for TT. TT's parents also attended the CPA meetings.

4.6 The patient review meetings discussing the day to day management and progress of TT and the CPA meetings provided the overarching review and future planning for TT including future placements. In total 10 placements were considered and Greenways staff visited these placements and also met with potential placement providers at Greenways.

4.7 TT's family say that they had little influence in the meetings, neither did their CW&C social worker. They were also critical of their IMHA who "said nothing during the meetings". They added that they felt advocacy for TT was "very poor indeed".

4.8 TT was not able to take part in these meetings due the level of anxiety he experienced. The decision for him not to attend was discussed and agreed with TT's mother. However, he continued to complete his patient review paperwork prior to the meeting and the Consultant Psychiatrist would feedback the outcomes of the meetings to him afterwards. TT's parents say that all TT wanted throughout his placement at Greenways was to go home.

4.9 The Greenways IMR states that throughout TT's hospital placement at Greenways he required a high level of observation. This usually varied between level 3 and level 4. (CWP Observation policy defines level 3 as "patient is kept within eyesight and can safely be given some privacy in the toilet/bathroom with the door unlocked" whilst level 4 is defined as "patient is within arms-length at all times".) Two staff were allocated to him at all times and were rotated usually on a half hourly rate as agreed as part of his risk assessment and behavioural support plan.

4.10 During TT's hospital placement at Greenways there were approximately 341 incidents involving TT. This equates to approximately 5 – 6 incidents per week. The majority of these incidents involved aggressive and challenging behaviour risking injury to TT, causing damage to the environment, aggression towards staff or causing actual injury to staff. A large number of these incidents required the use of physical restraint techniques requiring a level of restraint to prevent injury to either TT or staff.

4.11 Approximately 31 of these incidents were identified as safeguarding incidents and managed within CWP. Approximately15 were referred to the Local Authority safeguarding team (Cheshire East Council) for further investigation.

4.12 All incidents were reviewed by a senior nurse to ensure oversight and scrutiny of how the incidents were managed, appropriateness of physical intervention, and that the least restrictive action had been taken to ensure safety. The behavioural support plan and risk assessment were reviewed and amended to incorporate any learning. The weekly meetings and reviews provided opportunity for the multi-disciplinary team to contribute to the learning and make adjustments as required to both the risk assessment and behavioural support plan. TT's parents ask what Greenways was actually learning from this review process. Having discovered that a punitive approach to TT was counter-productive, why did Greenways persist with this approach? Greenways respond to TT's parents question by saying that the TT's Behavioural Support Plan was modified in response to learning from incidents and that each Patient Review Meeting included 'learning points' and the effectiveness of the approaches to his behaviour. Greenways deny that their approach to TT was ever punitive. They add that as part of Section 17 leave, TT's mental state was assessed and this may have restricted his leave if he had had episodes of challenging behaviour in the morning that meant his mental state did not allow him to access his leave safely. They say that this was always from a risk management perspective and was not a punishment. They add that staff recognised that his activities and outings reduced the anxieties that led to his challenging behaviours. Greenways acknowledge that restrictions on TT's activities may have been interpreted as 'punitive, however, they contend that these restrictions were always in response to a risk management approach.

4.13 Physical restraint varied between the requirements to hold TTs wrists to management in the prone position for short periods of time. On occasion a safe environment was used to ensure safety of both TT and others. Occasionally he was cared for in seclusion. Following incidents requiring restraint, the Greenways IMR states that TT's parents were notified. The IMR states that TT's father was wholly against the use of restraint and was not able to engage in discussions relating to this.

4.14 Additional advice and support in relation to managing TTs behaviour was sought from the Managing Violence and Aggression (MVA) co-ordinator. She spent over 20 hours on the unit observing TTs behaviour and responses from staff and offered further advice and support to inform his Behavioural Support Plan.

4.15 A friend of TT's family who visited him in Greenways often said that a regular cry of TT's was "don't let them call the PET team". The friend initially thought this might be some form of animal therapy but subsequently established that the PET team was the Psychiatric Emergency Team which was summoned to assist with multi-person floor restraints. Greenways respond to this point by saying that the Psychiatric Emergency Team is a response team called to the unit if further assistance is required in response to an episode of challenging behaviour. They would be called to ensure safety of all patients on the unit. They say the team is not defined as the team to manage 'multi-person floor restraints'. They add that the team may provide support to other service users if the ward staff are involved in a restraint or de-escalation of challenging behaviour.

4.16 The same friend of TT's family described the experience of visiting him in Greenways. She said that on all of her visits to TT, he had visible bruising to his arms which she found shocking as she had never seen this before. She added that TT was constantly held by two members of staff. She went on to say that she was told what she could and could not say to TT and she was told not to hug him. She said she felt very restricted and was closely observed in a small, clinical room. She said she felt scrutinised, uncomfortable and sometimes unwelcome.

4.17 She described how she was refused access to TT at times on the grounds that he was "unsettled". In those circumstances she said she insisted on waiting until he had settled – and was allowed to see him within minutes. She implies that restricting visits to TT by describing him as "unsettled" was a deliberate ploy by Greenways staff. Greenways deny that this was the case and say that this was not raised at Review Meetings as an issue.

4.18 The experiences of Greenways related by TT's family and friends seem to be at odds with the account of the management of TT as a patient provided in the Greenways IMR. What seems clear is that the intensity, frequency and severity of the incidents involving TT presented a significant challenge to a hospital which did not specialise in treating autism. Indeed in June 2012 Greenways commissioned an independent peer review of assessment and decision making in respect of TT. This and other evidence provided in the Greenways IMR indicates a conscientious effort to learn how to care for TT more appropriately. However it wasn't until July 2012 that staff discovered that TT was less aggressive when staff adopted a more collaborative, as opposed to controlling, approach. (Paragraph 3.28) And tension between staff who wished to adopt a more restrictive approach to TT and those who favoured a more positive approach to risk assessment was apparent in the reported difference of opinion between the lead nurse and the Consultant Psychiatrist referred to in Paragraph 3.43. Greenways reiterate their earlier point that "tension between staff" should be seen as a part of healthy challenge and reflection within a multi-disciplinary team.

4.19 The family state that one aspect of TT's treatment at Greenways which has "scarred him terribly" was that his bathroom door was locked as a "punitive measure". TT regarded the bathroom as a safe refuge where he could go to self-regulate and to sometimes remove his clothing. Amongst TT's most frequent repetitive phrases are references to his fear that his bathroom door will ever be locked for the rest of his life. Greenways state that TT's bathroom door was not locked as a punitive measure but for safety reasons. They add that at times TT had flushed clothing and bedding down the toilet causing flooding and that the door was always opened for him when he needed to use the toilet or needed to vomit.

4.20 The Greenways IMR states that despite the behaviours TT displayed, he was able to access regular periods of Section 17 leave which included twice weekly visits to 'Jump-Space' (for trampolining), weekly swimming trips, regular walks to local places and regular home visits always supported by staff. The IMR adds that in the later months of his treatment TT was only able to go on walks where he would not meet members of the public due to his aggressive behaviour and risk of exposing himself. The family felt that the not infrequent calls to the police for back-up whilst TT was being accompanied in the community were inappropriate and risked criminalising him. TT's family observe that he has only ever needed police intervention when in the care of professionals. They say that it has never been necessary to call the police when TT has been in the outside world with family and friends. Greenways has responded by saying that there were only 2 occasions when the police were called when TT was outside on activities.

4.21 TT's family also point out that there was no on site access to a trampoline. As a result TT was left to jump on a hard floor which has caused permanent damage to his feet and he is often in pain as a result. They say that there was a resident Occupational Therapist on site but that no preventative measures were implemented such as the provision of a soft mat. Greenways has responded to this point by saying that a trampet (small trampoline) was brought in for TT by his family but he did not want to use this. They add that TT had an x-ray of his feet due to pain in his feet which did not indicate any bone damage. Greenways also state that there had been some foam mats brought in for him which TT tore up.

4.22 In her statement to the Mental Health Act Tribunal held on 15th April 2013, TT's mother stated "Greenways have restricted TT's outings as they now deem him not fit for the public. This has had a very negative impact upon TT as no meaningful substitute has replaced his much loved outings. Even his therapy sessions of re-bound therapy and hydro-therapy have been regularly cancelled. If TT misbehaves in the morning his therapy sessions get cancelled in the afternoon and he is left to fester on the unit. Surely therapy sessions are essential not optional. It has been my experience that the more you restrict TT, the more his behaviour will challenge. There appears to be an attitude that somehow TT is totally responsible for his behaviour, like a naughty boy. TT is severely disabled by his autism and needs an environment that understands this and can work to reduce his anxieties which will in turn reduce his behaviours". TT's family add that at this same Mental Health Act Tribunal Greenways were asked what meaningful replacement have you put in place for all the activities and outings you have restricted?

2. The decision to commission a place for TT at Wast Hills: Was the hospital placement appropriate? How was the decision taken? Was all relevant information shared with all parties? Were sufficient efforts made to source an in-county hospital placement for TT including a bespoke package of individualised care. If no such efforts were made - why not? If any efforts were made, were they appropriate?

4.23 Cheshire West and Chester Council appear to have taken the lead in working with the family to make an extensive search for a suitable placement for TT. TT's parents were involved in the development of a person specification for TT to enable potential placements to be assessed against the specification. Health, in the form of the relevant outgoing Primary Care Trust should have played a greater role in the search for a suitable hospital placement as they would be responsible for commissioning the placement and TT was subject to Section 3 of the Mental Health Act and therefore may well require a further hospital placement. Lack of ownership of the search for the placement could conceivably have contributed to the subsequent lack of proactivity in monitoring the hospital placement secured at Wast Hills. TT's family say that Health were also actively involved in the search for a placement post Greenways, although they were not always well co-ordinated with CW&C Council.

4.24 It seemed to take an inordinately long time to secure a placement for TT which meant that he spent far longer at Greenways than was initially anticipated. This extended period at Greenways appears to have been a "holding" hospital placement and as previously stated the extended period spent at Greenways in these circumstances appears to have had some negative consequences for TT's presentation which could have made finding a suitable placement for him more challenging.

4.25 It appears that TT's current successful relatively local hospital placement at Recovery First was unavailable during the period a post-Greenways hospital placement was being sought. (Recovery First staff have advised the author that St. Mary's Hospital in Warrington provides a similar service to Recovery First and was apparently available at the time of the search for a hospital placement for TT post-Greenways) TT's parents say that St Mary's Hospital was considered as an option for TT but rejected by Greenways.

4.26 At the time that TT was placed at Wast Hills , the provider was "Castlebeck Care in Administration" as Castlebeck Care had gone into administration in March 2013 - four months prior to TT's hospital placement commencing. The demise of Castlebeck Care occurred because of the allegations of abuse of service users in the Winterbourne View Hospital which were highlighted in a BBC Panorama programme in 2011. Grant Thornton were the administrators for Castlebeck in Administration but their focus was on finding an alternative provider. Day to day management of Wast Hills and clinical decision making appears to have remained with the Castlebeck staff.

4.27 Danshell became the providers at Wast Hills on 4th September 2013, two months after TT's hospital placement began. Danshell have provided in IMR for this SCR which obligingly covers the entire period TT was placed at Wast Hills. In their IMR, Danshell state that the admission process for TT appeared to have been satisfactorily managed except for a lack of involvement of the responsible clinician.

4.28 TT's parents appear to have had initial misgivings about Wast Hills as a result of the Castlebeck connection but were impressed with the lodge building away from the main building of the hospital which TT would share with just two other service users. They were also impressed with the extensive grounds at Wast Hills because they felt that outdoor activities were an integral element in the treatment and care of their son.

4.29 It appears that TT's parents were given assurances about TT being able to remain in the lodge, even if his presentation deteriorated significantly, which Wast Hills may not have been in a position to honour.

4.30 The unsuccessful hospital placement of TT at Wast Hills Hospital, after months of searching for a placement which would meet his needs, raises wider issues of whether there is adequate provision of specialist hospital placements for adults with Autism Spectrum Disorder whose challenging behaviour makes it difficult for them to live with their families or in community settings, whether there is adequate provision of community placements and whether commissioning arrangements for specialist hospital placements and community placements could be organised differently – possibly on a wider footprint - in order to build the expertise necessary to commission optimal hospital placements in an under-provided market.

3. Worcestershire County Council's "large scale investigation" of Wast Hills: When did this begin? What prompted it? What was the outcome? Is there a report on the investigation? Was there a point at which hospital placements to Wast Hills were suspended? If so, when was any suspension lifted? Were the commissioners of TT's hospital placement in Cheshire West & Chester made aware of the large scale investigation when TT was placed at Wast Hills or at any time during his hospital placement at Wast Hills? How was the suspension communicated to commissioners both locally and nationally?

4.31 The Large Scale Investigation focussed on standards of care and treatment at Wast Hills Hospital and began on 17th May 2013 after a member of staff at Wast Hills contacted the CQC to make allegations of regular physical abuse across the whole service, emotional and psychological abuse and a lack of dignity and respect. Specifically the whistleblower alleged that "violence is met with violence" and restraints take place several times a day in the main house at Wast Hills. (Paragraph 3.70) There had been an earlier whistleblowing call to the CQC from the same member of staff at Wast Hills regarding physical abuse of a service user by a member of staff. (Paragraph 3.66)

4.32 The commissioners of hospital placements for service users currently placed at Wast Hills were notified of the Large Scale Investigation. However no action was taken to suspend future hospital placements and no system was put in place to notify prospective commissioners of future hospital placements, such as NHS Vale Royal CCG, which commissioned TT's hospital placement at Wast Hills, of the concerns which had led to the Large Scale Investigation. Nor did Worcestershire County Council ask the then provider – Castlebeck in Administration - to advise them of new hospital placements. Given the scale of concerns about standards of care and treatment at Wast Hills, these were significant omissions. (The WCC IMR author has confirmed that NHS Vale Royal CCG was not commissioning any placements at Wast Hills at the time the Large Scale Investigation commenced. However Paragraph 4.93 refers to a placement by CW&C Council of a service user at Wast Hills from 2012-14 who also had his diagnosis of autism removed. If CW&C Council were the placing authority for this placement they would presumably have been aware of the Large Scale Investigation at the time it was commenced. CW&C Council has been asked to comment on this point and have stated that they "have not been able to find any notification by Worcestershire County Council of the Large Scale Investigation in relation to TT or the other service user from CW&C then placed at Wasthills".

4.33 There was an obligation on NHS Vale Royal CCG to notify the host authority – Worcestershire County Council – of the hospital placement of TT at Wast Hills which they failed to do. (1) However it would have been unwise of Worcestershire County Council to have wholly relied on placing authorities to advise host authorities as this did not appear to be a system with 100% compliance.

4.34 New hospital placements to Wast Hills were not suspended until October 2013 following a third call from the whistleblower who expressed concerns about ineffectual leadership, macho culture, manipulative and dominant support workers and insufficient staffing levels to meet the needs of service users in the main hospital building (Paragraph 3.81) The suspension was lifted on 11th August 2014.

4.35 The investigation was lengthy, with a total of nine Large Scale Investigation meetings involving a range of cross border agencies. Whilst comprehensive minutes were recorded, no final report was completed, and there was no documented summary of outcomes in relation to individual investigations or conclusions reached regarding overall outcomes.

