Safeguarding Adults Review
in respect of
‘Una’
March 2024

Commissioned by Wigan Safeguarding Adult Board

Reviewers: Fiona Bateman and Sarah Williams

Independent Safeguarding Consultants, Safeguarding Circle

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Introduction

1.1 In March 2022, Wigan Safeguarding Adults Board ['WSAB'] commissioned a safeguarding adults review ['SAR'] following the serious sexual abuse of a patient by her care coordinator and subsequent concerns regarding the way the responsible mental health trust supported her recovery, and the manner in which the wider safeguarding partnership worked together to safeguard her. For the purposes of anonymity and with her agreement, throughout this review the adult who was harmed will be known as 'Una'.

1.2 Una, a young, white British woman, was described by many professionals involved in this review as intelligent, articulate and warm. She adored and was very proud of her child by her ex-partner, and was always focussed on their welfare. Una's new partner, who was highly supportive and had good insight into her needs, explained she would bend over backwards to help others, adopting a dog from a friend who had been hospitalised. She had a successful career in a senior managerial position before becoming unwell and was described as being very talented, with enormous potential. She valued doing well and wanted to be seen as capable, always wanting to put on her best front. Practitioners who knew her constantly praised Una for her strong sense of justice, supporting others and wanting things to be fair, wanting people to have a voice. She was dedicated to helping others with mental health needs included working as an "*incredibly valued*" member of a national inspection team, giving advice on how hospital wards should be designed to ensure these were therapeutic environments and working empathetically with service users to understand their experiences of care. Sometimes this was to her own detriment, as she would prioritise this work even when she was becoming unwell, as she did not want to let others down. She told the reviewers that it was extremely important to her that the learning from her experiences should be used to improve safeguarding systems. We were so grateful for her honesty, her insight and her courage when speaking with us, and found her very inspirational.

1.3 Una had a history of adverse childhood experiences, including childhood sexual abuse, neglect and poor parental attachment. As an adult Una experienced irregular mood, difficulty managing stress and often feeling overwhelmed by her emotions and inability to regulate these. Una reports a long history of deliberate self-harm, used as a way of coping with her internal distress. She experienced intrusive thoughts of harming herself and impulsive behaviours. She first came into contact with mental health services in 2008 but became more heavily involved with mental health services during 2010-11, including detention under s3 of the Mental Health Act 1983, ['the MHA'] after a number of serious incidents where Una was brought by police off motorways, train lines and an occasion where Una had covered herself in petrol. Her mental health support was provided by Five Boroughs Partnership NHS Trust, which subsequently changed its name to North West Boroughs NHS Foundation Trust ['the Trust']. She received care coordination from Wigan Mental Health Recovery Services and was diagnosed with Emotionally Unstable Personality Disorder (also known as borderline personality disorder), post-traumatic stress disorder and complex post-traumatic stress disorder.

1.4 Una was detained on several occasions under Section 2 of the MHA and on 16 January 2014, she was allocated a male care coordinator, whilst she was detained under s3 MHA. Prior to this, Una had requested a female care coordinator. No explanation was given by the Trust as to why her preference was not adhered to.[1] During 2014 Wigan's community safety team led on a multi-agency response to reduce risks that Una's self-harming behaviours could pose to the public and emergency workers and they agreed with Una and Greater Manchester Police an anti-social behaviour contract in which she promised to contact her wider support network or care coordinator if in distress. They also put in place a 'trigger plan' so that if it were necessary to detain her (in response to escalating risks) custody officers would be aware of her needs and support would be

[1] The Trust's policy was to allocate care coordinators according to gender preference.

in place to monitor her at all times and alert her treatment team.[2] In April 2014 Una wrote to the care coordinator's line manager seeking his replacement because she thought that no therapeutic relationship had developed, but (in breach of the Trust's policy[3]) was advised that there was no-one else available, so her request was denied.

1.5 In June 2014, she was detained under section 2 of the MHA before transferring to s3 and on discharge in November 2014, became subject of section 117 aftercare from the Trust. Over a period of months starting in January 2015, the care coordinator groomed Una, before starting a sexual 'relationship' with her involving penetrative sex[4] from July 2015 to May 2016 which was exploitative, a criminal offence under section 38 of the Sexual Offences Act 2003 and a gross breach of his duty of care as a nurse. Within this review, given the criminal nature of the care coordinator's conduct, we will refer to this as abuse and not as a 'relationship' in recognition of the coercive behaviours and power imbalance between Una and the care coordinator. Hereafter, after discussing this with Una, this care coordinator will be referred to as the 'perpetrator'.

1.6 The perpetrator informed the Trust[5] on 21 March 2016 that his wife, who also worked within the Trust, found messages between him and Una on his work mobile phone. He was immediately suspended and later resigned from his job, shortly before a disciplinary hearing for gross misconduct. A safeguarding referral was made to Wigan Borough Council, but the matter was not referred as a Serious Untoward Incident Review or notified, as a Serious Untoward Incident through the Strategic Executive Information System[6] ['StEIS'] reporting system, to the NHS Wigan Borough Clinical Commissioning Group's[7] (now NHS Greater Manchester Integrated Care ['GMIC']) safeguarding lead or Care Quality Commission ['CQC'] at this time. Neither CQC or WCCG's safeguarding leads were invited to the safeguarding strategy meeting held on the 23 March 2016. It is understood at the meeting the Trust's deputy team manager affirmed that Una "*would have full capacity to consent to engaging in the relationship*" though police confirmed the issue of consent/ capacity was not relevant to the offence under s38 of the Sexual Offences Act. The perpetrator was interviewed by police; a decision was made without consultation with the CPS to caution him for the offence under s38(3) of the Sexual Offences Act. Section 38(3) is a strict liability offence; it applies to cases involving penetrative sex and is an offence triable on indictment only, with a maximum sentence to be imposed of 14 years imprisonment. The perpetrator notified a director at the Trust when he moved in to live with Una and this was known to the police when they interviewed him and the caution was issued. He subsequently moved out of her home[8] immediately after receiving the caution and terminated any contact with Una. The perpetrator left knowing that she had self-harmed by swallowing scalpel blades, but he took no action to report this or support her to seek assistance.