4.36 At the time the investigation commenced Worcestershire did not have Large Scale Investigation procedures in place. This position was rectified on 9th August 2013 - almost three months after the investigation commenced - but the new procedures were not implemented throughout the remainder of the investigation. This was unwise. The lack of clear procedures undoubtedly impacted upon the co-ordination of the investigation and a review of the documentation conducted by Worcestershire County Council identified significant gaps which included:

- No agreed terms of reference
- No assessment of risk of harm to residents and recommendation about safety
- No consideration of suspending hospital placements whilst the investigation took place.
- No robust plan agreed about how ongoing monitoring would be undertaken during the investigation
- No clear communication strategy agreed including who would be the single point of contact
- No consideration of what information would be shared with the persons alleged to have caused harm
- No determination if individual protection plans were required
- No consideration of other policies and procedures to be taken into consideration for example emergency procedures, persons in position of trust, Association of Directors of Adult Social Services (ADASS) out of area safeguarding adults arrangements etc.
- No clear identification of resources required for undertaking the investigation i.e. the coordinating investigator from the host authority (WCC) and identified point of contact/investigator from partners and any other staffing or resources required.
- No contingency plan agreed should the situation have deteriorated

4.37 The Large Scale Investigation concluded on 11th August 2014, following multi-agency agreement that the risk of harm was reduced and that Wast Hills Hospital was operating safely. The Large Scale Investigation procedures implemented in Worcestershire on 9th August 2013 stipulate that following completion of the investigation it is the responsibility of the host authority to make an investigation report available to all relevant agencies and people prior to the concluding case conference outcomes meeting. This did not happen.

4.38 Additionally, rather than individual safeguarding investigations taking place and these then being reported into the Large Scale Investigation meetings, it is apparent that Large Scale Investigation meetings were used as case conference meetings with multiple safeguarding cases overseen and managed alongside broader concerns. There was a risk that the Large Scale Investigation, in attempting to address both concerns about individual cases and broader risks about standards of care and treatment at Wast Hills, did neither adequately.

4.39 Each Large Scale Investigation meeting appeared to conclude with an assessment of risk. The risk assessment appeared to be based on a summary of progress against indicators of concern such as numbers of safeguarding alerts. The risk assessment was reduced from "medium" at the January 2014 meeting, to "low" at the next meeting held on 29th April 2014 – at which the 3rd – 6th March 2014 critical incident involving TT was considered as a "new issue" on the agenda. The justification for reducing the risk assessment to "low" at this April 2014 meeting was partly on the basis that "no new concerns had been raised" which very difficult to reconcile with the fact that the critical incident involving TT was discussed at the very same meeting. The minutes of the April 2014 meeting record the discussion of the breakdown of TT's hospital placement in some detail including the removal of his autism diagnosis, the level and duration of restraint applied, his detention in police custody and the subsequent reinstatement of his diagnosis. There is no evidence in the minutes that the manner in which TT's hospital placement ending triggered any wider safeguarding concerns about other service users placed at Wast Hills.

4.40 The parents of TT say that they only became aware of the Large Scale Investigation when they were consulted on the draft terms of reference for this SCR in May 2015. Whilst there is reference to the Large Scale Investigation in the letter the parents received from the WSAB independent chair dated 16th January 2015, the significance of the Large Scale Investigation is not described or explained in that letter. TT's parents add that had they been aware of the Large Scale Investigation, they would have felt more confident in raising concerns about the care and treatment of their son at Wast Hills. They add that they felt a degree of reticence in challenging Wast Hills in case their son experienced adverse consequences as a result.

4.41 Worcestershire County Council as host authority first appear to have become aware of TT on 11th December 2013 following contact from CW&C Social Worker. During this contact there was an opportunity to inform CW&C Council – who Worcestershire County Council appeared to regard as the placing authority for TT - of the Large Scale Investigation but there is no record of this happening.

4.42 The CQC was aware of the Large Scale Investigation. They were invited to Large Scale Investigation meetings and attended twice. Paragraph 3.69 sets out the public commitments made by the CQC following the announcement that Castlebeck Care had gone into administration in March 2013. It appears that the CQC discharged these commitments in respect of Wast Hills Hospital by carrying out the responsive inspection referred to in Paragraph 3.75. The CQC has been asked what else it did to discharge the public commitments it gave when Castlebeck Care went into administration. In reply the CQC has stated that it "continued to monitor the service at Wast Hills through inspections, receipt of notifications and enquiries to ensure that patients using the service were kept safe and received the right care".

4.43 Had the commissioners of TT's hospital placement, or his parents been aware of the Large Scale Investigation at the time the decision to place TT at Wast Hills was made, it appears likely that the hospital placement would not have gone ahead. Indeed one alternative hospital placement for TT which was under consideration at that time, was discounted partly because of ongoing safeguarding investigations.

4. How effectively was TT's hospital placement monitored and reviewed by the placing authority? How did the placing authority respond to any concerns raised by Wast Hills that TT's hospital placement at the hospital was breaking down?

4.44 At the time of TT's hospital placement at Wast Hills in July 2013 the NHS was undergoing significant change. Primary Care Trusts (PCT) ceased to exist after 31st March 2013 and many of their responsibilities were transferred to Clinical Commissioning Groups (CCG). In Cheshire, the responsibilities of Central and Eastern Cheshire PCT were transferred to three CCGs - Vale Royal, South and Eastern Cheshire. At the same time, the Continuing Healthcare & Complex Care Service was transferred into Cheshire and Merseyside Commissioning Support Unit (CMCSU). This service included a Specialist Manager for Mental Health & Learning Disabilities and a Learning Disability Case Co-ordinator. The three above mentioned CCGs also commissioned two Learning Disability clinical case managers from Cheshire & Wirral Partnership Trust (CWP). In addition, two managers who were part of the Vale Royal and South Cheshire Management Teams had responsibility for monitoring the Winterbourne reviews and submitting the returns to NHS England.

4.45 The two Learning Disability clinical case managers had been previously employed by Central and Eastern Cheshire PCT focussing on cases that were joint funded out of a health and social care pooled budget. With the demise of the PCT, they transferred into Cheshire and Wirral Partnership Trust and were line managed by a manager in Cheshire and Wirral Partnership Trust. Their roles and responsibilities seem to have been unclear and their relationship with the CCG managers has been described as a 'working relationship' but with no supervisory responsibilities. Communication with CCG managers was largely in relation to completion of Winterbourne returns although CCG managers report that, on occasion, the case managers would alert them if there were problems or concerns with a hospital placement. CCG managers report that data protection issues prevented clinical case managers from sharing patient identifiable information with them so their role, at that time, was restricted largely to enabling access to appropriate funding streams and completing the Winterbourne returns.

4.46 Given these arrangements, it is difficult to see how NHS Vale Royal CCG could monitor the hospital placement of TT at Wast Hills effectively. Monitoring of his hospital placement seemed to be reliant on the two Learning Disability clinical case managers alerting the CCG managers to problems or concerns with hospital placements, which they did "on occasion." Raising hospital placement concerns "on occasion" does not indicate a process which is rigorous or which benefits from clear criteria for raising concerns. In any event unspecified "data protection issues" prevented the Learning Disability clinical case managers from sharing patient identifiable information with their CCG managers.

4.47 Additionally the relationship between these two Learning Disability clinical case managers and the Cheshire and Merseyside Commissioning Support Unit was unclear with tensions reported on some occasions. Additionally the rationale for which cases were managed by the clinical case managers and which by the Commissioning Support Unit was also unclear. On a number of occasions the clinical case managers would complete high cost request forms and submit them directly to CCG Directors for sign off whereas on others they would be submitted to the Commissioning Support Group Mental Health/Learning Disability Manager.

4.48 The Winterbourne View Serious Case Review recommended that commissioners funding hospital placements for adults with learning disability and autism should be proactive in ensuring patients are safe. (2) NHS Vale Royal CCG appeared to have signed up to an approach which disabled rather than enabled proactive monitoring.

4.49 NHS Vale Royal CCG as commissioners appear to have had no involvement in monitoring TT's hospital placement between 19th December 2013, when concerns about the Wast Hills hospital placement were beginning to surface and the start of the critical incident on 3rd March 2014. Given the level of TT's health needs and the CCG being the sole commissioner, one would have expected significantly more intense monitoring from health given the indications of deterioration in the hospital placement between November 2013 and March 2014. An additional concern is that there appears to be no evidence that the risks to the hospital placement were highlighted to a more senior level in the CCG until the evening of 3rd March 2014.

4.50 The high cost application form signed by NHS Vale Royal CCG on 20th May 2013, stated that CWP Specialist Healthcare Co-ordinator would take a lead role in monitoring and reviewing TT's commissioned service, negotiate costings to reduce after period of assessment, develop a discharge pathway when appropriate and ensure CW&C Council undertook their responsibility under Section 117 Mental Health Act. (Aftercare)

4.51 However the role of Case Co-Ordinator for TT's placement at Wast Hills appears to have been allocated to CW&C Social Worker, at a case conference on 26th July 2013 at which NHS Vale Royal CCG was not represented. It is unclear what the rationale was for the decision to allocate case co-ordination to CW&C Social Worker but the need to maintain continuity of the link to TT's family may have been an important factor.

4.52 Initially CWP Care Co-Ordinator monitored TT's hospital placement on behalf of Health until October 2013 when she discharged him to CWP Specialist Health Co-ordinator. The NHS Vale Royal CCG IMR suggests that it was felt inappropriate for CWP Specialist Health Co-ordinator to fulfil this hospital placement monitoring role because TT appeared to associate her with his negative experiences at Greenways. In these circumstances the decision to discharge monitoring of TT's hospital placement to her seems questionable. TT's parents question whether the suitability of CWP Specialist Health Co-ordinator to fulfil the placement monitoring role was an issue as far back as October 2013.

4.53 Under the Winterbourne Concordat regular monitoring meetings took place between Vale Royal and South Cheshire CCG Clinical Projects Manager and Vale Royal and South Cheshire CCG Service Delivery Manager and CWP Specialist Healthcare Co-ordinator and CWP Specialist Learning Disability Nurse. They would check a list of clients and identify any changes such as whether a CPA meeting had occurred, the outcome of that meeting and any changes to the care pathway. CWP Specialist Healthcare Co-ordinator had responsibility for monitoring that a CPA review had taken place every 26 weeks as a minimum. Apparently no guidance or protocols exist to determine the appropriate monitoring of hospital placements apart from frequency of routine CPA reviews. TT's parents take the view that monitoring the frequency of CPA meetings was a completely inadequate way of monitoring Castlebeck in Administration services.

4.54 Worcestershire County Council appeared to regard CW&C Council as the placing authority for TT. Once they became aware of TT, the professional they contacted in respect of TT was CW&C Social Worker. She was invited to Large Scale Investigation meetings from 28th January 2014 onwards. The actual placing authority, NHS Vale Royal CCG, does not appear to have been involved in the Large Scale Investigation meetings at all.

4.55 Danshell as provider state that they were in regular contact with NHS Vale Royal CCG and CW&C Council to advise them that the hospital placement was breaking down. This assertion is contradicted by the fact that the process of questioning and subsequently removing TT's diagnosis did not appear to be notified to NHS Vale Royal CCG as the placing authority. Once WH Consultant Psychiatrist began the process by which TT's diagnosis was ultimately removed, it must have been apparent that TT's placement in an autism specific hospital would be under threat. It would have been prudent to notify the placing authority as soon as TT's diagnosis began to be questioned as TT's placement was funded by the placing authority on the basis of the existing diagnosis. This was not done and represents a serious omission. However, Danshell attempted to bring forward the CPA meeting in respect of TT. This meeting had originally been scheduled for April 2014 and attempts were made to bring it forward to February 2014 before a date in March 2014 was settled upon. This CPA meeting never took place because TT's placement at Wast Hills ended beforehand. Had the CPA meeting taken place, it is assumed that the fact that TT's placement was in jeopardy would have become apparent to the placing authority.

5. How appropriate was the assessment and treatment received by TT whilst at Wast Hills? Were any effective steps taken to monitor and assess the effectiveness of the therapy and treatment that TT was receiving?

4.56 Evidence suggests that initially TT settled and demonstrated progress at Wast Hills and that the hospital placement was stable until at least the first CPA meeting on 1st October 2013. Indeed WH Consultant Psychiatrist in her Psychiatric Summary Report dated March 3rd 2014 stated that "up until few weeks ago TT appeared to be making considerable progress". TT's family were happy with TT's placement in the lodge. They said that "TT was not being physically held all the time - as he had been at Greenways - which was a joy to see". He had access to the grounds and there was a trampoline.

4.57 However the decision to move TT from the lodge to the main hospital which was taken in November 2013, and implemented the following month, may have been an indication that either there were issues with the treatment provided, or TT's response to it. TT's family note that the decision to move TT from the lodge followed on from Danshell taking over at Wast Hills. They said that the previous management team left. They added that the outgoing management team had been building up community access, taking TT on trips and promoting home leave and that once Danshell took over, that programme stopped.

4.58 WH Consultant Psychiatrist observed that TT was not responding to the care and treatment provided at Wast Hills as anticipated, or as service users with ASD usually did. This observation led to the removal of TT's diagnosis of autism and learning disability which will be explored in more detail later in this report.

4.59 TT's Independent Social Worker visited TT at Wast Hills fortnightly and was concerned that on most occasions when he visited TT he would be in bed in his bedroom. He added that as his visits progressed it concerned him that TT was not being actively engaged in activities to stimulate and make the most of his sensory needs, particularly his need to use his trampoline. Throughout the hospital placement he states he was concerned over whether TT was given sufficient opportunity to engage in activities. Danshell has confirmed that throughout TT's placement at Wast Hills, there was an unfilled vacancy for an Activities Co-ordinator.

4.60 TT's Independent Social Worker states that he also became increasingly concerned by the type of physical interventions staff were using on TT. This varied, but frequently led to full floor restraints. In feedback from the nurse in charge, he says he discovered it was a common practice to restrain TT which the Independent Social Worker felt was clearly affecting TT's progress and stability in his environment at Wast Hills.

6. How appropriate was the decision to move TT from the Lodge to the main hospital building at Wast Hills in December 2013?

4.61 TT was initially placed in the lodge at Wast Hills which is approximately 800 yards from the main hospital building. The availability of the lodge for TT was a key factor in convincing TT's parents that Wast Hills was a suitable hospital placement. They enquired of the then Assistant Manager of what would happen if TT's placement in the lodge was not working. They say they were told that a number of "revolving interventions" would be put in place before any transfer to the main hospital. TT's parents note that the Assistant Manager and many other staff left Wast Hills in the following months.

4.62 TT was moved from the lodge to the main hospital building on 4th December 2013. In her Psychiatric Summary Report of 3rd March 2014, WH Consultant Psychiatrist justified the move on the basis that the "level of relational and environmental security could not be provided" in the lodge. The decision appeared to be heavily influenced by the delay in providing staff support to the lodge during periods of aggressive behaviour by TT as it took staff around three minutes to travel from the main hospital to the lodge. Wast Hills staff have also said that the move was in anticipation of the Christmas period which had previously been a time of increased for TT. (If this was part of the rationale then one might have expected a return to the lodge to have been considered once Christmas was over.) WH Consultant Psychiatrist has advised this review that had she been involved in TT's admission to Wast Hills, she would never have recommended the lodge for someone who was detained under the Mental Health Act and was so acutely unwell.

4.63 The statistics provided by Wast Hills do not appear to indicate an increase in incidents involving TT in October and November 2013 when the option of moving TT to the lodge was actively considered and then decided upon. Incidents involving TT peaked at 51 in August 2013 and declined to 26 in September, increased slightly to 30 in October and declined to 23 in November 2013. The Danshell IMR also references a "change in management" at this time. It is unclear whether changes in perspective and practices which can accompany a change in management also played a part in the decision to move TT. TT's parents note that placements to Wast Hills had recently been suspended which may have adversely affected income, making tying resources up to care for TT in the lodge less affordable. Danshell state that cost played no part in the decision to move TT from the lodge and this review has received no evidence that cost was a factor.

4.64 However it is important not to diminish the seriousness of some of the incidents recorded as several resulted in Wast Hills staff requiring medical attention at Accident and Emergency for injuries.

4.65 The number of incidents involving TT increased to 32 in December 2013 (the month the move took place) and increased to 36 in January 2014 and declined to 22 in February 2014.The clinical decision was made for him to transfer to the main house in December 2013. The Danshell IMR author notes that after TT's move to the main hospital no further staff injuries which required medical attention were sustained due to "the more appropriate environment and response times".

4.66 TT's Independent Social Worker noted that when he was initially placed in the lodge TT was the only resident which appeared to suit him, as TT's Independent Social Worker felt he had a low tolerance of other people around him. The Independent Social Worker noticed that as other individuals were placed in the lodge, TT found this increasingly stressful.

4.67 The meeting at Wast Hills on 19th November 2013 at which WH Consultant Psychiatrist advised CW&C Social Worker and the CWP Specialist Healthcare Co-ordinator of the proposal to move TT from the lodge to the main hospital appeared to be an informal unplanned meeting. TT's parents were not present at the meeting. WH Consultant Psychiatrist has stated that TT's parents had been advised of the possibility of the move in advance. TT's mother states that she was advised of the move by telephone by WH Consultant Psychiatrist. She says she put up strong objections to the move and questioned how TT's sensory needs would be met in the main hospital where there was a lot of noise. TT's mother says she had a meeting with WH Consultant Psychiatrist a couple of days later when she was advised that the move was a "clinical decision".(Full stop!)

4.68 This was an important decision which marked a significant departure from the initial approach to caring for TT which had the potential to put at risk the outcomes anticipated from the hospital placement at Wast Hills. The informal manner in which the placing authority was consulted over this decision is troubling. A key decision such as this should have been made through MDT arrangements. It would not be the only time that Wast Hills made key decisions about TT without following a formal process.

7. The diagnosis of TT: Autism and Learning Disability diagnoses were "removed" whilst TT was placed in Wast Hills. What was the justification for this decision? Should this have triggered a review of detention under Section 3 of the Mental Health Act?

4.69 Clearly the change in TT's diagnosis whilst at Wast Hills was a controversial decision which could have had significant implications for his future care and treatment including the funding of that care and treatment.

4.70 The SCR Panel was advised by Dr. Carol Stott PhD CSci CPsychol AFBPsS, an Autism Consultant. She analysed the rationale for TT's diagnosis removal provided to this SCR by Danshell and observed that the "only reason explicitly stated for the querying and subsequent removal of TTs diagnosis was that he appeared not to be responding to treatment".

4.71 Dr Stott requested Danshell to provide more detail of the individual treatment plan for TT. Danshell advised that "treatment consisted largely of emergency interventions" which suggested to Dr. Stott that most interventions were not explicitly therapeutic but were deemed necessary for crisis intervention or management of severely challenging behaviour. These "treatments" would clearly NOT be included in any considerations of treatment success or failure in the broader sense in her judgement. Further, they would not contribute to evaluations of diagnostic accuracy.

4.72 She went on to say that it is "highly unusual (if not unknown) for a diagnosis of ASD to be queried or removed as a result of treatment failure. In fact it is relatively rare for a diagnosis of ASD to be removed at all; this stems from ASD being considered as a lifelong condition".

4.73 She added that "current shifts in our understanding of ASDs do mean that we are beginning to see instances of diagnostic change in an individual over time. This has occasionally resulted in a diagnosis of ASD being removed".

4.74 She went on to say that "currently, the circumstances under which a diagnosis of ASD is re-evaluated and potentially removed are where:

- the individual no longer presents with behaviours associated with ASD
- a known genetic condition is identified and ASD becomes a secondary diagnosis. In these situations the ASD component is ONLY removed if the individual no longer meets ASD criteria, otherwise (and usually) the ASD remains as the secondary (dual) diagnosis.
- the individual presents with behaviours that may have been misconstrued as indicating an ASD, but which are subsequently thought to represent an alternative known condition. In these situations, it is typically not poor response to treatment that leads to the reconsiderations and re-evaluation, it is the emergence of clearer signs and symptoms of an alternative disorder alongside lack of evidence of current ASD-like behaviours".

4.75 She concluded that "none of the scenarios listed above applied to TT. The only reason given for the initial query about his diagnosis was that TT was not responding to treatment". On treatment she observed that "there is no available treatment/intervention that has 100% success in all cases of ASD. All of the evidence-based treatments have demonstrated success, some of the time, with some people with an ASD. None has demonstrated success at all times".

4.76 She observed that "it stands to reason that treatment failure cannot validly be used as an indication of misdiagnosis, unless and until those for whom the treatment has failed can be demonstrated not to have had an ASD. As far as I am aware, no such evidence currently exists in the published literature".

4.77 She added that "the Word Health Organisation's International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) are internationally acknowledged diagnostic guidelines for Autism Spectrum Disorders and Pervasive Developmental Disorders. Neither set of guidelines has ever included reference to failure of treatment as a diagnostic indicator".

4.78 She therefore concluded that "the reasons for re-evaluating TT's ASD diagnosis appear to be in error, or at best, not clearly stated".

4.79 Dr Stott then went on to set out the guidelines for ASD diagnostic assessment which apply whether the assessment is for initial diagnosis or for re-evaluation – as in TT's case. "Where an individual's ASD diagnosis comes into question, a full diagnostic re-assessment is required. The two major sets of international diagnostic guidelines come from the World Health Organisations International Classification of Diseases, currently in its tenth edition (ICD-10) and the American Psychiatric Association's Diagnostic and Statistical Manual, currently in its fifth edition. (DSM-5) In the UK the two sets of guidelines tend to be used interchangeably although the NHS formally advise use of ICD-10. Until 2013 the two sets of guidelines were well synchronised, but DSM are currently ahead of ICD, since changes introduced in DSM-5 in 2015".

4.80 "National best practice (NICE) guidelines for NHS England supplement the international diagnostic guidelines with recommendations about best practice, and state that any ASD diagnostic assessment should ideally include direct observation of the individual and, where possible, a detailed interview covering developmental history and current presentation. Information should be taken from someone who knows the individual well enough to comment on their past and current presentation. New diagnostic guidelines outlined by DSM-5 do allow for an absence of knowledge re developmental history, when considering adult diagnosis, if no-one is available for interview. This was not the case for TT, whose parents were available".

4.81 "Until 2013 the term ASD had never been used by any diagnostic guidelines. Rather, the "autism related" diagnostic classifications came under the umbrella term Pervasive Developmental Disorder (PDD). The main diagnostic categories under this umbrella term (in both ICD and DSM were: (ICD terminology /DSM terminology):

- Childhood Autism / Autistic Disorder
- Aspergers Syndrome / Aspergers Disorder
- Atypical Autism / No DSM equivalent
- Pervasive Developmental Disorder - Not Otherwise Specified (PDD-NOS)"

4.82 "Up to 2013, despite it never appearing in formal guidelines, ASD was a term used increasingly by clinicians worldwide, to mean a number of different things. Broadly speaking it indicated a diagnosis of one or other of the conditions listed above. The term ASD was introduced to guidelines by the American Psychiatric Association in 2013, when DSM-5 dispensed with the PDD umbrella term and replaced it with ASD".

4.83 Having set out the guidelines for ASD diagnostic assessment which apply for initial diagnosis or for re-evaluation, Dr. Stott went on to evaluate the process by which TT's diagnosis was re-evaluated and the ASD diagnosis removed.

4.84 She observed that in TT's case "clear efforts were made to access information, from TT's parents, about his past presentation" and that "there was a reported delay in the team being given access to this information".

4.85 She noted that in the Danshell IMR there was a reference to the intention of carrying out an Autism Diagnostic Observation Schedule (ADOS) and an Autism Diagnostic Interview – Revised (ADI-R). She states that "these instruments are well recognised, and amongst the gold standard measures for ASD diagnosis in the UK and worldwide". Therefore there was a stated intention to follow NICE guidelines for diagnostic assessment of ASD.

4.86 However, she noted that "the ADOS and ADI were not completed as the critical incident occurred before the team had an opportunity to carry out all the recommended parts of the diagnostic assessment. Despite acknowledging that it had not been possible to complete a full diagnostic assessment prior to the incident, the team appear to have come to a decision to remove TTs diagnosis on the basis of the information available to them at that time. Specifically, this comprised documentation from the past, a non-standardised clinical interview with TTs parents and general observations of TT's behaviour day-to-day".

4.87 Dr. Stott stated that "whilst these are valid sources of information, NICE guidelines indicate that they would be insufficient, taken in isolation, to allow a diagnostic decision to be made, and that the information should be supplemented by an ASD related interview, such as the ADI, covering current presentation and where possible developmental history, and a standardised direct observation of TTs current behaviour, using an instrument such as the ADOS".

4.88 She went on to say that "in relation to day-to-day observations, the primary presenting feature was TT's extremely challenging behaviour, which was at least partly conceived of as resulting from treatment failure. At the time of writing (23.9.2015) it is not clear exactly what treatment was delivered, what behaviours were targeted for improvement and what the success vs. failure rate was in relation to any specifically targeted behaviours".

4.89 She noted that "past documentation included a number of reports from various sources. WH Consultant Psychiatrist and the team re-evaluating TT's diagnostic status appear to have relied primarily on a report dated October 9th 2003, provided by a Speech and Language Therapist - SALT and a Specialist Teacher, both from Cheshire Autism Support and Development Team (CASDT)".

4.90 Dr Stott noted that "the process of evaluating this 2003 report was fraught with confusions and misunderstandings, deriving from long-standing confusions around ASD terminology, some apparent errors in the SALT report itself and compounding of those errors by the re-evaluation team at Wast Hills."

4.91 Dr. Stott stated that the CASDT authors did refer to TT's unusual ability to express and empathise with feelings and emotions of others. They went on to say that "for this reason, and due to his motivation and ability to relate to people (more particularly adults) he did not meet criteria for an ICD-10 diagnosis of autistic spectrum disorder." The CASDT team also stated that their decision was inconclusive, because of the need for multi-disciplinary endorsement".

4.92 Dr. Stott points out that "it is important to note here that neither the Speech and Language Therapist nor the Specialist Teacher had a diagnostic remit, and the two of them together did not constitute a multi-disciplinary team in the context of what is recommended for ASD diagnosis".

4.93 Dr Stott then moved on to consider how WH Consultant Psychiatrist interpreted the CASDT report. WH Consultant Psychiatrist's Psychiatric Summary Report (March 3rd 2014) referred to the CASDT report as follows:

4.94 "A DISCO was done by SLT, CASDT when TT was 9 years old. The results were inconclusive and conflicting. However ASD (according to ICD-10 diagnostic criteria) was not confirmed". WH Consultant Psychiatrist then quoted the 2003 report directly: "TT does not fulfil the diagnosis of ASD according to ICD-10". "TT does not meet the criteria for a diagnosis Asperger Syndrome." "TT meets the criteria for ASD as outlined by Wing and Gould in 1979".

4.95 As Dr. Stott pointed out above, "ICD-10 does not set out criteria for a diagnosis of autistic spectrum". She goes on to say that whilst "one might not expect a Speech and Language Therapist or Specialist Teacher to know this – having no formal diagnostic remit - but an individual who does have a formal diagnostic remit (such as a Consultant Psychiatrist), should reasonably be expected to know this".

4.96 Dr. Stott then observes that WH Consultant Psychiatrist went on to say that "the lack of evidence for a diagnosis of Childhood Autism was corroborated by pre-existing assessments, in which core features of autism were not evident, such as difficulties with empathy, deficits in relation to Theory of Mind and Central Coherence..."

4.97 Dr. Stott states that "it is important to note that difficulties with empathy, deficits in relation to Theory of Mind and Central Coherence are features of the social cognition of some people with an ASD, but they are by no means 'core features', nor do they appear anywhere in ICD or DSM guidelines as diagnostic indicators".

4.98 Dr Stott concludes that "whilst the terminology is confusing, overall the evidence for the presence of some form of ASD is clear and frequently stated in the CASDT report" and that "any queries relating to diagnosis were more specifically about what type of ASD was presented". "The CASDT team were accurate in pointing out that TT's early language problems ruled out a diagnosis of Asperger Syndrome. However, as noted earlier, their reference to TT not meeting ICD-10 criteria for ASD was confusing and inaccurate. The CASDT team did refer to TT meeting Wing and Gould criteria for ASD and they listed several examples of ASD behaviours, specifically referring to TT having difficulties with:

- Social Interaction
- Social Language and Communication
- Flexibility of Thought and Imagination
- Sensory and Motor Difficulties"

"This in itself suggests that CASDT felt there was sufficient evidence to indicate a diagnosis consistent with ASD, but were unsure quite where TT should be placed in relation to "the spectrum.""

4.99 Dr Stott observes that "overall, despite confusions in terminology, the lack of diagnostic remit of the report authors and the need for MDT endorsement, it is clear from the CASDT report that the behaviours reported are highly consistent with an ASD presentation".

4.100 Thus Dr. Stott's conclusion is that "it is clear that while a full diagnostic assessment had been arranged, it was not possible to complete the assessment before the critical incident. Even had the evidence for misdiagnosis been strong at that stage, it does not appear reasonable that TT's diagnosis should be removed before full assessment had been completed. Added to this is the fact that the evidence relied upon by WH Consultant Psychiatrist was confusing and often incorrectly formulated" which "derives from long-standing confusions about ASD terminology. The confusions were compounded by the Wast Hill team's misinterpretations of past reports".

4.101 Additionally the final decision to remove TT's diagnosis appeared to have been taken and documented in WH Consultant Psychiatrist's Psychiatric Summary Report on 3rd March 2014. This was a highly significant date. TT was "in crisis" at Wast Hills. Staff were unable to cope with his behaviour and during that day they summoned help from the police on two occasions whilst requesting the placing authority - NHS Vale Royal CCG– to urgently find a suitable alternative hospital placement. Indeed the sense of crisis was evident in the Psychiatric Summary Report. On page 6 of the report there is a reference to TT having "remained in full restraint for a number of hours and several members of staff have sustained injuries." The report concluded on page 7 with a single recommendation that a PICU be urgently identified to meet TT's needs.

4.102 There may be occasions when making an important decision in a crisis situation is unavoidable. In this case the clear intention was that TT would be transferred from Wast Hills without delay. In these circumstances taking such a critical decision about TT's diagnosis appeared ill advised. And taking the decision on such a difficult day made it virtually impossible for WH Consultant Psychiatrist to comply with National Institute for Clinical Excellence (NICE) guidelines which recommend consultation with the commissioner who was funding the hospital placement on the basis of a diagnosis which was about to be changed, and that the family should be consulted. Neither of these important steps were taken.

4.103 The WHCT IMR author states that there is not a universally agreed process for removing a diagnosis but that "it would not normally be done by one professional without wider consultation and documentation". Although WH Consultant Psychiatrist consulted with a Consultant Psychologist employed by Danshell, she does not appear to have sought peer review or even advice from an independent fellow professional before making the decision. The Winterbourne View SCR raised concerns about the independence of psychiatrists employed by private hospitals. WH Consultant Psychiatrist was employed by Danshell who is the provider at Wast Hills. This appears to strengthen the case for seeking the view of an independent fellow professional still further.