1.7 Consequently, the level and nature of Una's self-injurious behaviours escalated. Una's care and treatment under s117 MHA remained the responsibility of the Trust. Following the disclosure of the abuse, the Trust failed to adequately provide care or treatment for her mental health which contributed to her delayed recovery and impacted on the course of her illness. Una instructed

[2] This practice was as a result of learning applied from a previous review which had been critical of statutory partners for not utilising civil and criminal injunctive orders to protect an adult at risk exhibiting anti-social behaviours.
[3] Confirmed in Expert report (dated 20.11.20) filed for the purposes of Court proceedings and made available to this review by way of Court order (dated 30.07.23)
[4] Including an incident when he initiated intercourse whilst she was subject to detention under s2MHA. She would not have had capacity to consent to sex at that time and, as her care coordinator and qualified psychiatric nurse, he would be fully aware of that fact and, consequently, such action constitutes rape under criminal law.
[5] He disclosed this to a colleague who had previously acted as his line manager, that colleague immediately notified his line manager and senior managers within the Trust.
[6] The NHS England Serious Incident Framework 2015 definition of a serious incident sets out circumstances in which a serious incident must be declared, including sexual abuse, neglect, exploitation and organisational abuse where abuse occurred during the provision of NHS-funded care. The Framework requires a serious incident to be reported on STEIS within 2 days and an alert sent to the CCG. The provider must complete an investigation within 60 working days or 6 months for independent reports, with the final report and action plan submitted to the CCG for assurance and monitoring.
[7] During the review period, following the enactment of the Health and Care Act 2022, Wigan Clinical Commissioning Group (CCG), was incorporated within Greater Manchester Integrated Care Board (ICB). Where decisions were made prior to the formation of the ICB, we have referred to the CCG. However, future facing findings and recommendations are addressed to the ICB.
[8] While she was self-harming by swallowing scalpel blades, and without calling an ambulance.

solicitors to advocate on her behalf in June 2016, who repeatedly contacted the Trust to request urgent assistance for Una and a review of her care and treatment plan. In April 2017 they issued civil proceedings against the Trust, seeking restitution for breaches of the duty of care and her rights under Articles 2, 3 and 8 of the Human Rights Act 1998. Una reported those proceedings were not for financial gain, but to secure on-going appropriate care to aid her recovery and to ensure real change in policy and practice. She received an interim payment in July 2017 to enable her to privately arrange suitable mental health support, though crisis interventions remained the responsibility of the Trust.

1.8 The perpetrator was subsequently struck off by the Nursing and Midwifery Council.

1.9 On 1 April 2021, North West Boroughs NHS Foundation Trust transferred responsibility for the mental health services in Wigan to Greater Manchester Mental Health Trust. However, Mersey Care NHS Foundation Trust ['Mersey Care'] agreed to be responsible from June 2021 for Una's care[9] and the ongoing litigation, supported by external solicitors and NHS Resolutions.[10] The High Court gave final judgment on 15 October 2021, following mediation which resulted in a last-minute agreement to settle. Prior to this, Una had been advised she would be expected to give evidence at a full trial. The High Court declared that the Trust had breached Una's Convention rights which included her right to life (Article 2); her right to not being subjected to degrading or inhuman treatment (Article 3) and her right to a family life (Article 8). Mersey Care accepted these breaches and that there had been corporate failures in respect of inadequate supervision of the perpetrator[11] and the duty to report the matter through StEIS. A substantial settlement figure was agreed to reflect the gravity of harm Una experienced.

1.10 Una's advocate wrote to the WSAB in August 2021 and in further correspondence, enquiring why a safeguarding adult review had not been undertaken. Following a meeting between Una, her advocate and solicitor and the WSAB Board manager after the conclusion of the civil proceedings, WSAB commissioned Safeguarding Circle as independent safeguarding consultants to undertake a review in February 2022. It was agreed the case met the statutory s44 criteria for a review given the agreed facts set out in the High Court judgment, specifically that serious abuse took place which materially harmed Una, who had care and support needs, and there is reasonable cause for concern about how partner agencies worked together to safeguard her, both against the abuse and to seek assurance agencies were supporting her recovery in line with their statutory duty. The terms of reference and scope of the review were agreed by the SAR panel on 20 September 2022, having consulted with Una and considered representations from her legal team. The review was paused in October 2022. Further information was also sought from the Court proceedings, with Una's agreement, to protect against re-traumatising her. These were made available on the 30 June 2023.

Scope of Review

Purpose of a Safeguarding Adult Review, methodology and engagement

2.1 The purpose of having a review is not to re-investigate or to apportion blame or to undertake human resources duties, as other processes exist to fulfil those functions. The purpose is to consider the circumstances of the case and identify the lessons to be learned about the way in which local professionals and agencies work together to identify abuse and safeguard adults. This review will also explore the effectiveness of procedures (both multi agency and those of individual organisations).

[9] Merseycare completed the acquisition of North West Boroughs Mental Health Trust on the 01.06.21
[10] NHS Resolutions is an arm's length body of the Department of Health and Social Care which provides claim management support to NHS Trusts.
[11] An independent review of the case commissioned by the Trust found he did not engage well with any supervisory support or take part in multi-disciplinary meetings, so his management of Una's care was rarely discussed or escalated for review by senior managers.

2.2 There is a strong focus on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect Una from harm. Whilst relevant agencies involved in this case received full details of Una's experiences during the review period, the narrative chronology is not included for publication in order to protect her anonymity and, in line with her instructions, to safeguard her child. Instead the focus of this review is on systems findings and learning for agencies. We have identified the social and organisational factors that make it harder or easier for practitioners to proactively safeguard, within and between agencies. Partner agencies are then expected to use the review findings and recommendations to inform and improve local interagency practice by acting on learning.

2.3 Fiona Bateman and Sarah Williams are safeguarding experts who have considerable experience undertaking statutory practice reviews to identify systems learning and prevent future harm. Both are independent of WSAB and have no direct association with any of the agencies involved in this review in the past or currently. A learning together methodology was used for this review. Reviewers had access to a wide range of case materials. In addition, Una met with the reviewers where she shared some of her experiences and the impact this had on her recovery, she was supported in this meeting by an independent advocate who was also appointed to represent her voice at panel meetings. Una was clear that she wished the review would "*help make changes for everyone".* She wished that, by sharing her experiences, learning from the review would shape future policy and practice change when responding to sexual abuse. In the words of her treating psychologist she is '*passionate about making a difference for people*'.[12] Una's partner also met with Reviewers and provided valuable insight into the long-term impact the abuse had on her recovery.

2.4 Despite the passage of time, we were able to speak with many of the frontline workers and safeguarding leads involved in the case. The reviewers also met with practitioners and clinicians involved in delivering care (including crisis care) during the period under review both employed directly through the Trust and those privately appointed following an interim Court order. We also met with senior and operational managers who had overseen the case to discuss the themes that were identified through the discussions with practitioners and with Una's legal team and Court appointed expert witnesses.

2.5 Shortly before the review concluded we spoke with one senior leader who worked within NWBH Trust at the time the abuse was disclosed. They accepted there was much to learn from Una's case and that inadequate record keeping of senior managers' decisions made following the disclosure impeded our ability to understand the rationale behind those actions. Mersey Care staff also reported the paucity of records that transferred to them was extraordinary. Documents disclosed within the civil proceedings indicate that a decision was taken by senior leaders at the Trust "*not to communicate about the relationship [between Una and the perpetrator] through email trails*". We have, in line with a systems approach, provided context where available from all those involved in discussions during this review and other sources to inform our findings.

2.6 The reviewers, with agreement from the panel and Una, did not believe it would be beneficial to meet with the perpetrator of abuse. This decision was based on his reported inability to recognise culpability for the harm caused by the abuse. A statement he had provided in the course of the safeguarding enquiry in 2016 was seen, which set out his view that he was a victim and that Una had been responsible for the abuse he perpetrated.