4.104 It is also questionable whether the decision to change the diagnosis of TT was adequately documented. As stated above, the decision is contained in the "Psychiatric Summary Report" consisting of 7 pages. A ten line paragraph on page 6 of the report states that TT "does not fulfil the criteria" for learning disability and "evidence supporting a diagnosis of childhood autism has not been confirmed". Page 7 of the report contains just one recommendation – "To urgently identify a Psychiatric Intensive Care Unit that can currently meet TT's needs". The fact that the report contains no recommendation that TT's diagnosis should be removed seems an odd omission. Perhaps it is indicative of a report written in haste on a very difficult day. Certainly TT's parents have pointed out errors of fact in the section of the report which addresses TT's personal and developmental history. Indeed the only definitive evidence that TT's diagnosis was formally removed is contained in his discharge notice from Wast Hills.

4.105 A not entirely unpredictable consequence of questioning and then removing TT's diagnosis is that communication deteriorated between Wast Hills and TT's parents to the point where it appeared to the Danshell IMR author that "communication around TT's care was compromised".

4.106 The Psychiatric Summary Report which apparently removed TT's diagnosis of Learning Disability and autism did not consider the immediate legal issue of whether the grounds for detaining TT under Section 3 of the Mental Health Act had now been removed also. It is assumed that WH Consultant Psychiatrist believed the criteria for TT's ongoing detention under the Mental Health Act was still fulfilled after revising his diagnosis but it seems strange that WH Consultant Psychiatrist did not include consideration of this issue in her report. Perhaps it is another indication of the problems which one encounters when making a critical decision in crisis circumstances. The Mental Health Act advisor to the SCR Panel has observed that he would have expected WH Consultant Psychiatrist to have contemporaneously recorded the continuing grounds for TT's detention under the Mental Health Act at the time she decided to remove his diagnoses. No evidence of such a contemporaneous recording has been shared with this review.

4.107 Danshell's solicitors believed the criteria for detention under Section 3 was still fulfilled on the basis of TT's "abnormally aggressive behaviour". However this only applies to service users with a learning disability for which WH Consultant Psychiatrist concluded that TT did "not fulfil the criteria". Danshell's solicitors highlight a view expressed by WH Consultant Psychiatrist earlier in 2014 that it was not possible to say definitively that TT did not have a mild learning disability.

4.108 However the Mental Health Act advisor to this SCR Panel offered the view the Mental Health Act provided the legal underpinning for treatment to be provided, given TT's ongoing need for use of medication and treatment on a routine and PRN basis. (including psychotropic medication)

4.109 But the Mental Heath Act advisor also noted that WH Consultant Psychiatrist had concluded that TT only had diagnoses of Adult ADHD and behaviour problems and wondered if this firm diagnostic conclusion would mean the 'learning disability' "abnormally aggressive" criteria would need to be reconsidered. He went on to say that this would not in itself mean detention under the Mental Health Act was not appropriate if another diagnosis of mental disorder was present to "a nature or degree" that warranted treatment in hospital. The evidence provided to this SCR demonstrates an ongoing need for intensive nursing support in relation to TT's complex needs. When interviewed for this SCR, WH Consultant Psychiatrist appeared to support this line of argument in stating that TT "had a mental disorder or disability of the mind that was of a nature and degree for which hospital treatment was necessary for TT's health and safety and the protection of others".

4.110 The Mental Health Act advisor added that there may have been a stage before the critical incident when the Wast Hills clinical team felt unable to provide "appropriate treatment". There is an "appropriate treatment" test set out under the criteria in Section 3 in the Mental Health Act. Therefore if the clinical team felt unable to provide "appropriate treatment" then this would also question the appropriateness of ongoing detention in this particular unit. The Mental Health Act advisor acknowledges that this is speculative comment because it is unclear how well the clinical team felt able to cope with TT's needs leading up to the critical incident. The Wast Hills IMR gives an indication of the high needs of TT and the associated challenges in meeting those needs, but it does not give an indication of how well the unit felt they were able to cope.

4.111 What is clear from the analysis provided by the Mental Health Act advisor to this SCR Panel, is that following the change in diagnosis of TT, the legal basis for his detention under the Mental Health Act was in doubt. The decision to remove TT's diagnosis should therefore have been accompanied by a review of his detention under the Mental Health Act. There is no evidence that WH Consultant Psychiatrist considered this.

4.112 The removal of the diagnosis on 3rd March 2014 raises the question of whether this influenced the information provided by Wast Hills staff to the police when they contacted them for a second time at 5.29pm that day. The police state that they were advised that TT had capacity and therefore could be held to account for his actions in assaulting members of Wast Hills staff. Danshell deny that their staff advised the police that TT had capacity. The recording of the call from Wast Hills to the police is not available to shed light on this matter as they are retained for 12 months only.

4.113 Therefore it can only be speculation that there is any link between the removal of TT's diagnosis and the specific content of the call to police which led to TT's arrest. However some professionals involved in the case and the parents of TT suspect that it was more than a coincidence. Danshell express concern that any link is suggested between the removal of TT's diagnosis and TT's arrest on the grounds that the process of reviewing TT's diagnosis began much earlier than 3rd March 2014.

4.114 TT's diagnosis had not been questioned during his placement at Greenways- prior to his placement at Wast Hills. A mental health tribunal –after his placement at Wast Hills - confirmed TT's diagnosis of autism with a degree of learning disability.

4.115 TT's Consultant Psychiatrist at Recovery First was of the opinion that TT met the criteria for both ASD and Learning Disability diagnosis. The Recovery First IMR author states that the confusion over the change in diagnosis was distressing for TT's family. It was the opinion of the Recovery First clinical team that TT clearly has an Autism Spectrum Condition, and that repeating formal tests would not be necessary and would cause the family further distress. TT's second Consultant Psychiatrist at Recovery First, following discussion with the MDT, gave TT a formal diagnosis of ASD in 2014. She has advised the review that "the evidence for a diagnosis of ASD is of longstanding, is unequivocal and is TT's primary diagnosis". She adds "that there is no indication that his constellation of difficulties are attributable to any other diagnosis".

4.116 It is troubling that it appears that TT may not have been the only service user to have a diagnosis of autism removed whilst at Wast Hills. The Danshell representative on the SCR Panel acknowledged that autism diagnosis removal had happened "on a couple of other occasions." WH Consultant Psychiatrist has since stated that no other service user had their diagnosis of autism removed during the period of TT's residence at Wast Hills but that "previously there were patients who had their diagnosis reviewed as a result of the assessment process". However enquiries with CW&C Council have established that a man they placed at Wast Hills in 2012 had his autism diagnosis questioned, then removed by the Wast Hills MDT. His subsequent placement, which commenced in 2014, assessed and treated him as a person with an autistic spectrum disorder. Danshell was asked to comment on apparent conflict between their assertion that no-one else had their diagnosis removed during the period that TT was placed at Wast Hills and the case study provided by CW&C Council. Danshell's response is as follows: "There have been a small number of occasions when someone's diagnosis has been reviewed and changed as part of their assessment and treatment but this is a very small percentage of the patients who have been admitted to the service over the last few years (less than 5%). Often patients are admitted who don't have a definite diagnosis or a diagnosis has been suggested but there has been no confirmation via a normal assessment route. The MDT at Wast Hills offer an external diagnostic service which is well respected so are very experienced in diagnostic testing".

8. Was there compliance with the Mental Capacity Act? Did TT have capacity? Was this assessed?

4.117 From a safeguarding perspective issues of mental capacity and the ability to give informed consent are central to decisions and actions. All interventions need to take account of the ability of adult to make informed choices about the way they want to live and the risks they want to take.

4.118 It is of concern that throughout the safeguarding processes in respect of alerts arising from TT's hospital placement at Wast Hills there was no consideration of TT's mental capacity to understand the implications of his situation and participate to the fullest extent possible in decision making about interventions. The safeguarding co-ordinating Social Worker recorded that TT had capacity to raise concerns and for the adult protection process to follow however, there is no justification to show how this was determined and no mental capacity assessment was completed. The assertion that TT had capacity would have required an issue specific assessment of capacity to support this. As no capacity assessment was completed it is not possible to determine retrospectively whether TT had capacity or not.

4.119 The consideration of best interest principles in the decision to move TT from the lodge into the main building at Wast Hills is considered good practice as there was no statutory requirement to do this as TT was subject to Section 3 of the Mental Health Act. However, whilst it was positive to adopt the principles of best interests in making decisions about moving from the lodge, the said principle would require wider consultation with those involved in TT's care, such as his family. This appears to have happened in a cursory way once a decision had been made.

4.120 TT's Independent Social Worker noted that whilst placed in Wast Hills, TT's speech deteriorated to such a degree that he was no longer coherent and it was very difficult to assess his capacity to make decisions. He adds that prior to his speech deterioration he had been able to express his agreement to decisions and consulted with him when he visited him.

9. How was TT's family involved in key decisions about the care of TT? How were concerns raised by TT's family and third parties (in particular in relation to the use of medication, the use of restraint, the decision to transfer TT to the main house and TT's segregation) addressed?

4.121 TT's family were fully involved in the decision to place TT at Wast Hills. However, they, along with the placing authority, were unaware of the concerns about standards of care at Wast Hills or the Large Scale Investigation.

4.122 In the light of subsequent events, it would appear that inappropriate assurances were given at the time of hospital placement that TT would be able to remain at the lodge. Failure to ensure this created a breakdown in trust between the provider and TT's family. This raises questions about the quality of pre-admission assessments which Danshell accept should have had greater clinical input.

4.123 There are conflicting views over the extent to which TT's parents were consulted over the critical decision to move TT from the lodge to the main hospital.

4.124 WH Consultant Psychiatrist states that TT's parents "were practically a part of the care team. Mum was here two days a week and Dad would come at the weekend." She described communication as being very open. WH Consultant Psychiatrist states that she spoke to TT's mother about the possibility of moving TT to the main hospital several weeks before the move took place and she appeared very upset by the prospect. WH Consultant Psychiatrist says that Wast Hills tried to involve TT's mother in the process of moving TT to the main house but she declined.

4.125 TT's parents state that they were advised by WH Consultant Psychiatrist ringing them to advise that a "unanimous" decision had been made to move TT from the lodge to the main hospital. TT's mother said she responded to WH Consultant Psychiatrist by saying to her "so you are not asking me, you are telling me?" TT's mother said she was distraught at the decision and that she had no idea that things were going so badly. She added that as she visited TT at Wast Hills so regularly, she would have thought that she would have been made aware that the move to the main hospital was being considered.

4.126 Danshell's IMR states that it is not clear how TT's parents were engaged in the process to enable them to fully appreciate the range of other considerations in deciding to move TT to the lodge. Danshell have also identified the learning point that where parents of carers disagree with a decision, it is important to discuss and record the rationale for the decision.

4.127 Turning to medication, TT's parents have expressed a concern that his medication increased four fold whilst at Wast Hills. During the time that TT was a patient at both Greenways and Wast Hills he received treatment via psychotropic medication alongside other medicines. The statutory basis for provision of such medical treatment is provided by compulsory powers under the Mental Health Act 1983. The Mental Health Act Code of Practice (2008) notes that treatment in a hospital is "rarely likely to be helpful for a person with autism". (Para 34.18) The use of medication to help alleviate the significant distress TT was experiencing appears an appropriate response as part of a wider approach to managing TT's health and care needs.

4.128 Section 58 of the Mental Health Act 1983 requires the use of medication for a patient subject to compulsory powers of detention to be reviewed by a "Second Opinion Appointed Doctor" (SOAD) in circumstances where the said patient is unable to consent to their treatment due to reasons of mental capacity or refuses to do so. The Danshell IMR states that a review of medical treatment by a SOAD was arranged within the statutory timeframe and a further SOAD review was requested as a result of changes to medication. The review of a treatment plan by a SOAD is a safeguard under the Mental Health Act to help assure both consistency and the appropriateness of the medication provided to a detained patient.

4.129 Ensuring antipsychotic an antidepressant medicines are used to ensure the best course of action for the patient and not over-used is part of the post-Winterbourne View "Transforming Care" Programme. (4) This part of "Transforming Care" continues to be taken forward under the Winterbourne Medicines Programme. (5)

10. Did TT have access to an advocate whilst at Wast Hills? Why was access to Wast Hills denied to TT's Independent Social Worker who was employed by the family to monitor the effectiveness of TT's hospital placement?

4.130 TT did not appear to have access to an Independent Mental Health Advocate (IMHA) whilst at Wast Hills. This is a statutory entitlement for patients detained under the Mental Health Act and that the duty to ensure provision rested with Worcestershire County Council as the local authority in which Wast Hills Hospital was located. Apparently there were problems with the locally contracted service. Danshell's SCR Panel member advises that general independent advocacy was provided via VoiceAbility throughout TT's stay at Wast Hills.

4.131 The Winterbourne View SCR emphasised the importance of access to an IMHA (3)

4.132 TT's parents decided to employ a suitably qualified professional to monitor their son's hospital placement and identified TT's Independent Social Worker to fulfil this role. He is an authority on autism and lived close by Wast Hills. He visited TT at Wast Hills fortnightly and provided a written report to TT's parents after each visit. The reports covered TT's healthcare, including mental health care and safeguarding and the extent to which his autism, particularly his sensory needs, were being appropriately addressed.

4.133 TT's Independent Social Worker states that he became increasingly concerned about the care that TT was receiving, in particular the frequency and duration of restraints, and asked for a consultation with WH Consultant Psychiatrist which he says was denied. He states he was asked to make a formal referral to request a meeting to Castlebeck in Administration's HQ in Darlington. After consulting TT's parents he decided not to pursue a formal referral.

4.134 In December 2013 he sent a report to CW&C Social Worker expressing his deep concern about TT's care and treatment at Wast Hills and the lack of understanding of autism displayed by the staff. On the 28th December 2013 he raised his concerns with the CQC who referred him to WCC Adult Safeguarding who he states he rang and left a message on their answerphone but never received a reply.

4.135 After visiting TT at Wast Hills for several months, TT's Independent Social Worker states that Danshell questioned his role in respect of TT. Having initially invited him to attend the meeting at which TT's diagnosis was questioned on 11th February 2014, TT's Independent Social Worker says that he was presented with a letter which sought to clarify his role. He says that he was advised that the Data Protection Act precluded him from being present. He states he was asked to leave the meeting and sit in a room next door where TT's parents, who had also been invited to the meeting, could consult him. TT's Independent Social Worker states that he decided to leave and says he entertained suspicions that the reason for his exclusion was because he had informed the CQC of his concerns about TT's care and treatment. TT's parents said the exclusion of TT's Independent Social Worker came as a "huge shock".

4.136 TT's Independent Social Worker states that he never visited TT in Wast Hills after being excluded in February 2014. He says he wrote to Danshell in response to the letter they handed him at the CPA meeting but received no reply. Danshell state that a meeting was held to discuss the letter of reply from TT's Independent Social Worker and the task of composing a reply was allocated to a senior manager who has since left the organisation. As a result Danshell are unable to say whether a response to the letter received from TT's Independent Social Worker was sent or not.

4.137 In their IMR, Danshell state that it was unfortunate that his access was restricted immediately prior to his attendance at a meeting at Wast Hills. Danshell's IMR author adds that it was even more unfortunate that this event appeared to have fractured an effective communication channel between TT's Independent Social Worker and Wast Hills. TT's parents felt that TT's independent social worker was excluded because Wast Hills felt threatened by him.

4.138 A subsequent WCC investigation found that there was a lack of clarity over TT's Independent Social Worker's role. The investigation report stated that he had apparently stated in the Wast Hill visitors' book that he was TT's advocate and this had been confirmed in a letter from TT's mother. He also referred to himself as TT's Independent Social Worker. Danshell sought written confirmation of his role in order for TT to make an informed decision whether he should be involved in multi-disciplinary review meetings. Until such time as confirmation of role was received, TT's Independent Social Worker was not permitted to attend multi-disciplinary meetings. This concern was closed to adult protection as "not substantiated" although it was acknowledged that Wast Hills could have handled this issue better in terms of clearer communication with all parties.