2.7 We are grateful to all those who supported this review. It was clear to the reviewers that all those involved understood there was significant learning from this case and demonstrated commitment to improving practice with respect to sexual safety and supporting effective recovery to adults who have experienced sexual abuse whilst under the care of a Mental Health NHS Trust. We are particularly grateful to Una and her partner for their input. The courage both have shown in

[12] Taken from Expert witness statement dated 03.12.20

contributing to this process and their commitment to making a difference for others is a testament of their strength and humanity.

Key lines of enquiry and timescale for the review:

2.8 The review will cover the period from March 2015 to 21 December 2021. The key lines of enquiry ('KLOE') are:

- Are systems robust to prevent abusive professional/client relationships? Are obligations fully understood and capable of implementation? What governance structures within organisations are in place in respect of investigating sexual abuse and do these include mechanisms for supporting and understanding victims who report abusive professional/client relationships?
- What was the professional understanding of the legal framework surrounding s38 of the Sexual Offences Act 2003, sexual exploitation and the impact of coercion and control on Una's capacity to consent more generally? What can be understood, and learning applied regarding s42 safeguarding enquiries and criminal justice processes and outcomes for survivors that have potential coercion and control elements at the investigatory stage?
- How was Una, as a victim and survivor of abuse that was admitted by the perpetrator, supported by all statutory agencies from 21 March 2016 onwards? What systems were and are in place to facilitate and provide such support?
- What is the understanding of unconscious bias across the professional network and what mechanisms are in place to prevent this impacting on the support provided to adults with care and support needs?
- What governance structures are in place in respect of reporting of safeguarding and serious incidents and how is adherence to these frameworks quality assured? How are staff supported to develop and maintain an open culture that promotes accountability, transparency and continual practice improvement? What oversight does, or should, the Safeguarding Adults Board and Regulator have into investigations of sexual abuse by professionals so that learning from the circumstances of this case is applied in the future?
- How did the civil litigation process impact on compliance with safeguarding procedures and the professional response to Una's needs and treatment under s117? How was she, as a survivor of abuse that was admitted by the perpetrator, supported through the court process and how was her mental health protected during this time?
- In respect of each of these issues, how has practice developed over time and would that reduce the risk of similar issues arising in the future?

Legal and practice context relevant to this review

Section 38 Sexual Offences Act 2003

3.1. Section 38 of the Sexual Offences Act 2003[13] made it an offence for care workers, including a care coordinator, to have sexual activity with someone whose care they are involved with, where they could reasonably be expected to know that person has a mental disorder. Under s38(1), offences that do not involve penetrative sex can be tried by way of summary conviction with a potential term of imprisonment of up to 6 months or on indictment for a term of up to 10 years. Where that sexual activity includes penetrative sex, s38(3) sets out that this is an indictable-only offence and the perpetrator is liable on conviction to imprisonment for up to 14 years. Section 38 does not refer to consent, coercion or the mental capacity of the victim – these will be relevant to whether the perpetrator should additionally be charged with rape, but do not provide a defence or mitigation to an offence under s38. There is a clear reason for this, as a care worker is a person in a position of trust and power. The offence is designed to protect a vulnerable victim who develops an emotional dependency on or attachment to the person caring for them which is exploited by the offender. "*The purpose of these provisions is to protect a person with a mental disorder who has*

[13] Sexual Offences Act 2003 (legislation.gov.uk)

the capacity to consent but who may be particularly vulnerable to exploitative behaviour and may agree to sexual activity because of dependence upon their carer."[14]

3.2. Harm is therefore determined by the type of sexual activity that has taken place, "…*because the victim may be reluctant or unable to articulate any harm done to them and may regard themselves as being in a genuine relationship with the offender*."[15]

3.3. The Sentencing Council's guidelines for a conviction under s38[16] set out that where penetrative sex has taken place, and culpability factors such as grooming behaviour against the victim, recording, retaining or soliciting sexual images of the victim or use of alcohol/drugs to facilitate the offence are present, (as they were in Una's case), the starting point for sentencing will be a 5 year custodial sentence. This will vary within a range of 4-10 years in custody depending on the aggravating or mitigating features of the offence.

3.4. Section 17(2) of the Criminal Justice and Courts Act 2015, which came into force in April 2015, removed police powers to give a simple caution (i.e. a caution without conditions) to someone who has committed an indictable-only offence unless there are exceptional circumstances relating to the offender or the offence, which can only be determined by an inspector (or officer of higher rank) and requires the consent of the Director of Public Prosecutions.

3.5. The Ministry of Justice guidance on Simple Cautions for Adult Offenders[17] states that the decision-maker is only permitted to conclude that there are exceptional circumstances if, on conviction, an offender would be unlikely to receive a custodial sentence (whether immediate or suspended) or high-level community order. Mitigating and aggravating features must also be considered, however, a 'romantic' relationship between a victim and perpetrator is not a mitigating factor to a sexual offence.

S117 Aftercare and suicide risk

3.6. A person can be detained for the purpose of assessment for up to 28 days under section 2 MHA if an application for admission is made by an Approved Mental Health Practitioner (AMHP) or the patient's nearest relative. Two doctors must confirm that: a) The patient is suffering from a mental disorder of a nature or degree that warrants detention in hospital for assessment (or assessment followed by medical treatment) for at least a limited period; and b) He or she ought to be detained in the interest of his or her own health or safety, or with a view to the protection of others. If they are assessed as needing to remain in hospital for treatment, a further application can be made under s3 MHA. A patient detained under has a right of appeal to the Mental Health Tribunal, and to support through an independent mental health advocate.

3.7. Section 117 of the MHA places an enforceable duty on the ICB and local authority to provide aftercare services to a person who has been detained under sections 3, 37, 45A, 47 or 48 of the MHA on discharge from hospital. An aftercare service is a service provided to meet a need arising from or related to the individual's mental disorder, to treat and prevent a deterioration in their mental disorder, and reduce the risk of the individual being returned to hospital. The ultimate aim is to maintain patients in the community, with as few restrictions as are necessary, wherever possible.

3.8. The duty to provide s117 aftercare services is triggered on discharge from hospital, however, discharge planning should begin as soon as the person is detained under section 3. Whenever the Responsible Clinician is considering discharge, they should consider whether the person's aftercare needs have been identified and all appropriate aftercare services necessary to meet

[14] Rook and Ward on Sexual Offences Law and Practice 4th edition para 7.165
[15] Sexual Offences Guideline (justice.gov.uk)
[16] Care workers: sexual activity with a person with a mental disorder/ Care workers: causing or inciting sexual activity – Sentencing (sentencingcouncil.org.uk)
[17] Simple Cautions guidance (publishing.service.gov.uk)

their needs are addressed before they are discharged. The individual must be fully involved in any decision-making process with regards to the ending of aftercare, including, if appropriate consultation with their carers and advocate.

3.9. Aftercare should be kept under review to ensure this continues to meet the person's needs and will only end if both the ICB and local authority are satisfied that the person no longer needs this. It cannot be withdrawn simply because someone has been discharged from specialist mental health services, readmitted to hospital (unless they are readmitted for treatment under s3 MHA. Nor should it be withdrawn after an arbitrary period. If aftercare is withdrawn, services can be reinstated if it becomes obvious that was premature.

3.10. The legal framework around managing the risks to individuals who express suicidal ideation is complex and personal freedoms must be weighed against duties placed on public bodies to protect lives and mitigate risks to vulnerable people. All public bodies must exercise their legal powers in an ethical way that complies with duties to the adult under the MHA, Mental Capacity Act 2005, Human Rights Act 1998 and Equality Act 2010. While Article 2 of the European Convention on Human Rights (ECHR) places a duty on public bodies to prevent avoidable deaths, this must be balanced against the right to freedom from inhumane treatment (Article 3), the right to liberty (Article 5) and respect for your private and family life (Article 8). The Supreme Court has found that an NHS Trust can violate its positive duty under Article 2 EHCR to take reasonable steps to protect a formal or informal patient known to be suffering mental illness from the risk of suicide, if there is a 'real and immediate' risk of death.[18] This duty to take reasonable steps to protect someone from a real and immediate risk of death will apply to all public bodies in exercise of their duties, including CMHTs, the police and those carrying out public functions.

Assessment of risk and management of personality disorders

3.11. Many people who experience adverse childhood experiences, particularly neglect and abuse in their childhood, develop cognitive maladaptive schemas and psychological distress, both symptoms of personality disorders. Despite this understanding, there is a recognised stigma towards patients who have been diagnosed with personality disorder. In 2002 the UK Government/ Department of Health introduced bills to 'break the cycle of rejection' and prevent personality disorder being a diagnosis of exclusion (DoH, 2002). Royal College of Psychiatry (2018) supported research completed by Cartonas (et al 2018) suggestive of negative attitudes of clinical staff towards patients with diagnosis of personality disorder. Notably, this was still present after 16 years of the introduction of national personality disorder development programmes. The study referenced nurses as scoring lowest in self-rating scales on caring attitude towards patients with personality disorder. A simple online search provides the extensive study, articles and forums of discussions surrounding the stigma of personality disorder.

3.12. There is also a common misperception about the availability of support and appropriate treatment options to address risk and needs associated with personality disorders. To redress this we have included information within this section about the link between adverse childhood experiences and poor mental health and best practice guidance to support effective recovery for patients with personality disorders.

3.13. Cognitive distortions are also a common feature in many mental health presentations and play an important role in maintaining the negative core beliefs that form early maladaptive schemas, through the perceptional distortion of fact. Cognitive distortions are common thoughts that happen quickly, involuntarily and in a distorted manner.[19] Cognitive Behavioural approach to treatment usually seek to modify such cognitive distortions by supporting the patient to recognise and

[18] Savage v South Essex Partnership NHS Foundation Trust (2008) UKHL 74 (10 December 2008) (bailii.org) and *Rabone and another v Pennine Care NHS Foundation Trust (2012) UKSC 2* https://www.supremecourt.uk./cases/docs/uksc-2010-0140-judgement.pdf

[19] da Luz FQ, Sainsbury A, Hay P, Roekenes JA, Swinbourne J, da Silva DC, da S Oliveira M. Early Maladaptive Schemas and Cognitive Distortions in Adults with Morbid Obesity: Relationships with Mental Health Status. Behav Sci (Basel). 2017 Feb 28;7(1):10. doi: 10.3390/bs7010010. PMID: 28264484; PMCID: PMC5371754

challenge unhelpful cognitive distortions. The diagnostic criterion for personality disorders recognises such cognitive distortions, defining these as '*enduring disturbance characterised by problems in functioning of aspects of the self (e.g., identity, self-worth, accuracy of self-view, self-direction), and/or interpersonal dysfunction (e.g., ability to develop and maintain close and mutually satisfying relationships, ability to understand others' perspectives and to manage conflict in relationships)*.[20] Patients with EUPD can present with cognitive distortions which present as '*a pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation*.' (DSM5)

3.14. Dysfunctional patterns, beliefs, and assumptions that affect a patient's perception of other people often affect their perceptions and behaviours towards clinicians providing treatment or therapy. This is called 'transference' and presents an important factor to monitor for those treating and supporting a patient's recovery to provide against intentional or unintentional abuse as '*excessively positive and negative transference can block or slow down the therapeutic process, especially if it is not recognised and processed.'* [21] Clinicians can equally experience countertransference, adversely impacting on the therapeutic relationship. The role of clinical supervision and reflective practice is crucial in ensuring that clinicians are supported to recognise transference and counter-transference to ensure continued effective treatment.

3.15. In 2020 Mersey Care published their personality disorder policy. This was based on clinical guidance, issued by NICE [22] in 2015 (so applicable during the review period) and warned *'historically, service users with BPD[23] have been excluded from receiving mental health services, and a negative attitude still remains for some professionals. This in turn greatly affects any therapeutic alliance and engagement in collaborative working. To overcome this, the Trust advocate for:*

- *Continuity and consistency of approach: Given the high risk with this service user group for patterns of escalating action and reaction, consistency between different teams, staff within the same team and between a professional and service user are essential. Hence, it is critical that there is a shared plan, including a formulation to inform the team's understanding of each individual service user.*
- *Attending to individual countertransference feelings: Working with service users with BPD often leaves the professionals and teams involved with strong feelings (both positive and negative). For example, commonly staff can find themselves feeling powerfully protective/caring or rejecting/critical in relation to service users with BPD. Processing these feelings in a professional manner is important in maintaining appropriately professional interactions. This both protects service users from harm but also ensures that the "caring system" does not become hopeless, pessimistic and risk averse.*
- *Understanding organisation anxiety and defenses: Teams working with service users with BPD sometimes find themselves feeling "stuck" in clinical dilemmas and uncertain about how best to proceed. This can manifest itself as extreme ambivalence from the clinical team towards the particular service user, who then is at risk of "malignant alienation" (Watts 1994) from the staff team. This commonly happens during inpatient admissions, during which time service users can present with an intense and confusing paradox of emotions: feeling contained by being in a supportive environment and not wanting to be discharged, whilst simultaneously feeling claustrophobic and agitated about the restrictive environment on the ward and expressing a wish to leave and harm themselves. This can lead to an escalating spiral of threats, acts of self-harm and violence, with the mental distress within the service user becoming translated into anxiety within the care system…*

[20] ICD for Mortality and Morbidity Statistics (1/2003) available at: https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/941859884
[21] Prasko J, Ociskova M, Vanek J, Burkauskas J, Slepecky M, Bite I, Krone I, Sollar T, Juskiene A. Managing Transference and Countertransference in Cognitive Behavioral Supervision: Theoretical Framework and Clinical Application. Psychol Res Behav Manag. 2022 Aug 11;15:2129-2155. doi: 10.2147/PRBM.S369294. PMID: 35990755; PMCID: PMC9384966.
[22] Available at: https://www.nice.org.uk/guidance/qs88
[23] 'BPD' or Borderline personality disorder is another term used for Emotional Unstable Personality Disorder

- *Formulations (biopsychosocial): should be at the centre of care, co-created with service users, and drawing upon psychological models. Medication: can offer symptomatic relief but due to (1) a lack of evidence that it can effectively change the disorder itself (2) the risks associated with poly-pharmacy and (3) because it can promote the "sick-role" and reduces personal agency, the role of medication should not be the most prominent part of care.'*