4.139 Given that TT did not benefit from an IMHA it seems extremely regrettable that any role confusion could not have been resolved more amicably given that TT's Independent Social Worker had been visiting TT at Wast Hills for eight months. It is particularly regrettable that TT's Independent Social Worker should be excluded at a point just before the hospital placement broke down.

11. The provider's escalation policies: How did the provider raise and escalate concerns which arose from the hospital placement of TT at Wast Hills? How effectively did the provider direct and support their staff in this regard?

4.140 Danshell's IMR author states that there were a number of emails detailing the efforts from the provider to try to secure a more suitable environment when it became apparent that Wast Hills could no longer manage TT's behaviours safely. However this communication appears to have taken place only after the critical incident began.

4.141 The NHS Vale Royal CCG IMR author takes the view that there was little warning that the hospital placement was breaking down and that there was no evidence that concerns were escalated.

4.142 The risk of breakdown of the hospital placement did not intensify until 27th February 2014. However there were indications that the hospital placement was at risk from the point at which TT was moved from the lodge to the main hospital. Additionally the questioning of TT's diagnosis, which began in January 2014 had the potential to render TT's hospital placement in an autism specialist facility as no longer suitable for his needs. As stated previously Danshell could and should have shared their thinking around diagnosis with NHS Vale Royal CCG at an earlier stage to enable the placing authority to begin to consider alternatives.

12. The critical incident from 3rd – 6th March 2014: What appear to be the triggers for the critical incident? Was the use of restraint by the provider's staff at West Hills and by the police appropriate and in accordance with law and policy? Was the action taken by the police in response to requests for assistance from Wast Hills appropriate? How appropriate was the information provided to the Police by Danshell as to TT's needs and diagnosis? Was action taken by the provider and the police in accordance with Mental Health Act protocols and procedures? Why was TT denied an appropriate adult whilst in police custody?

4.143 The immediate trigger for the critical incident appears to have been a meeting between TT and his mother and a solicitor at Wast Hills on 27th February 2014. It appears that the solicitor, who was meeting TT for the first time, may have inadvertently raised TT's hopes of returning to the lodge.

4.144 The police initially attended Wast Hills at 9.20 am on the 3rd March 2014 following a telephone call from Wast Hills staff stating that they were struggling to deal with TT. Wast Hills staff requested the police take TT into custody as they were no longer able control him. The police provided advice to the effect that police custody was not an appropriate course of action for a person already detained under the Mental Health Act. The police also stated that it was Wast Hill's responsibility to contact the placing authority and seek an alternative hospital placement. The author of the police IMR concluded that this was an appropriate response by the police.

4.145 At 5.29pm on the same date a further call was received by Police from the WH Clinical Nurse Lead who is alleged to have stated that "we have a male detained under the Mental Health Act. He has assaulted pretty much every member of staff and we need Police assistance" The Police message also recorded that at the time of the call there were eight members of staff trying to restrain TT. The police contend that WH Clinical Nurse Lead also stated that TT had capacity and that staff wished to press charges in respect of the assaults on them. Danshell deny there was any reference to TT having capacity. They say that the police would have been told that TT had fluctuating mental capacity.

4.146 In any event the outcome was completely different to the earlier call to the police. On this occasion TT was arrested on suspicion of assault. Due to his violent behaviour he was handcuffed, although he continued to struggle, kicking out at officers and attempting to bite them. He was then conveyed to Kidderminster Police station.

4.147 The police did not link this second call from Wast Hills with the earlier call. Had they done so, it seems likely to have affected police decision making in respect of the second call. The police may then have reiterated the advice they had given Wast Hills staff in the morning.

4.148 It has not been possible to conclusively say whether Wast Hills staff claimed that TT had capacity when they contacted the police on the second occasion on 3rd March 2014. The police retain audio recordings of calls for service for twelve months. Therefore it has not been possible to listen to the recording in view of the time that has elapsed. TT's parents say that it is very regrettable that the delay in commissioning a SCR has resulted in the audio recording of the calls made by Wast Hills staff to the police being unavailable.

4.149 What is clear is that the police record of the earlier call makes no reference to TT having capacity whilst the record of the later call makes specific reference to TT having capacity. After a day of restraining TT in the most challenging of circumstances, Wast Hills staff appeared willing to pursue allegations of assault against TT when this does not appear to have been the case at the time of the earlier call to the police.

4.150 It is assumed that during the period between the two calls to the police on 3rd March 2014, the decision to remove TT's diagnosis of Learning Disability and Autism was finalised and documented. It is unclear how widely this decision was shared with Wast Hills staff on 3rd March 2014, so it can only be speculation to suggest that there was any link between the removal of TT's diagnosis and the alleged reference to TT's capacity to be held responsible for his actions when Wast Hills staff summoned the police for the second time at 5.29pm. (As stated in Paragraph 4.60, Danshell deny there was any such link.)

4.151 If Wast Hills staff did claim that TT had capacity when they contacted the police on the second occasion, this does not appear to have been questioned by the officers who attended Wast Hills and made the arrest, although the Custody Sergeant at Kidderminster Police Station appears to have quickly formed the view that interviewing TT for criminal offences was not an appropriate option. The Mental Health Act and Mental Capacity Act advisor to this SCR Panel states that determining whether TT had capacity to be held responsible for inflicting injuries on Wast Hills staff would have required a formal assessment of his capacity in relation to this specific issue with full and detailed recording. This did not take place.

4.152 After his arrival at Kidderminster Police station TT remained in handcuffs, as any attempts made to remove were met with violence by TT. It is recorded that he continually spat at officers which resulted in them applying an approved mesh "spit" hood. He was also placed in Emergency Restraint Belts on occasions for his safety and that of the custody staff. TT remained under constant watch supervision throughout his time in custody and custody staff reported that he did become calmer over time.

4.153 The police did not call out an Appropriate Adult in respect of TT. As the FME had examined TT and concluded he was not fit to be detained, this precluded an interview for the allegations of assault which negated the need for an appropriate adult for interview purposes. However the role of appropriate adult is not only limited to interviews.

4.154 When TT's parents were informed of their son's arrest they asked TT's Independent Social Worker to attend Kidderminster Police Station. He was unable to do so as he was attending a conference in Harrogate. However he contacted the Director of Autism Inclusion and she and her husband, who also works for Autism Inclusion, attended Kidderminster Police Station.

4.155 The Director of Autism Inclusion said that TT's mother was distraught at what had happened to her son. She said she hoped she might be able to calm TT down in what was certain to be a very stressful situation for him. She also anticipated that she could be there to offer her services as an Appropriate Adult in respect of TT and subsequently be able to give TT's parents an update.

4.156 The Director of Autism Inclusion spoke to two custody staff who said they couldn't permit access to TT as he was very agitated. She says she didn't introduce herself as an Appropriate Adult but made it clear that she was attending the police station on behalf of TT's parents and his Independent Social Worker. She felt that their single focus appeared to be to get TT out of the police station to somewhere more suitable. She says they said that they had almost completed the paperwork for his transfer to "St. Andrews" – a secure unit.

4.157 The Director of Autism Inclusion stated that she didn't feel that the custody staff saw her as a potential resource or were open to her professional advice. However the custody staff took her contact details and she received telephone updates from the police during the night.

4.158 During TT's detention he was examined by the Police FME and visited twice by a member of Worcestershire Psychiatric Assessment Team. A member of staff from Wast Hills also attended the police station initially, conferred with the FME and left medication and other items for TT. TT's parents ask whether Danshell had a duty of care to their son and whether someone from Wast Hills should have remained with him throughout his period in custody so that there was a familiar face during this ordeal. TT's parents, solicitor and Independent Social Worker were also kept updated regarding his detention.

4.159 TT was in police custody from the early evening of 3rd March until around 4am the following morning. He was restrained for the entire period after spending most of the day prior to his arrest being restrained by large numbers of Wast Hills staff. And on his release from police custody he was returned to Wast Hills.

4.160 This must have been a terrifying experience for TT.

4.161 Turning to the use of restraint on TT, the Mental Health Act 1983 Code of Practice (2008) acknowledges that for people with autism spectrum disorders, compulsory measures under the act can become necessary, particularly when that person is unable to prevent themselves from causing harm to themselves or others. Episodes of distress often associated with aggressive behaviour were a feature of TT's presentation during his hospital placement at both Wast Hills and Greenways. The Code of Practice referred to above provides guidance for care providers in relation to "safe and therapeutic responses to disturbed behaviour". The guidance acknowledges that there are occasions where physical restraint can be needed to prevent physical assaults or destructive behaviour or dangerous behaviour and the Mental Health Act provides a legal underpinning for such actions. Danshell report that TT required four instances of "T-supine" restraint from the point of his admission to Danshell until 3rd March 2014. On 3rd March 2014 they state that he required ten instances of "T-supine restraint on that single day.

4.162 The statutory guidance sets out very clear expectations that such interventions are both a proportionate and justified response to the particular risk posed by the patient. A hospital should have a written policy on the management of disturbed behaviour, which staff involved in care provision should be aware of, and such techniques should only be used as a last resort. In cases where physical restraint is used the reasons for its use should be recorded and every episode documented. The statutory guidance places an expectation on hospitals to have individual care plans for the management of such behaviour where the focus is on early identification, which recognises the context of such behaviour and considers how de-escalation can be used. Danshell has provided information which indicates that breakaway techniques and verbal redirection were used in advance of physical intervention. TT's parents observe that physical restraint on TT only happened at Greenways and Wast Hills and did not prove necessary before or after these two hospital placements.

4.163 Reducing the need for physical restraint is also included the post-Winterbourne "Transforming Care" programme. (6) Currently the Department of Health state that they are unable to routinely collect data on the use of restraint but that they are working with the Health and Social Care Information Centre (HSCIC) to agree a single definition of restraint and to expand the detail of what is routinely published in this area from 2016. TT's parents strongly feel that the same weight and priority should be given to the recording of instances of restraint as is given to the recording of assaults and other challenging behaviours by patients such as their son.

13. Attempts to find an alternative hospital placement for TT: What action was taken by the provider and the placing authority in an effort to find an alternative hospital placement? Were attempts to find an alternative hospital placement for TT affected by the change in his diagnosis referred to at 6 above? Is there sufficient availability of psychiatric beds to meet needs?

4.164 Danshell state that they made attempts to obtain a psychiatric in-patient hospital placement for TT. They also say that the removal of the diagnosis made no difference to their efforts as the need to transfer TT was based on his acute presentation and level of aggressive behaviour.

4.165 CWP on behalf of NHS Vale Royal CCG made strenuous efforts to find a suitable hospital placement for TT including approaching Specialist Commissioning at NHS England on several occasions. They state that attempts to find a hospital placement were not affected by the change in his diagnosis. In fact hospital placements were sought on the basis of a Learning Disabilities diagnosis with challenging behaviour. The NHS Vale Royal CCG IMR Author states that this case illustrates the lack of suitable PICU beds. However the SCR Panel felt that TT's original diagnosis meant that he did not fit local PICU criteria.

4.166 The Worcestershire Health and Care NHS Trust PICU Operational Policy, which was last updated in 2013 sets out criteria for admission and exclusion. Whilst admission criteria include patients detained under Section 3 of the Mental Health Act, the Mental Health Act advisor to the SCR Panel expressed the view that admission to a PICU would not have been appropriate for TT because he could have been vulnerable in that environment and staff may not have possessed the range of skills necessary to meet his needs.

4.167 Police officers involved in attempting to identify suitable accommodation for TT whilst he was in custody described frustration at being advised "nothing could be done until the following day". They spent around two hours on the telephone speaking with different secure mental health units, which all declined to accept TT. The officers concerned feel that they received little support from health services in attempting to identify suitable accommodation for TT.

4.168 The police state that when they contacted with Worcestershire Emergency Duty Team (EDT) they informed the police that they had not heard of Wast Hills and when it was clarified with Worcestershire EDT that Cheshire were the funding authority, they reportedly told them to contact Cheshire EDT. The Worcestershire Psychiatric Assessment Team were contacted and apparently advised the police that they could not secure a bed for TT as the funding needed to come from the authority responsible for placing him at Wast Hills. TT's parents express surprise that Worcestershire EDT had not heard of Wast Hills hospital given that it was subject to a Large Scale Investigation.

4.169 WHCT state that discussions did take place with the PICU Intensive Care Unit in Worcestershire and another Intensive Care Unit. A bed would have been available at PICU on the morning of 4th March. However it was considered inappropriate at that time and as TT was expressing a wish to return to Wast Hills, this would have been the most appropriate decision to be taken in the circumstances.

4.170 When the Recovery First assessing team visited Wast Hills to assess TT on 5th March 2014, they state that they were informed that, in the opinion of TT's current MDT, being placed in an autism specific service, with clear structure, boundaries and routine, had actually exacerbated some of TT's difficult behaviours. Wast Hills staff added that a hospital placement in any similar service would not be helpful as TT was not on the autism spectrum. This suggests that the change in TT's diagnosis could well have affected attempts to find an alternative hospital placement.

4.171 Danshell was advised by WCC to write an escalation policy for hospital placement breakdown and ensure that this is addressed in pre-hospital placement assessments and contractual arrangements. Danshell advised this review that instead of a generic escalation policy, each patient has a care plan which addresses placement break down.

14. How appropriate was the transfer and handover of TT from Wast Hills to Recovery First? Were TT's comfort items transferred with him? If not – why not? Was it appropriate for TT to be transferred in a spit hood?

4.172 The transfer of TT by private secure ambulance from Wast Hills to Recovery First appears to have been planned thoroughly although arriving at Recovery First at 10.40am on 6th March 2014 when Recovery First were not expecting TT until noon, created a number of problems.

4.173 The approach adopted by the secure ambulance company and Wast Hills staff appeared to operate effectively until around 20 minutes before the end of the journey when TT became agitated which necessitated the operation of blue lights.

4.174 A spit hood was used after TT arrived at Recovery First whilst the secure ambulance staff restrained him during the admission process which appeared to have been prolonged by the early arrival of the secure ambulance. This lengthy admission process understandably appeared to provoke anxiety in TT. The secure ambulance staff say that the spit hood was used after TT had begun to spit at staff, and only after consulting Wast Hills and Recovery First staff.

4.175 The Recovery First IMR states that the nursing staff on the ward felt the level of restraint by a large number of secure ambulance and Wast Hills staff was excessive. The Recovery First IMR states that their MDT felt that the use of a spit hood was inappropriate. They acknowledge that TT does spit at staff when agitated or anxious but that Recovery First nursing staff prevent spitting to the face using verbal prompts to stop, attempt redirection or simply put a hand up to block this. In their experience TT usually stops before he actually spits and so it is viewed as more of a gesture to spit.

4.176 The manner of the transfer of TT to Recovery First, restrained by up to seven staff and wearing a spit hood, coupled with a lack of information about TT at that point, was said to have significantly increased the anxieties of nursing staff at Recovery First and diminished confidence in their belief that they could safely nurse TT. (It is noted that the secure ambulance service – then known as Definitive Secure Ambulance but now known as Secure 24 - dispute the accuracy of this statement; the concerns they have raised have been considered by the independent author and the SCR panel, and a judgement has been made based on a full analysis of the evidence submitted by all agencies.) The nursing staff were also concerned that Wast Hills staff departed without spending anytime to support TT in his initial transition to Recovery First.

4.177 TT's comfort items were sent with him in the secure ambulance which transported him to Recovery First. They were not handed to Recovery First staff at the point that TT was transferred and were only discovered when the ambulance returned to the company's base at London Gatwick at the end of the day. The comfort items were then posted by the secure ambulance service to Wast Hills on Friday 7th March 2014 and so the earliest they are likely to have arrived at Wast Hills appears to be Saturday 8th March 2014.