3.16. The policy advises '*effective recovery for people with BPD requires a careful balance between encouraging the service user to take responsibility for change, owning the consequences of their own behaviour and offering support and intervention when needed. Achieving this balance is not easy and cannot be reduced to a simple set of rules. ... Of particular importance is the need for clinicians to feel supported in taking clinically indicated risks, especially around reducing admissions to hospital. This is important; although admissions to hospital might reduce risk in the short term, often they have a counter-therapeutic effect fostering dependency, and causing further harm by increasing the long-term risk. In turn it is hoped that service users with BPD will then feel more contained themselves, through their experience of receiving care that is more integrated and cohesive, which in itself might reduce the need for admission to hospital.*'[24]

3.17. A core principle within the policy is to seek to reduce in-patient admission by providing relational continuity as the '*quality of therapeutic alliance is key to promoting growth and minimising admissions*.' The policy sets out the role of specific teams:

- CMHTs will provide the majority of care to most of service users with EUPD, but as with any Tier 2 service can seek further support from the Tier 3 personality disorder hub in Spring House.
- CRHT will act as gatekeepers to inpatient units and aim to provide short crisis admissions for service users who are well known and guidance on the management of these is these is offered.
- Psychotherapy offer specific therapy for EUPD, as well as training and consultation to teams.
- The PD Case Management Team offer 100 weeks of intensive support to those service users with the most complex presentations. In addition, the PD Hub with its combined Day and Safe service offer structured activities and support in crisis.

Case Analysis

KLOE 1: A system approach to preventing sexual abuse

Are systems robust to prevent abusive professional/client relationships? Are obligations fully understood and capable of implementation? What governance structures within organisations are in place in respect of investigating sexual abuse and do these include mechanisms for supporting and understanding victims who report abusive professional/client relationships?

4.1. Una, who sits at the heart of this case, required mental health support to address complex PTSD in the context of a severe personality disorder. Partner agencies were acutely aware of her inability to keep herself safe, particularly at times of heightened emotional distress. Her expectation, understandably, was that agencies with statutory responsibilities would work together and in line with their legal obligations to ensure her care and treatment was provided in a safe environment.

4.2. The legal framework to protect children and vulnerable adults[25] against sexual abuse is comprehensive. It is a mixture of civil actions and criminal sanctions. Within the context of mental

[24] Mersey Care Personality Disorder policy, revised in May 2021

[25] We have used the term vulnerable adults in this context because much of the criminal and civil legal frameworks use this term. We are, however, clear that the victim's ability to protect themselves due to care and support needs is only relevant in that it increases risk, because perpetrators may deliberately target adults with care needs and enhances the statutory duties of partner agencies to actively protect.

health professional/client relationships the criminal sanctions (under s38 Sexual Offences Act) and safeguarding responsibilities are addressed below in response to KLOE 2. However, it is widely acknowledged that it is not sufficient for statutory safeguarding partners to only respond effectively to sexual abuse, there is also a myriad of legal powers aimed at empowering private individuals, organisations, professionals and regulators to prevent abuse occurring. The system approach to ensuring risks are reduced is multi-layered; relevant agencies are expected to actively disrupt perpetrators whilst also ensuring anyone at higher risk (e.g. given what is already known of indicators) are provided proactive advice and support to sexual safety and recognise abusive relationships.

4.3. Significant academic research confirms a link between experiences of childhood sexual abuse with a higher risk of sexual re-victimisation in adolescences and adulthood, particularly for adults with more severe personality disorder features such as dissociation and maladaptive emotional regulation such that one study[26] reports these are '*significant predictors of sexual intimate partner violence'*. Another study [27], reported in 2009, also linked child neglect, poor mother/child attachments (both of which were features in Una's childhood) as heightening a risk of adult sexual exploitation and re-victimisation. There are also evidential studies highlighting increased presentations of suicidality, self-harm or mutilation, PTSD and dissociation may indicate experiences of sexual abuse.[28] The indicators of higher risk of abuse, therefore, should have been understood within a clinical context as heightened risks for Una during the period under review.

4.4. Since 2016 any professionals registered with the GMC, NMC, HCPC or Social Care England are required to take appropriate action to address and report concerns about the safety or wellbeing of service users, follow up any concerns and be open and honest if something has gone wrong. Those in professional roles working with children or 'adults at risk' are also expected to undertake safeguarding training (including during any undergraduate study and induction into a new role) to a requisite level of competency. Local and national policy requires, at a minimum staff have met the NHS safeguarding assurance framework (based on the Bournemouth competency model[29]) and WSAB's safeguarding policy applicable at the time.

4.5. Those acting in breach of those standards are, as the perpetrator was in this case, expected to be subject to disciplinary action by their employer and referred to their professional regulatory body. The local safeguarding policy also required health bodies to fully comply with any enquiry undertaken in line with s42 Care Act duties. At a basic level, the Trust complied with expectations to notify relevant bodies. However, accepted failures by senior managers to act in line with ongoing duties to support those enquiries, most crucially, to ensure transparency, the Trust (as an employer of a regulated service provider) [30] should have notified the Care Quality Commission, WCCG (now GMIC) through StEIS and, in accordance with local safeguarding policies, WSAB of any critical incident.

4.6. WSAB's multi-agency safeguarding policy[31] confirms abuse can '*occur within a relationship of care giving*' (s2.4), that '*each organisation has a responsibility to ensure… a system of leadership and accountability that monitors safeguarding systems (and best practice in relations to safe recruitment and retention is adhered to'* (4.2). It required *'the Clinical Commissioning Group will hold provider services to account if they are not supportive of Local Authority led safeguarding investigations*' (5.3.1) and that '*early involvement of the Police will help ensure that forensic*

[26] Krause-Utz, A., Dierick, T., Josef, T. *et al*. Linking experiences of child sexual abuse to adult sexual intimate partner violence: the role of borderline personality features, maladaptive cognitive emotion regulation, and dissociation. *bord personal disord emot dysregul* **8**, 10 (2021). https://doi.org/10.1186/s40479-021-00150-0

[27] A model of vulnerability for adult sexual victimization', Reid et al, Violence and Victims and Victims, Vol 23, 4 (2009)

[28] de Aquino Ferreira LF, Queiroz Pereira FH, Neri Benevides AML, Aguiar Melo MC. Borderline personality disorder and sexual abuse: A systematic review. Psychiatry Res. 2018 Apr;262:70-77. doi: 10.1016/j.psychres.2018.01.043. Epub 2018 Feb 1. PMID: 29407572.

[29] This has now been replaced by NHSE's safeguarding accountability and assurance framework available at: https://www.england.nhs.uk/wp-content/uploads/2015/07/B0818_Safeguarding-children-young-people-and-adults-at-risk-in-the-NHS-Safeguarding-accountability-and-assuran.pdf

[30] As defined by schedule 1 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014

[31] Revised in November 2014, so appliable throughout the review period

evidence is not lost or contaminated, and may prevent the alleged abused adult being interviewed unnecessarily on subsequent occasions. Any police investigation will be planned alongside managing and dealing with the health and social care issues. (5.5)

4.7. Prior to the disclosure of sexual abuse, the Trust (as accepted during the civil proceedings) failed to properly supervise the perpetrator in respect of his employment duties. It is understood that the perpetrator rarely attended team meetings or supervision, he did not (as had been requested) attend the office prior to going to clients' homes for visits and was reported to be poor at record keeping. These issues had not been addressed through disciplinary mechanisms. There was no systematic way by which senior leaders in the Trust could ensure compliance with employment obligations or safe working practices. A review of the case was undertaken by Niche.[32] This investigation referenced pressures within the team; it is understood the team manager had been re-deployed temporarily to support another part of the service, so the deputy had stepped up to the role whilst the deputy post remained vacant. However, there was no evidence that poor working practices had been escalated as a concern to senior Trust managers. The lack of structured managerial oversight of working practices would likely have impeded the acting team manager's ability to identify this as a risk to their client group. In addition, as was evident following the disclosure, failure by senior Trust managers to act on concerns escalated by that person (when subsequently acting as Una's care coordinator) demonstrates a complete lack of organisational support. In conversations with reviewers, practitioners who worked alongside the perpetrator were very clear his actions were abusive and that he would have known the significant immediate risk and long-term impact for Una of his behaviours. They explained until disclosure of his abuse, he was believed to be a competent professional and that, as such, he was permitted a wide degree of autonomy over how he undertook his role. Practitioners reflected that, notwithstanding pressures within the team at that time, an important lesson to be learnt from this case is the importance of quality supervision and careful managerial oversight into the care provided to high-risk patients, especially where such care is provided by lone workers.

4.8. There are also, however, wider questions regarding the culture that had developed which permitted a lone worker to exert such control, with little or no professional curiosity from other professionals involved in Una's care. It is highly concerning that such disregard to Trust policies did not prompt any managerial concerns. Una and practitioners spoke of the perpetrator's avoidance of key managerial meetings (such as allocation meetings and supervision). He had explained to Una this was a tactic to ensure he would not be allocated additional cases which would prevent him spending time with her. He was reportedly known to be bad at record keeping, but this (and poor compliance with other key employee duties) if commented on by more senior management was never followed up effectively in line with the Trust's employee policy framework. On a very practical level, Una commented that had the lone policy or employee contract required managerial oversight of telephone communications by lone workers with patients, the grooming behaviours may have been identified much sooner and action taken to prevent the abuse. She recommended this should form part of any mobile phone/ IT policy and that the purpose to ensure professionalism and enable accountability for practice standards (including preventing abuse or neglect) be explicitly stated.

4.9. This lack of structured managerial oversight over workforce practice did not form part of any action planning arising from the disclosure, either immediately after the abuse was uncovered or at any time before the Trust was dissolved in 2021. This indicates poor culture within senior leadership, highlighting a fundamental misunderstanding of the underlying purpose of those provisions, namely, to ensure safe, effective care and accountability.

4.10. The lack of oversight by senior managers with respect to workforce issues was also apparent in terms of clinical judgement. There are examples, even prior to the perpetrator's grooming, when Una's heightened risk of sexual re-victimisation and her voice was ignored within clinical decision

[32] Niche are an external firm who were commissioned in 2017 by the Trust to investigate the abuse and identify lesson to learn for the Trust

making, in breach of Trust policies, but left unchecked or unchallenged by senior managers. For example, she was twice denied a request to replace the perpetrator with a female care coordinator and advised that there was no-one else available.[33] Likewise, opportunities to review her care plan (given the high level of serious incidents of self-injurious behaviours and dependency on a lone worker) were ignored throughout 2015-2016.

4.11. Crucially, Una's disclosure that he manipulated her by providing other patients' medication to create highs and lows in her mental state was never investigated despite this being an indicator of predatory behaviour that placed other patients at high risk. Prior to that disclosure, the perpetrator had admitted to crossing professional boundaries to a criminal standard. Despite this, there is no evidence that Trust senior managers took appropriate action to ensure other patients within his case list had not also come to harm. This is despite an independent report commissioned by the Trust which recommended such action in 2017, or their statutory duties and local safeguarding obligations to actively support the local authority, health and police partners carry out their functions. This is explored in more detail below in response to KLOE 2.

4.12. Disclosures of this nature should have prompted Trust leads to explore how they were assuring themselves that their services promoted sexual safety. During the review period, in 2020 CQC published findings of their research into promoting sexual safety.[34] They found cultures where sex is treated as a taboo subject enables predatory behaviours. Their report calls for SCIE and providers to update guidance to staff working across health and social care to ensure staff are vigilant to changes in behaviours, improving the understanding of when someone has capacity to consent to sexual relations and duties to effectively collaborate with police, safeguarding teams, support groups to ensure sexual safety incidents are understood, taken seriously and addressed appropriately. This includes ensuring people who have experienced sexual abuse are supported, including by offering counselling and that the needs of specific groups are better understood so that their person-centred needs are met. Compliance with this guidance now forms part of any CQC inspection.

4.13. Whilst, therefore, there is no evidence of direct complicity with the perpetrator to support his grooming and exploitation, the High Court concluded that failures admitted by the Trust resulted in an environment that facilitated the abuse. Subsequent failings by Trust senior managers to review affected patients, support the criminal investigation or safeguarding enquiry but instead simply limit their role to undertaking disciplinary matters, ensured a continued culture which perpetuated harm to Una and, potentially has failed to protect other patients on the perpetrator's case list. This is explored in more detailed below in KLOE 3.

4.14. The impact for Una's recovery of those failings were detailed within expert testimony in the civil litigation as early as 2020.[35] By this time, Una had experienced not just the sexual abuse but over 4 years of inadequate care to address her needs arising from the abuse. In conversations with reviewers many staff responsible for providing crisis care, throughout the review period, commented that it was only through their involvement with this review that they had understood the context of Una's presentations. The secrecy that developed from the date of disclosure and throughout the civil litigation directly impacted on not only practitioner's ability to offer her safe, person-centred care, it continues to have perceptibly (to the reviewers at least) impact on staff wellbeing. Her treating psychologist, funded privately through the interim award, described the necessary steps she took to provide safe care, given that this was provided by someone from a

[33] Confirmed in Expert Clincial Psychologist's report (dated 20.11.20) filed for the purposes of Court proceedings. Within that report he commented the Trust's own Policy on Care Co-ordinator Roles and Responsibilities (dated 04.02.2015) stated at paragraph 2.1.5:
'.....Decisions about who should be a Care-Co-ordinator are to be based on consideration of the service user's wishes and needs. Service users are to be afforded a choice of care co-ordinator that takes account of any cultural or religious needs, or gender preference due, for example, to damaging experiences of abuse or violence....'

[34] Available at: https://www.cqc.org.uk/sites/default/files/20200225_sexual_safety_sexuality.pdf. In response to this SCIR published revised guidance which is available at: https://www.skillsforcare.org.uk/resources/documents/Developing-your-workforce/Care-topics/Supporting-personal-relationships/SfC-Supporting-Personal-Relationships-Sept21.pdf

[35] Witness Statement of her treating clinical psychologist, dated December 2020

profession Una had, through her experiences, learnt to perceive as abusive. Other experts, including experts instructed jointly by the Trust and her legal team, reported the increased risks Una would experience throughout her life if her current stable arrangements (and personal relationships) were to deteriorate, such that she would likely continue to require significant support to maintain her mental health for many years. This care continued, despite Una's improved insight, because of the continued heightened risk of sexual abuse re-victimisation.