4.178 Danshell initially stated that the comfort items that were left in the private ambulance were sent to TT the "following day" It has not been possible to establish when, or if, Danshell sent the comfort items, or when, or if, Recovery First received them.

4.179 TT's parents say that the comfort items did not reach Recovery First until "weeks after" TT transferred there. They say that a nurse from Recovery First had to write to Wast Hills in order to secure the comfort items.

4.180 The Director of Autism Inclusion says that in order to expedite the transfer of the comfort items, she and her husband visited Wast Hills on Friday 7th March 2014 in order to collect the items and deliver them to Recovery First as quickly as possible. The Director of Autism says that they collected a number of items identified by Wast Hills staff to belong to TT, which were stored in the lodge. They delivered them TT's parents the next day – Saturday 8th March 2014 and discovered that TT's comfort items were not amongst the items they had collected from Wast Hills.

4.181 It seems likely that when the Director of Autism Inclusion called at Wast Hills on Friday 7th March, the comfort items would probably not yet have arrived by post from the secure ambulance company.

4.182 The Recovery First IMR describes the repeated attempts to request Wast Hills to forward TT's comfort items to them. (Paragraph 3.134)

4.183 Recovery First state that in addition to the missing comfort items, TT was not sent with any food items which are very important to his routines. TT was very concerned about his drink of coke at supper time, and this had not been handed over. A member of Recovery First staff went to purchase this in order to reduce his anxiety.

4.184 TT's parents take the view that the failure to ensure that TT's comfort items were transferred to Recovery First is a serious omission. They say that, given the agitated state their son was in at that time, not ensuring the transfer of his comfort items risked the new hospital placement getting off to a very unsatisfactory start. They add that Wast Hills staff were well aware of the importance of the comfort items to TT and that they had always ensured these accompanied TT on his home visits from Wast Hills.

4.185 The transfer of TT from Wast Hills to Recovery First appears to be viewed in a quite different light by the staff involved from Wast Hills and Definitive Secure Ambulance on the one hand, and Recovery First on the other. This may in part be a reflection of their experiences of TT. Wast Hills staff had emerged from a very difficult period in which TT was extremely agitated and violent to which they had responded by using lengthy periods of restraint. Definitive Secure Ambulance staff would have been briefed accordingly. Recovery First staff have a much more positive view of TT as a result of the considerable progress they have made in caring for him which may have affected their perceptions of how his arrival and handover to Recovery First was managed. However it is clear that the failure to ensure that TT's comfort items were handed over had the potential to seriously disrupt the beginning of his hospital placement at Recovery First and the inexplicable and unexplained delay in forwarding these items on to Recovery First compounded the failure. It indicates an extremely troubling lack of care for TT.

15. How effectively have agencies responded to and investigated allegations and concerns arising from TT's hospital placement at Wast Hills including the critical incident?

4.186 As the host authority it was the responsibility of Worcestershire to co-ordinate investigations and ensuring clear communication with the placing authority and other agencies involved.

4.187 On 26th February 2014, Wast Hills completed their internal investigation of the 14th December 2013 incident and concluded that physical intervention in the form of a "supine T" on TT's bed had been used". (The Winterbourne View SCR recommended that the Department of Health, Department for Education and the CQC should consider banning the T-supine restraint of adults with learning disabilities and autism in hospitals and assessment and treatment units. (7))

4.188 Whilst there is evidence of prompt responses to safeguarding alerts, multiagency working, and actions taken to safeguard TT, there are also some significant gaps. The co-ordinating WCC Social Worker did not inform CW&C Social Worker (WCC incorrectly believed CW&C Council to be the placing authority) at all about the first safeguarding alert at Wast Hills and did not include CW&C Social Worker in strategy discussions and key decisions made when agreeing protection plans for two subsequent Wast Hills safeguarding alerts. Also the safeguarding concerns regarding three safeguarding alerts for TT were not investigated through individual safeguarding procedures but incorporated into the Large Scale Investigation process. Whilst strategy discussions did take place over the telephone there were no individual strategy meetings for TT and no individual case conferences. Rather, information specifically relating to TT was shared at the Large Scale Investigation meetings together with information concerning multiple investigations relating to other service users. This negated an individualised approach and made it difficult to obtain a clear picture of the investigations, to track progress, and identify individual outcomes.

4.189 WCC add that there is little evidence that TT and his parents were engaged meaningfully, if at all, in any of the safeguarding investigations that were carried out. At no stage was a mental capacity assessment carried out for TT to determine his understanding of the adult protection procedures, and there is no real sense of TT as an individual with no record of the outcomes he wanted to achieve and how he was supported through the process.

4.190 The police carried out full criminal investigations in relation to the assaults reported by staff that occurred on the 3rd March 2014 and also assaults disclosed by TT which he alleged were carried out by members of staff at Wast Hills whilst he was resident there.

4.191 In relation to the assaults reported by staff against TT, these have been filed as undetected due to "lack of mental capacity held by the suspect to be prosecuted".

4.192 Despite enquiries there was insufficient evidence, independent or otherwise to take further action in relation to the incidents disclosed by TT. His parents have been informed. However, the investigation remains open pending the outcome of Wast Hills internal investigation which is not yet known

16. How appropriately were diversity issues in respect of TT addressed?

4.193 TT's ethnic heritage appeared to have been recorded by only a minority of agencies involved with him.

4.194 Greenways staff appeared to have made efforts to understand the importance of sons in the culture of TT's father and the difficulties he initially experienced in coming to terms with his son's disabilities.

4.195 In terms of equity of access to medical services TT had access to primary care when required and had an annual health check as he was entitled to as a person with learning disabilities.

4.196 The GP practice which cared for Wast Hills Hospital service users has stated that in their experience: "Wast Hills routinely accesses the GP or practice nurse, or requests visits with a frequency that would most likely exceed patients not in a cared for environment. It would be fair to say that clients at Wast Hills probably have better access to health care than patients who do not have carers to help them as the carers always err on the side of caution"

4.174 There was a lack of clarity about whether a local enhanced service was in place for Wast Hills service users during the period of TT's placement. The Large Scale Investigation meeting minutes of April 2014 state that there was no evidence of a local enhanced service. However the Birmingham South Central CCG has confirmed that a local enhanced service has been in place since 2007 or 2008.

5 Engagement with TT and his family

5.1 TT's parents were eager to contribute fully to this SCR, having felt so strongly that a SCR was justified that they had initiated a judicial review of the initial decision by WSAB not to commission a SCR.

5.2 They both obviously care deeply for their son and are understandably concerned that he receives the best possible care and support. They appeared to have been traumatised by the events of the past three years in which TT had been sectioned under the Mental Health Act first at Greenways and then at Wast Hills Hospital. The circumstances surrounding the breakdown of TT's hospital placement at Wast Hills left them angry and upset. They wish to hold agencies to account for failings in the care and treatment of their son, and his mother in particular is passionate about using the learning from her son's treatment to make changes in the system.

5.3 TT's mother and father met the author and provided a detailed account of events from their perspective which has been incorporated into this overview report. They also made detailed comments on the terms of reference which were also shared with their lawyer.

5.4 They were keen that the author should meet with TT if this could be arranged, in order that his voice could be "heard". It was agreed that a person who had known TT all his life and who had advocated for him in the past would arrange a meeting with TT when he was on home leave from Recovery First. The advocate prepared a social story to help prepare TT for the meeting in order to try and minimise any anxiety he might feel. A two hour meeting subsequently took place with TT. He was accompanied by two nurses from Recovery First who managed the anxiety and agitation he exhibited with consummate skill. TT appeared to link the meeting with a fear that he might be taken back to "hospital" by which the author assumed he meant either Wast Hills or Greenways or both. Throughout the meeting he sought constant reassurance from his advocate and another trusted person he contacted by phone that he would not be returning to hospital. The author is neither a social care professional or clinician, but gained the strong impression that TT's experiences in Greenways and Wast Hills had left him traumatised and extremely fearful of being made to return there. It was not possible to explore any issues with TT on this occasion such as his wishes for the future.

5.5 However the advocate who arranged and supervised the meeting with TT helpfully prepared a document which set out many of the phrases that TT repeats constantly in order to provide further insight into his perspective. Some of the key phrases are set out below:

"I'm worried about nasty hospital people holding me and not allowing Blue Pepsi at supper time." (Advocate suggests this is as a result of his favourite drink being denied him as consequences for behaviour whilst at Greenways.)

"I'm so anxious. I'm worried about an ambulance taking me away to a monster hospital."

"What has happened to the monster hospital? If I'm sent to a monster hospital I will kill myself."

"I want to go back to the lodge. It was comfortable there." (Said whilst on home leave in February 2014)

"Will (name of his sibling) be going to the monster hospital now she is 18"?

"Will the bathroom door be open all my life?" (Advocate suggests that this is related to his bathroom door being locked whilst at Greenways)

“I am worried they will take my mattress and fan.” (Advocate suggests this is a consequence of Greenways and Wast Hills)

“I am anxious about bad things happening this year.”

“Look I’m free.” (Said to the advocate whilst TT at Recovery First)

5.6 The independent author and the SCR Panel would like to express their gratitude for the work of TT’s advocate in facilitating the meeting with TT and providing such a valuable insight into TT’s wishes and concerns.

5.7 A meeting was subsequently held with TT's parents to enable them to read the final draft of the SCR Overview Report, provide any additional comments and say what changes they felt were justified by the learning from this SCR. The comments they made at this meeting have been incorporated into this SCR Overview report.

6. Findings

6.1 TT is a young man with complex needs associated with autism spectrum disorder who requires skilled and specialist support to meet his needs safely and effectively. His behaviour can be extremely challenging. This SCR has demonstrated that there have been serious multiple failings within and across agencies in ensuring TT received support appropriate to his needs.

6.2 Although this is outside the scope of this SCR, TT’s transition from Children’s Services to Adult’s services in Cheshire West and Chester Council does not appear to have been well planned. This contributed to him spending far too long in Greenways Treatment and Assessment Centre. Whilst there are conflicting views about the treatment and care TT received at Greenways, no-one has put forward the view that staying there so long contributed positively to his wellbeing. And TT’s understandable anxiety about his future appears to have heightened his distress and challenging behaviours leading to more restraint and less stimulation at Greenways. This was a vicious cycle in which TT was trapped, largely powerless. And as TT’s behaviours became more challenging the choice of placements able to care for him appeared to narrow, until finally Wast Hills Hospital emerged as the only viable option.

6.3 NHS England's recent report entitled "Transforming Care for People with Learning Disability – Next Steps" (8) set out further steps to prevent adults with a learning disability and/or autism being admitted to hospital inappropriately. It envisages that CCGs and local authorities will draw up registers which identify those individuals most at risk of being admitted to hospital so that the right support can be made available to them to prevent the need for admission. It is also envisages that where admission is considered, a robust challenge process will be put in place to check that there is no available alternative. Where individuals are admitted, they would have an agreed discharge plan from the point of admission, with monitoring processes put in place to ensure that the discharge plan is followed. All of these measures could have been of benefit to TT and his family if they had been policy at the time he was detained under the Mental Health Act.

6.4 After the decision was taken to place TT at Wast Hills, failings multiplied. Serious concerns existed regarding the quality of care provided at Wast Hills, where multiple safeguarding investigations were underway. NHS Vale Royal CCG, the agency which placed him there, failed TT by not notifying the host authority (Worcestershire County Council) of his hospital placement and largely failing to monitor that placement. Worcestershire County Council failed him by not notifying placing authorities of the Large Scale Investigation they had initiated in respect of Wast Hills. They also failed him by poorly managing the Large Scale Investigation, which lasted so long that it eventually encompassed the concerns about the manner in which his hospital placement at Wast Hills ended.

6.5 TT's placement at Wast Hills completely failed. There appeared to be unduly heavy reliance on restraint to manage his presenting behaviour before it was decided that because he did not respond positively to their approach, TT's diagnosis of autism and learning disability should be removed. And Danshell, the providers at Wast Hills, did not appear to notify the placing authority that the placement was breaking down until the critical incident had commenced on 3rd March 2014. And when the critical incident occurred, TT's agitation was met with more or less continuous restraint until Wast Hills contacted the police who arrested him and placed him in police custody which must have been a terrifying experience for TT.

6.6 In spite of this TT has made significant progress at Recovery First. TT's hospital placement there began in the most inauspicious circumstances imaginable. He was delivered there in a secure ambulance wearing a spit hood and in continual restraint by up to seven staff. He was left there without his comfort items which included his favourite books and DVDs and the food and drink he liked which seriously exacerbated the difficulties experienced on his arrival. Despite this, Recovery First staff have "worked wonders" with TT (in the words of his parents). He undoubtedly remains a challenging young man to care for and designing a suitable environment for him outside a hospital setting will be equally challenging.

Voice of TT

6.7. An advocate who has known TT all his life carefully facilitated a meeting between TT and the independent author and provided the review with valuable insights into TT's areas of concern and wishes for the future.

6.8 TT appears to have endured significant trauma during his hospital placements at Greenways and Wast Hills. At times his anxiety levels must have been excruciatingly high as he waited six months before being allowed to go on home leave from Greenways and when he was arrested and placed in police cells whilst at Wast Hills for example. We must all remember that TT lacks the facility to unburden himself by discussing his anxieties and fears with people he trusts. This is an outlet most of us take for granted but which is largely denied TT as a result of his disabilities. It must be said that empathy for TT's plight has not always been apparent in the reports shared with this review.

Large Scale Investigations

6.9 The Large Scale Investigation conducted by Worcestershire County Council was seriously flawed. When it commenced there were no Large Scale Investigation procedures in place to guide it and when procedures were introduced five months after the Large Scale Investigation began, they were not adopted. No terms of reference were agreed at the outset and no report was prepared at the conclusion. The meetings operated as both case conferences for individual service users at Wast Hills and as a forum for considering general concerns about Wast hills. The methodology adopted for assessing risk lacked rigour and the investigation drifted on for 15 months. One of the functions of a Large Scale Investigation is to provide senior management with assurance that action is being taken to address identified risks. There was a risk that the Large Scale Investigation may have provided senior managers in WCC and other agencies with a greater level of assurance than was merited by the manner in which the Large Scale Investigation was conducted.

6.10 Crucially the Large Scale Investigation took no action to suspend new hospital placements to Wast Hills or notify placing authorities of the Large Scale Investigation until a further whistleblowing call was received six months after the Large Scale Investigation began. By this time TT had been placed at Wast Hills by NHS Vale Royal CCG who remained ignorant of the Large Scale Investigation for several months thereafter. (Placing authorities such as NHS Vale Royal CCG have an obligation to notify the host authority of the hospital placement which they failed to do in respect of TT.)

6.11 Had the Large Scale Investigation procedures been adopted it is unclear whether the process would have been an effective method for addressing the concerns about Wast Hills which began to surface in the first half of 2013. The SCR Panel was unconvinced by the usefulness or even the need for Large Scale Investigation procedures. It is noted that the West Midlands Regional Safeguarding Network is currently reviewing Large Scale Investigation guidance and it is suggested that the network is made aware of this SCR and specifically the failings the SCR highlights in the Large Scale Investigation approach.

Recommendation 1:

That Worcestershire Safeguarding Adults Board shares this SCR Overview Report with the West Midlands Regional Safeguarding Network review of Large Scale Investigation procedures.

Failure of hospital placement at Wast Hills

6.12 NHS Vale Royal CCG decided to commission a hospital placement for TT within a specialised autism unit with the ability to help him to transition to the least restrictive environment after a period of stability and reduction in the presentation of his behaviours. This desired outcome was not met therefore the hospital placement failed.