4.15. Having taken expert advice, Una and her legal team believed failings by senior managers to follow their organisational polices and professional standards designed to provide safe systems amounted to a breach of their own professional conduct. In November 2016 they referred a number of Trust employees, including four senior managers, to the NMC. This action was seen by the Trust as overtly aggressive; it appears they sought to defend these by refuting all allegations. However, they recused those senior managers from the case pending an outcome of the referral. We also understand, from discussions with those involved, that actions taken by practitioners involved in her care and the Trust that sought to mitigate risks for Una were not shared with the NMC, Una or her legal team. A senior manager has explained that bi-weekly meetings took place, which included leadership oversight of Una's care, in addition to the managerial oversight of the perpetrator's disciplinary and regulatory processes. It was the senior manager's recollection that notes of those meetings were taken by the legal team, but not formally minuted. This approach adopted reinforced for Una (and, objectively, this review) that there was a poor culture within senior managers of learning from adverse incidents to improve sexual safety and prevent abuse.

4.16. The NWB Trust's Managing Allegations Against Staff policy required that, following the strategy meeting, a report should have been made to the Patient Safety Panel in line with the Trust's Incident Investigation policy and procedure (s2.3). This review has received no evidence that was undertaken. In fact, senior managers made repeated decisions not to comply with their own policies. The policy sets out, within that panel would have been responsible for monitoring compliance but is silent on how that will be achieved.

4.17. Mersey Care's Policy for Managing Allegations Against Professionals[36] articulates an aim that all Mersey Care colleagues are familiar with the process which must be followed for considering information arising from an allegation or concern about the behaviour or alleged actions of a colleague working with children or vulnerable adults. The policy enforces its aim is to enable effective support of Mersey Care Service Users. The key principles of this policy are that the safety of the child / adult is paramount, and that suspected or alleged abuse must be taken seriously. An allegation of harm or abuse (such as Una's) would be expected now to progress to 72hr Review and given the severity of circumstances a comprehensive serious incident report would likely be completed. The policy requires that throughout the process, the Trust's safeguarding service and executive leadership for safeguarding are involved and updated, ensuring that a safeguarding voice and presence is maintained throughout decision making and at all levels of the organisation. The policy confirms that, resignation by an alleged perpetrator should not stop the allegations being fully investigated (6.29 of the policy). This is crucial as both regulators and the DBS service rely heavily on information submitted by employers under such policies. The policy confirms adherence to the policy is mandatory. That any consideration to deviate from policy requirements must be reported to their safeguarding leads so that an action plan can be agreed. Compliance with the policy is monitored through the annual safeguarding report which should detail the number of allegations made, outcome and timeliness of the process (including any internal disciplinary action taken as a result of the allegations). Whilst inclusion of this into the annual report which goes before the Trust Board provides some reassurance, Mersey Care (alongside GMMH, GMIC and local authority and WSAB) may wish to consider if this provides adequate assurance that

[36] Available at: https://yourspace.merseycare.nhs.uk/application/files/3116/9538/1616/HR-G9_Allegations_Against_People_in_a_Position_of_Trust_PIPOT_Child-Adult_Services_V1-Up22Sep-23-Rev_Aug-26.pdf

allegations which involve sexual safety concerns have sufficient multi-disciplinary, coordinated investigations so that perpetrators understand they will held to account in accordance with the full range of criminal, as well as civil, sanctions.

4.18. Of note, and commented by experts within the court proceedings and to the reviewers, is that the Trust's applicable policies were, at the time of the sexual abuse disclosure, of good quality. Their view was that, properly applied, those policies should have offered a level of protection: "*It was not a failure of the system, but implementation of the system.*" Mersey Care and the wider partnership must therefore maintain a clear focus that the current policies, which are consistent with good practice, are consistently followed through a robust quality assurance process.

4.19. In addition, many practitioners involved in this review highlighted that there are still significant issues to address sexual safety from a preventative approach. There is an inherent conflict within the current system which relies almost entirely on adults at risk or professionals to recognise and report abuse which contrasts with widespread recognition that predatory behaviours are too frequently normalised or overlooked. Issues raised in this case of inadequate monitoring by senior leaders and staff not being supported to raise concerns or challenge poor compliance with policy remain unaddressed. A significant increase in workload across all statutory partners, but particularly CQC as regulators, without a corresponding increase in capacity further undermines well-meaning and genuine aspiration to proactively prevent sexual abuse.

System Finding

4.20. In 2016 the Trust did not have effective mechanisms to monitor staff adherence to safe working practices so did not enforce lone working policies designed to reduce risk of abusive professional/client relationships. Their policy to manage allegations against staff was not robust, but was also not followed by senior managers. The system did (and still does) rely on managerial oversight escalating and reporting serious incidents. There are very few mechanisms for wider system monitoring if managerial/ strategic oversight is weak. Trust senior managers did not comply with obligations to report this abuse, frustrating CQCs and GMICs ability to support safe practice or hold the Trust senior managers to account for their poor practice. Since 2021 Mersey Care NHS Trust have introduced policies, but current workforce pressures across all statutory providers, commissioners and regulators means this remains a high risk. Sexual abuse by care staff happens rarely, but the adverse impact (for the adult and organisation) is so high that it should remain a critical risk on corporate risk registers and partners need to urgently agree sustainable mechanisms for triangulating safeguarding concerns, allegations against people in positions of trust and criminal investigations and auditing the outcomes to enhance current practice.

KLOE 2: Understanding grooming, coercion and control and victims' rights

What was the professional understanding of the legal framework surrounding s38 of the Sexual Offences Act 2003, sexual exploitation and the impact of coercion and control on Una's capacity to consent more generally? What can be understood, and learning applied regarding s42 safeguarding enquiries and criminal justice processes and outcomes for survivors that have potential coercion and control elements at the investigatory stage?

4.21. Newcastle's Joint Case Review into sexual exploitation[37] identified the lack of a national definition of adult sexual exploitation undermines safeguarding practice because partner agencies have '*little scope for proactively looking for abuse. …Sophisticated grooming means victims may not recognise they are being abused and believe they are in control, in healthy consensual relationships. Apparent close relationships may develop to involve intimidation, threats and coercion. Victims may have mild cognitive difficulties that do not impact significantly on ability to cope with education or functioning as an adult. However, involvement with perpetrators, use of drugs and alcohol and the abuse itself may increase vulnerability*.' The report also highlights that *'bad experiences of the criminal justice system deter victims from coming forward or persisting*

[37] Available at: https://www.newcastle.gov.uk/sites/default/files/Final%20JSCR%20Report%20160218%20PW.PDF (accessed 05.05.23)

with complaints. Perpetrators will adopt cruel tactics and, being aware of agencies' processes, become skilled at undermining attempts to safeguard victims.' The review also acknowledged '*the application of the law and professional standards of practice relating to consent, capacity and the right to choose is complicated and uncertain. The presence of some form of exchange or benefit complicates assessments. Working with challenging adolescents and adults requires particular skills.*'