6.13 Hospital placements sometimes fail. But the way in which the failure of this hospital placement was handled was poor. Whatever view one takes of the care and treatment of TT at Wast Hills, the manner in which his placement at Wast Hills ended represented a serious failure. A very vulnerable young man suffered a sequence of traumatic experiences which may adversely affect him for many years. This was a wholly undesirable outcome of the decision to place TT in a specialist autism hospital.

6.14 Out of area placements such as TT's placement at Wast Hills generate a number of practical difficulties when they break down, given the geographical remoteness of the placing authority. It is therefore incumbent on all placing authorities in out of area placements to put in place a contingency plan with the provider to ensure that any indication that an out of area placement is breaking down is immediately notified to the placing authority.

Recommendation 2:

That Worcestershire Safeguarding Adults Board write to NHS England to draw their attention to this SCR and request that they write to all CCGs to remind them of the need for a placement failure contingency plan for all out of area placements.

Monitoring of placements

6.15 The monitoring of TT's hospital placement at Wast Hills by the placing authority NHS Vale Royal CCG was extremely limited. The desired outcomes for TT's hospital placement were set out in the high cost funding application. The contrast between the care with which these outcomes were articulated in the high cost funding application and the lack of attention paid to monitoring whether these outcomes were achieved is extremely stark.

6.16 It is TT and his family's misfortune that his hospital placement took place during a period of huge change in the health service. Primary Care Trusts (PCT) ceased to exist on 31st March 2013. (four months before TT's hospital placement at Wast Hills began) PCTs were replaced by CCGs. This review makes it absolutely clear that it took some time before CCGs began to function as conceived. The NHS Vale Royal CCG IMR author indicates that for a time, confusion reigned: "TT's hospital placement at Wasthills therefore took place in the context of significant organisational change within health commissioning, where key clinicians and managers were distracted by changes in organisational structures as well as roles and responsibilities and well established systems and processes within health and across health and social care were torn apart. The net result was confusion between health and social care professionals and crucially, with clients and families".

6.17 This was clearly a change of the utmost complexity and the evidence considered by this review suggests it was not as well managed as it should have been. One of the key indicators of how well a major change has been implemented is the extent to which the change recognises and mitigates risk to vulnerable service users. Measured against that indicator the implementation of CCGs failed in this case of TT.

6.18 It is also TT and his family's misfortune that the introduction of CCGs impacted on local quality assurance checks of Wast Hills. It is clear that initially there was a lack of clarity over which health organisation was responsible for undertaking Quality Assurance visits to Wast Hills at the time of TT's hospital placement there. Quality Assurance visits were not undertaken by Primary Care Trusts, but from April 2013

they were required to be undertaken by CCGs. It was not until November 2013 that CCG Quality Assurance visits were made to Wast Hills.

Recommendation 3:

That when Worcestershire Safeguarding Board write to NHS England to draw their attention to this SCR, (see Recommendation 2) they also suggest that the SCR Overview Report would be a valuable case study to circulate to CCGs to remind them of the importance of monitoring out of area hospital placements.

Recommendation 4:

That Safeguarding Adults Boards seek assurance that Worcestershire CCGs have robust arrangements for monitoring out of area hospital placements.

Recommendation 5:

That Worcestershire Safeguarding Adults Board should write to the CQC to recommend that they include an assessment of Provider arrangements for communicating and escalating concerns about hospital placements to commissioners of those placements in their inspection regime.

Removal of TT's diagnosis

6.19 Clinical staff at Wast Hills had begun to question TT's diagnosis when he did not respond to a care and treatment regime which had proved effective with other service users with similar diagnoses. Removing TT's diagnosis was a huge step to take with potentially far reaching implications for his future care and treatment. The autism advisor to the SCR Panel concluded that the reasons provide by Danshell for re-evaluating TT's ASD diagnosis appeared to be in error, or at best, not clearly stated. The autism advisor went on to state that even if the evidence for autism misdiagnosis had been strong, it was not reasonable that TT's diagnosis should be removed before full assessments had been completed. She added that the evidence relied upon by WH Consultant Psychiatrist in reviewing TT's autism diagnosis was confusing and often incorrectly formulated.

6.20 The process followed was not in accordance with NICE guidelines in that there was no consultation with the placing authority or the family although the family were aware that the diagnosis was being reviewed. The omission of consultation with the placing authority appears to be a serious omission given that the funding for TT's expensive hospital placement at Wast Hills would rest, in part, on his diagnosis.

6.21 The removal of TT's diagnosis of Learning Disability and Autism should have led to an immediate review of his detention under the Mental Health Act. No such review was recorded as having taken place at the time by WH Consultant Psychiatrist.

6.22 The removal of TT's diagnosis could easily have prevented his ultimately successful hospital placement with Recovery First from taking place.

6.23 This flawed diagnosis removal is particularly troubling given that it appears that TT was not alone in having his diagnosis of autism removed by Danshell.

6.24 The Winterbourne View SCR questioned the independence of decisions taken by Consultant Psychiatrists employed by private hospitals. (9) In this case it would have protected the interests of all concerned if WH Consultant Psychiatrist had been obliged to submit her decision to remove TT's diagnosis to review by a peer unconnected to Wast Hills.

Recommendation 6:

Danshell should submit their autism diagnosis and treatment pathway at Wast Hills to independent review and share the outcome of that independent review with Worcestershire Safeguarding Adults Board.

Recommendation 7:

That Worcestershire Safeguarding Adults Board should write to the National Institute for Clinical Excellence to draw their attention to this SCR and seek advice on whether a protocol for the removal of a diagnosis of Autism Spectrum Disorder should be developed.

Recommendation 8:

That Worcestershire Safeguarding Board should write to the National Institute for Clinical Excellence to draw their attention to this SCR and seek their views on the proposal that a responsible clinician considering the removal of a diagnosis of autism spectrum disorder should be obliged to submit their decision to peer review by another clinician unconnected with the case, the responsible clinician or the establishment which employs the responsible clinician.

Recommendation 9:

That Worcestershire Safeguarding Adults Board should seek assurance from commissioners of relevant local providers which employ Responsible Clinicians to recommend that a Responsible Clinician should consider the impact of a change of diagnosis on the legal status of the patient in question and provide appropriate contemporaneous recording of this.

Recommendation 10:

That Worcestershire Safeguarding Adults Board should refer WH Consultant Psychiatrist to the General Medical Council because of the manner in which TT's diagnosis was removed.

Police detention

6.25 Wast Hills Hospital was perfectly entitled to seek the assistance of the police on 3rd March 2014. However to seek the arrest of TT for assaults on staff members was a very bad decision. The only mitigating factor is that the decision appears to have been borne of desperation. It contradicted the judgement of TT's responsible clinician who concluded the report which removed TT's diagnosis by recommending that "a PICU be identified that can currently meet TT's needs." Involving the police seemed most unlikely to improve the situation in any way – other than providing the Wast Hills staff with a period of respite - and simply passed the buck to the police to contain TT whilst attempting to find a suitable alternative hospital placement for him.

6.26 However if the police had connected the two calls from Wast Hills the outcome of the second call from Wast Hills on 3rd March might have been very different.

Mental Capacity

6.27 The review has also highlighted key practice issues in relation to knowledge and skills around mental capacity. Assumptions were made regarding TT's mental capacity without any assessment, demonstrating a lack of understanding of the crucial importance of considering his capacity to understand the implications of his situation, and to participate to the fullest extent in decision making about interventions.

Recommendation 11:

That Worcestershire Safeguarding Adults Board seek assurance from partner agencies that staff have the training and support to ensure that mental capacity considerations are an integral part of their professional practice.

Provision of specialist hospital placements and community placements for adults with ASD

6.28 The excessive time TT spent at Greenways and the unsuccessful hospital placement of TT at Wast Hills Hospital after months of searching for a placement which would meet his needs, raises wider issues of whether there is adequate provision of specialist placements for adults with Autism Spectrum Disorder whose challenging behaviour makes it difficult for them to live with their families or in community settings or appropriate community based placements where it is possible to avoid detaining adults under the Mental Health Act.

Commissioning of specialist placements

6.29 This case raises the question of whether commissioning arrangements for specialist placements for adults with ASD and challenging behaviours could be organised differently – possibly on a wider footprint - in order to build the expertise necessary to commission optimal placements in an under-provided market.

Recommendation 12:

That Worcestershire Safeguarding Board writes to NHS England (Specialist Commissioning) to draw their attention to this SCR and to specifically highlight:

- *the apparent lack of appropriate hospital and community placement provision for adults with ASD and challenging behaviours, particularly at points of transition*
- *the deficiencies in commissioning specialist placements for adults with ASD and challenging behaviour*

Engagement with the families and carers of adults with ASD

6.30 The parents of TT have been through an extremely distressing experience in seeing their beloved son detained under the Mental Health Act in two hospital settings in which hey witnessed a significant deterioration in his wellbeing. Their experience of engaging with the services funded by their taxes to care for people such as their son has been bruising and has greatly diminished their trust in "the system". Does it have to be like this? Is it not possible to build a model for engaging families which is founded on mutual respect, where clinical decisions are not handed down on tablets of stone and where the views of independent social workers are valued rather than marginalised? The independent review carried out by Sir Stephen Bubb (10) has recommended that the Government should draw up a Charter of Rights for people with learning disabilities and/or autism and their families, and that it should underpin all commissioning. The report indicated that "the system needs to do a better job of respecting and upholding their rights and listening to what they have to say". The report also stressed the importance of "empowering people who could help change the way the system works for the better, but who often struggle to make themselves heard". Worcestershire Safeguarding Adults Board may wish to take a lead in this important area of work. Commissioning an "easy read" version of this report for TT and others to read would be a very positive step.

6.31 The steps taken by the parents of TT to initiate Judicial Review proceedings in order to challenge the decision taken by Worcestershire Safeguarding Adults Board not to commission a Serious Case Review have been entirely vindicated by the failings revealed and the learning identified through this review. Having been traumatised by the manner in which their son's hospital placement ended at Wast Hills, TT's parents should not have been required to go to the lengths they went to in order to secure the commissioning of this Serious Case Review, particularly as Worcestershire Safeguarding Adults Board had received two separate referrals and one re-referral for a Serious Case Review to be conducted. The Board should consider making an apology to the parents of TT. Additionally, the Board should consider making an apology to TT on behalf of all of the agencies which have contributed to this SCR for the multiple failures identified by this review.

Recommendation 13:

Worcestershire Safeguarding Adults Board should consider apologising to the parents of TT for their handling of the decision not to commission a Serious Case Review.

Recommendation 14:

Worcestershire Safeguarding Adults Board should consider apologising to TT on behalf of the agencies which have contributed to this SCR for the multiple failures identified by this review.

6.32 This Serious Case Review overview report contains much learning for NHS Vale Royal CCG and Cheshire West and Chester Council. It therefore appears entirely appropriate for this overview report to be shared with Cheshire West and Chester Safeguarding Adults Board.

Recommendation 15:

That Worcestershire Safeguarding Adults Board share this report with Cheshire West and Chester Safeguarding Adults Board.

6.33 The Care Quality Commission as regulator publicly recognised that they had a significant role to play in ensuring that Castlebeck Care provided services to the required standards after that company went into administration in March 2013. However the CQC do not appear to have recognised that they had a significant role to play in this Serious Case Review which encompasses a period of time during which TT was placed at Wast Hills Hospital when the provider was Castlebeck Care in Administration. Clearly the CQC must exercise caution over their involvement in Serious Case Reviews, as providers they regulate may also be involved in the Serious Case Review and those providers may be reticent about sharing learning from failings in a process in which the CQC are involved. However if the aim of Serious Case Reviews, or Safeguarding Adults Reviews as they are now known, is to identify learning which may enhance safeguarding standards, then the CQC should be prepared to contribute appropriately to this process.

Recommendation 16:

That Worcestershire Safeguarding Adults Board write to the Care Quality Commission, to recommend that it clarifies its policy in respect of contributing to Safeguarding Adults Reviews in order that the Care Quality Commission is able to contribute appropriately to identifying and applying learning from such Reviews in the future.

Physical Restraint

6.34 The aims of the Department of Health guidance "Positive and Proactive Care: reducing the need for restrictive interventions" include the development of therapeutic environments where physical interventions are used only as a last resort and the achievement of a lasting reduction in the use of all forms of restrictive interventions. (11) The frequency with which restrictive interventions in the form of physical restraint were used in respect of TT suggests that the desired lasting reduction in the use of restrictive interventions may be an extremely challenging aim to achieve.

6.35 This report demonstrates that restrictive interventions in the form of physical restraint were a consistent feature of the care and treatment of TT during his placements at both Greenways and Wast Hills. In both establishments, physical restraint was carried out by appropriately trained and accredited staff and incidents of physical restraint were subject to regular internal and periodic external review. Yet the use of physical restraint continued. At the point at which TT's placement at Wast Hills completely broke down, he was in more or less continuous physical restraint involving up to 9 staff.

6.36 It is clear that TT frequently presented as violent and aggressive whilst detained at both Greenways and Wast Hills. It is also clear that staff in both establishments found his behaviour extremely challenging at times. Indeed, staff at Wast Hills appear to have turned to the police for assistance on 3rd March 2014 partly out of desperation.

6.37 However, the frequency with which physical restraint was used on TT at Greenways and Wast Hills raises the question of whether physical restraint was indeed the "last resort" aspired to in the Department of Health guidance referred to above. It seems reasonable to contend that the frequency of physical restraint was an indication that the placements were not meeting TT's needs. In the case of Greenways, TT spent far too long in an establishment which did not provide autism specific care. In the case of Wast Hills, TT's "failure" to respond to the care and treatment provided ultimately led not to an adjustment in the care and treatment provided but the removal of his diagnosis of autism and learning disability.

6.38 If one accepts that the frequency of the use of physical restraint was an indicator that neither placement was meeting TT's needs, then it seems reasonable to expect that the commissioners of those placements should have picked up on this. Whilst Cheshire West and Chester Council engaged with safeguarding investigations of instances of physical restraint of TT at Wast Hills, there is little evidence that NHS Vale Royal CCG, as commissioners of the Wast Hills placement, questioned whether the frequency of physical restraint could have been reduced by a different approach to the care and treatment of TT, or whether the frequency of physical restraint might be an indication of placement unsuitability.

6.39 The Department of Health and Skills for Care have produced further guidance to complement "Positive and Proactive Care" (Paragraph 6.34) which, amongst other things, aims to inform decision making by commissioners when purchasing services to ensure that that any restrictive practice or intervention by the provider of the commissioned service is legally and ethically justifiable. (12) Entitled "A positive and proactive workforce", the guidance includes the following advice to commissioners:

- Understand the implications and role of restrictive practices in the services they are commissioning
- Understand the settings and situations and the incidents where workers may be required to use restrictive practices – and how to provide positive and proactive alternatives.
- Engage with people being supported by services, and with their families and communities – particularly if there is a risk of someone having to move away from their home area, such as in "out of area placements".

Gaining assurance that relevant commissioners are following this guidance – which was not published until after TT's placement at Wast Hills ended – would be a useful contribution by Worcestershire Safeguarding Adults Board to achieving a lasting reduction in the use of all forms of restrictive interventions.

Recommendation 17:

That Worcestershire Safeguarding Adults Board seeks assurance that relevant commissioners of services in which restrictive practices or interventions may take place, follow relevant Department of Health guidance when commissioning and monitoring such services, in an effort to achieve a lasting reduction in the use of all forms of restrictive interventions.

List of Recommendations:

Recommendation 1: (Local)

That Worcestershire Safeguarding Adults Board shares this SCR Overview Report with the West Midlands Regional Safeguarding Network review of Large Scale Investigation procedures.

Recommendation 2 (National)

That Worcestershire Safeguarding Adults Board write to NHS England to draw their attention to this SCR and request that they write to all CCGs to remind them of the need for a placement failure contingency plan for all out of area placements.

Recommendation 3: (National)

That when Worcestershire Safeguarding Board write to NHS England to draw their attention to this SCR, (see Recommendation 2) they also suggest that the SCR Overview Report would be a valuable case study to circulate to CCGs to remind them of the importance of monitoring out of area hospital placements.

Recommendation 4: (National)

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Recommendation 5: (National)

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Danshell should submit their autism diagnosis and treatment pathway at Wast Hills to independent review and share the outcome of that independent review with Worcestershire Safeguarding Adults Board.

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That Worcestershire Safeguarding Adults Board should write to the National Institute for Clinical Excellence to draw their attention to this SCR and seek advice on whether a protocol for the removal of a diagnosis of Autism Spectrum Disorder should be developed.

Recommendation 8: (National)

That Worcestershire Safeguarding Board should write to the National Institute for Clinical Excellence to draw their attention to this SCR and seek their views on the proposal that a responsible clinician considering the removal of a diagnosis of autism spectrum disorder should be obliged to submit their decision to peer review by another clinician unconnected with the case, the responsible clinician or the establishment which employs the responsible clinician.

Recommendation 9: (Local)

That Worcestershire Safeguarding Adults Board should seek assurance from commissioners of relevant local providers which employ Responsible Clinicians to recommend that a Responsible Clinician should consider the impact of a change of diagnosis on the legal status of the patient in question and provide appropriate contemporaneous recording of this.

Recommendation 10: (Local)

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That Worcestershire Safeguarding Board writes to NHS England (Specialist Commissioning) to draw their attention to this SCR and to specifically highlight:

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- *the deficiencies in commissioning specialist placements for adults with ASD and challenging behaviour*

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Worcestershire Safeguarding Adults Board should consider apologising to the parents of TT for their handling of the decision not to commission a Serious Case Review.

Recommendation 14: (Local)

Worcestershire Safeguarding Adults Board should consider apologising to TT on behalf of the agencies which have contributed to this SCR for the multiple failures identified by this review.

Recommendation 15: (Local)

That Worcestershire Safeguarding Adults Board share this report with Cheshire West and Chester Safeguarding Adults Board.

Recommendation 16: (National)

That Worcestershire Safeguarding Adults Board write to the Care Quality Commission, to recommend that it clarifies its policy in respect of contributing to Safeguarding Adults Reviews in order that the Care Quality Commission is able to contribute appropriately to identifying and applying learning from such Reviews in the future.

Recommendation 17: (Local)

That Worcestershire Safeguarding Adults Board seeks assurance that relevant commissioners of services in which restrictive practices or interventions may take place, follow relevant Department of Health guidance when commissioning and monitoring such services, in an effort to achieve a lasting reduction in the use of all forms of restrictive interventions.

Single Agency Plans

Worcestershire County Council

- To improve knowledge skills and competencies in relation to adult safeguarding practice with a focus upon embedding the West Midlands multi agency policy and procedures, making safeguarding personal, mental capacity, out of area safeguarding procedures
- To ensure effective and safe co-ordination of large scale investigations
- Worcester Safeguarding Unit and/or contracts team should ensure that providers are obliged to make referrers aware of any ongoing large scale investigations and open safeguarding investigations (Recommended in CW&C IMR)

NHS Vale Royal CCG

- Develop robust person-centred commissioning and procurement procedure including quality and safeguarding checks of potential providers together with clear standards for monitoring and review
- Ensure robust contractual arrangements in place with specialist providers
- Clarify roles and responsibilities of professionals and managers involved in cases such as TT's and ensure clear communication with the individual, his family and advocate.
- Ensure robust critical information sharing processes with regard to out of area hospital placements are in place.
- Review criteria for local PICU to establish feasibility of including clients with a wider range of specialist needs including LD and autism.
- Review need for and availability of specialist beds within reasonable geography and, alongside LAs, engage with providers to manage the market to ensure sufficient capacity
- Develop multiagency escalation protocol for managing emergency situations with regard to hospital placements.

- Establish requirement for Specialist on call system for Mental Health and LD cases linked to CCG on call systems.

Cheshire West and Chester Council

- Health Commissioners need to be involved in CW&C panels to promote better joint decision making in 2015-16 (the new Integrated Personal Commissioning approach starts from April 2016)
- CW&C should review its Learning Disability framework to ensure that it can deal with very challenging behaviours, taking into account a wide range of complex needs including those that would require hospital hospital placements/dual registration
- CW&C should write formally to the safeguarding team in any area it is considering making a hospital placement of an adult with learning disabilities and/or autism to ascertain whether there are any significant safeguarding investigation underway

NHS Cheshire and Wirral Partnership (Greenways Treatment and Assessment Centre)

- To ensure that knowledge of entry criteria to services is clear and understood by everyone involved in adolescent services.
- To use the expertise of the Learning Disability service to strengthen the understanding and knowledge of Commissioners in relation to complex adolescents. This should inform the commissioning for post 16 transition services between children and adult services.
- To continue to identify roles and responsibilities to ensure a consistent approach with families in ensuring effective communication

Wast Hills (Danshell from 4.9.2013)

- Ensure a clinical audit of all patients/ service users who are known to make allegations to ensure their care plans comply with Danshell Safeguarding Vulnerable Adult/Adult Support and Protection, Managing Allegations Policy and Clinical Record Keeping Policy.
- Review the Danshell Managing Service User Allegations Policy in Danshell Policy Review Group.
- Ensure all staff are made aware of Managing Allegations Policy as part of safeguarding training and clinical supervision.
- Ensure all clinical and operational decision making relating to a referral is clearly documented and in accordance with the Danshell Referral Policy

- The responsible clinician and unit manager should always ensure that they work in close partnership prior to planned admissions to ensure clear and purposeful leadership of the process in accordance with policy.
- Ensure an audit of Multi-Disciplinary Team notes to ensure transparency of clinical decision making and all actions outlined are completed within the timeframes highlighted.
- Ensure parents and carers are consulted and engaged and evidence of engagement is documented in assessments and care plans and key meetings in agreement with the patient. If there is disagreement with the outcome of the decision, the rationale for the decision has been discussed and recorded.
- That all change of diagnoses should be undertaken with family involvement and written confirmation is sent to family members and commissioner.
- That all diagnoses of autism follow NICE guidelines using recommended tools.
- Ensure parents and carers are consulted and engaged and evidence of engagement is documented in assessments and care plans and key meetings in agreement with the patient. If there is disagreement with the outcome of a decision, the rationale for the decision has been discussed and recorded.
- Ensure Danshell Clinical Record Keeping Policy and Service User Engagement policies outline issues relating to non-compliance or non-participation and a range of methods and approaches to engage are evidenced within care plans
- Ensure all visiting professionals to Danshell sites outline their role and purpose for visiting patients/service users and ensure consent to visits is given by the respective patient

Worcester Health and Care NHS Trust

- A formal process is required for obtaining the opinions of professionals to inform safeguarding Investigations.
- A process to provide advice to staff who are asked to provide an 'expert opinion' by another organisation

NHS Redditch and Bromsgrove CCG

- Review how information is shared between the Complex Needs Team (ICU), CCGs and other agencies (between QA visit dates)
- Wast Hills Hospital to report serious incidents in accordance with Worcestershire CCG Serious Incident Protocol.
- Improve evidence of communication to and from Nursing Homes/ Independent Hospitals, including Wast Hills Hospital.
- Due to the level of potential risk posed, undertake minimum of an annual QA visit at Wast Hills Hospital, or more frequently as indicated.

NHS Birmingham South Central CCG on behalf of Bournville GP Surgery

- For Bournville surgery to review their current contract for service provision with Wast Hills to ensure that it is appropriate to all parties

CQC

- During ongoing safeguarding issues the central inspection and local authority safeguarding team to maintain communication.
- CQC staff to ensure alerts are sent to local authority safeguarding team promptly.

West Mercia Police

- Officers and staff to be reminded of importance of identifying and understanding previous incidents to inform decision making process and risk assessment at scene of incident.

Definitive Secure Ambulance

- To amend the DSA transport form to include a "property log" to ensure all property is accounted for when performing a patient transfer.
- The SCR Panel decided that DSA should also consider a recommendation about raising the awareness of their staff to the importance of "comfort items" to patients they may transport. (No response from DSA at time of writing.)

Recovery First

- Review Recovery First procedure for conducting urgent assessments and highlight the need to ensure information about capacity and the views of the service user and family are considered.
- Review Recovery First procedure in relation to the guidelines on admitting a service user with ASD without the opportunity to develop a transitional plan.
- Review Recovery First diversity assessment process.
- Evaluation of Recovery First policies and procedures in line with ASD national guidelines.

NHS England

- The findings of the final SCR report and its recommendations to be shared with NHS England (North) Specialised Commissioning

Glossary

ADHD - attention deficit hyperactivity disorder is a group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness. Common symptoms of ADHD include: a short attention span or being easily distracted. restlessness, constant fidgeting or overactivity, being impulsive.

Autism - is a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them. It is a spectrum condition, which means that, whilst all people with autism share certain difficulties, their condition will affect them in different ways. Some people with autism are able to live relatively independent lives but others may have accompanying learning disabilities and need a lifetime of **specialist** support. People with autism may also experience over- or under-sensitivity to sounds, touch, tastes, smells, light or colours.

Behaviour Problems - symptomatic expression of emotional or interpersonal maladjustment especially in children (as by nail-biting, enuresis (involuntary urination), negativism, or by overt hostile or antisocial acts)

Hyper Flex – to excessively bend so that the angle between the bones of a joint is smaller than usual

MAYBO training – a national suite of qualifications in conflict management and physical intervention which are accredited by the British Institute of Learning Disability. (BILD)

PICU – Psychiatric Intensive Care Unit

PRN Medication – medication administered when required i.e. when the service user presents with a defined intermittent or short-term condition.

Responsible Clinician - has overall responsibility for care and treatment for service users being assessed and treated under the Mental Health Act. These responsibilities include:

- Making decisions about treatment
- Reviewing detentions
- Assessing whether the criteria for renewing detention are met
- Granting leave of absence for detained patients
- Barring the Nearest Relative from discharging the patient in specific situations.
- The power of discharge from detention.

  Although the Responsible Clinician has overall responsibility, decisions about the service users care and treatment are made in discussion with the multi-disciplinary team.

Responsive Inspection – a Care Quality Commission (CQC) inspection which can be carried out any time in response to identified concerns.

T-Supine – A restraint position in which the service user is restrained on their back whilst staff use their body weight

References

(1) National Protocol for Notification of NHS Out of Area Hospital placements for Individual Packages of Care, March 2012

(2) Winterbourne View Hospital: A Serious Case Review, South Gloucestershire Safeguarding Adults Board, Margaret Flynn and Vic Citarella July 2012

(3) Ibid

(4) Winterbourne View: Transforming Care Two Years On, Department of Health (January 2015) retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399755/Winterbourne_View.pdf

(5) Ibid

(6) Ibid

(7) Winterbourne View Hospital: A Serious Case Review, South Gloucestershire Safeguarding Adults Board, Margaret Flynn and Vic Citarella July 2012

(8) Transforming Care for People with Learning Disabilities – Next Steps

(9) Winterbourne View Hospital: A Serious Case Review, South Gloucestershire Safeguarding Adults Board, Margaret Flynn and Vic Citarella July 2012

(10) Winterbourne View – Time for a Change

(11) Positive and Proactive Care: reducing the need for restrictive interventions

(12) A Positive and Proactive Workforce: A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health

Appendix A

Process by which the SCR was conducted.

Worcestershire Safeguarding Adults Board established a Serious Case Review Panel to oversee the completion of this SCR Overview Report. Membership of this SCR Panel is shown in Appendix B. The membership included an advisor on autism, an advisor on the Mental Health Act and Mental Capacity Act and an advisor on issues from a carer perspective.

Worcestershire Safeguarding Adults Board appointed David Mellor as independent chair of the SCR Panel and as independent author of the SCR Overview Report.

The SCR Panel drafted terms of reference for this SCR on which the parents of TT and their legal advisors were fully consulted. The terms of reference were approved by Worcestershire Safeguarding Board.

The following organisations were requested to provide individual management reports (IMR) to the SCR Panel.

- Care Quality Commission
- Cheshire and Wirral Partnership NHS Trust (for Greenways Treatment and Assessment Centre)
- Cheshire West and Chester Council
- Danshell (for Wast Hills)
- Designated Secure Ambulance
- NHS Birmingham South Central CCG (for Bourneville GP Surgery)
- NHS England
- NHS Redditch and Bromsgrove CCG
- NHS Vale Royal CCG
- Recovery First
- West Mercia Police
- Worcester Health and Care NHS Trust
- Worcestershire County Council

Most IMRs were completed to a satisfactory standard or above. All IMRs were scrutinised by the SCR Panel and where additional work was required to address SCR Panel queries or improve the IMR, this was done. Additionally the SCR Panel held a full day's meeting with IMR authors to explore the terms of reference questions more fully.

Cheshire and Wirral Partnership NHS Trust's IMR was requested only after the SCR Panel decided to extend the terms of reference for this SCR to encompass TT's placement at Greenways. This decision was made in July 2015. As a result, it was not possible for Cheshire and Wirral Partnership NHS Trust to participate in the SCR as fully as the other agencies involved. The Trust was not represented on the SCR Panel nor was it possible for the Trust IMR author to participate in the SCR Panel meeting with IMR authors.

When TT was initially placed at Wast Hills Hospital in July 2013, the service was provided by Castlebeck Care in Administration until Danshell became the provider in September 2013. Since there was a degree of staff continuity between Castlebeck Care in Administration and Danshell, Danshell obligingly prepared an IMR to cover the entire period that TT was placed at Wast Hills. Grant Thornton were, until recently, the administrators of Castlebeck Care in Administration. Grant Thornton was given the opportunity to comment on the part of the Danshell IMR which covered the period that Castlebeck Care in Administration was the provider at Wast Hills and they were also given the opportunity to comment on the final draft of this SCR Overview report.

Paragraphs 5.4 and 5.5 set out how TT himself was engaged in the SCR process.

The various drafts of the SCR Overview report were considered and commented upon by members of the SCR Panel and a late draft of the report was shared with TT's parents who made a number of comments which were incorporated into the report.

Appendix B

SCR Panel members

Advisor on Mental Health Act and Mental Capacity Act	Practice Educator/Approved Mental Health Professional Lead – Worcestershire Health and Care NHS Trust
Care Quality Commission	Invited but did not attend
Cheshire West and Chester Council	Senior Manager, Adult Safeguarding and Domestic Abuse
Danshell (Wast Hills Hospital)	Chief Executive Officer
Independent Advisor on Autism Spectrum Disorder	Dr. Carol Stott
Independent Advisor on Carer's Perspective	Chief Executive Worcestershire Carers Association
National Probation Service	Deputy Head of Service (did not attend)
NHS Birmingham South Central CCG	Lead Nurse for Domestic Abuse and Domestic Homicide Reviews
NHS Redditch and Bromsgrove Clinical Commissioning Group	Designated Nurse for Safeguarding
NHS Vale Royal CCG	Designated Nurse Adult Safeguarding
West Mercia Police	Detective Chief Inspector
Worcestershire County Council	Team Manager Transition Team
Worcestershire Health and Care NHS Trust	Safeguarding Service Manager
Worcestershire Safeguarding Adults Board	Worcestershire Safeguarding Adults Board Coordinator
Independent SCR Panel Chair and Author	David Mellor