4.22. Understanding what motivates a perpetrator of sexual abuse, such as Finkelhor's four pre-conditions model[38] has enabled the development of clear policies and practices to identify and disrupt sexual abuse and exploitation of children and adolescents. There is no evidence that practitioners working to investigate and support Una immediately following the perpetrator's disclosure understood this model or acted to prevent further abuse. Understanding the techniques perpetrators employ is equally crucial. Controlling behaviour is described as "…*a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour… Due to the ongoing, pervasive nature of coercive control, behaviours can be difficult to spot, for victims themselves, family and friends, and wider society. Perpetrators are often clever manipulators, and to the outside world may appear charming and incapable of committing these crimes."* [39]

4.23. The nature of the role of a care coordinator is inherently a powerful one, which exerts considerable control over their patients. They oversee the patient's medications, can recommend that they are assessed for detention under the MHA and, in Una's case, control contact with her child. Una reported, in conversation with reviewers, that '*he controlled so much of my life, he controlled my medication, whether I was in the community, whether I could see my child. I couldn't even decide not to speak with him as, if I did, he'd get the police to do a welfare check'*. For her, the giving or withholding of care and support was equally effective as a means of control.

4.24. The closest correlation in law would be a teacher having a sexual 'relationship' with a 16-year-old pupil (although arguably a teacher holds less power and control than a care coordinator for the reasons highlighted above). While the young person may be over the legal age of consent to sexual intercourse in general, it is difficult to imagine any professional characterising such a 'relationship' as anything other than exploitative and abusive. It is difficult to conceive that the police would not pursue a prosecution where a teacher has admitted such an offence, and children's services generally have robust policies to ensure a strategic approach to safeguarding a child in such circumstances.

4.25. In conversations with reviewers, practitioners expressed how appalled they were by the perpetrator's abuse. As noted above, they reported senior managers had instructed staff not to talk to Una or each other about the abuse, even in therapeutic sessions. Consequently, this was not how Una perceived their response at the time. It is also rare to identify within case files or reports examples of any partner agency acknowledging (to Una or each other) the sexual abuse and exploitation. For example, during the strategy meeting on 23 March 2016 to consider the s42 safeguarding enquiry, staff from the Trust affirmed that Una "*would have full capacity to consent to engaging in the relationship*". They also provided later a statement to police which asserted, when not in crisis, Una was high functioning and had capacity "*in all areas of life and decision making*" including to consent and engage in sexual relationships. No explanation given by the Trust for why they provided this evidence without consultation with Una. This demonstrates a poor understanding of the nature of sexual exploitation, heightened risks of sexual abuse re-victimisation for adults with severe personality disorders and a history of childhood sexual abuse and the impact of grooming. Police officers explained they asked for this information in order that,

[38] As detailed in 'Steps towards Prevention- ECSA toolkit' published by Lucy Faithful Foundation at: https://ecsa.lucyfaithfull.org/sites/default/files/attachments/Steps%20towards%20prevention.pdf
[39] CCInformHowToIdentifyCoerciveAndControllingBehaviour.pdf (communitycare.co.uk)

alongside the s38 offences, they could also consider additional charges such as rape. The Trust accepted within subsequent court proceedings that this approach was harmful to Una's immediate needs and delayed her recovery. As was later reported within the civil proceedings by her privately funded treating psychologist, this not only served to undermine her confidence in professionals within the Trust to apply their own policies to keep her safe, it triggered her into '*the state she found herself as a child when she was so badly abused… what I have to deal with in therapy is the fact that she perceived what (the Trust) did to her from March/April 2014 onwards was tantamount to what was done to her by those men when she was a child. The brain will try to protect against future threats by looking for similarities and making associations. It is an important and crucial aspect in the human survival response.*'[40]

4.26. It is understood the investigating police officers discussed the case with a detective inspector who determined that the perpetrator was eligible for a caution, believing mitigating factor apply. Despite s17(2) of the Criminal Justice and Courts Act 2015 and the Ministry of Justice guidance on Simple Cautions for Adult Offenders[41] the detective inspector authorised a caution on the basis it was "…*a relationship of genuine affection confirmed by both parties. There is no history of intimidation, no use of drugs/alcohol to facilitate the offence, no threats to the victim to prevent them from reporting it, no abduction or detention involved. The offender has fully admitted the offence and has no previous bad character.*" In conversation with the reviewers, the officers explained they were acutely aware of the criminal nature of his offence. They gave serious consideration to charging the perpetrator, but feared doing so would result in increased risks to Una given the high risk of self-injurious behaviour. They explained they discussed this internally at length, aware of the serious nature of the offence and the need to have a clear record that could prevent the perpetrator from accessing other vulnerable victims in the future. They took this decision reluctantly but did so weighing up that acting against the victim's stated wishes could reduce the risk of successful prosecution and pose significant risks to her wellbeing.

4.27. It remains, however, unclear why this decision was reached without a more considered protection plan having been discussed within the context of the ongoing s42 enquiry. In particular, the officers recognised they may have formed a different view about her immediate safety if they arrested and charged the perpetrator had they had assurance about actions would be taken by the Trust to provide Una with the protective (if necessary restrictive) care to ensure, if he were removed from her home and prevented from ongoing sexual abuse, her wellbeing was prioritised. Those officers, with benefit of hindsight and additional training on coercive control and grooming behaviours, accept that they would push partners to provide stronger wrap around support for a victim of sexual abuse of this nature. It is so unfortunate that the rationale for this decision was not clearly articulated at any time to Una. That failing, as well as the language used to justify exercising an exception which minimises the perpetrator's responsibility and the egregious nature of the offence, caused further trauma to Una. These actions reinforced the abuse she had suffered as a child, feeding directing into her maladaptive schemas.

4.28. In May 2016 Una disclosed to the police that she felt she had been manipulated by the perpetrator to reduce the likelihood he would face prison. She disclosed that during the abuse he had visited her on a daily basis, contacted her frequently throughout each day and had provided her with other patients' prescriptions. She was advised by the police to notify his employer (the Trust) as it would form part of their disciplinary investigation and so that she can get necessary support for her own mental health. The police also reported the conversation to the perpetrator's line manager, but did not open a further investigation in respect of other possible offences. In response to this review, the officers explained he had been cautioned for the most serious offence under s38 Sexual Offences Act and, for that reason, they did not believe there were reasonable grounds to explore alternative charges in respect of sexual abuse. This does not explain why

[40] Taken from the witness statement of Dr R dated 03.12.20
[41] Simple Cautions guidance (publishing.service.gov.uk)

offences such as ill-treatment or willful neglect[42] (given he had provided Una with medication required by other patients) could not be explored.

4.29. Una also reported in March 2018 that she had been raped by the perpetrator (in October 2015 following her detention under s2MHA). She also was interviewed by the police in line with 'Achieving Best Evidence' guidance, following that interview the police recorded additional offences, classified as ill treatment (s20 CJCA) and supply of controlled drugs. GMP were made aware that solicitors acting on behalf of Una were in receipt of messages exchanged between the perpetrator and Una which may be of evidential value. The officers reported to this review, they made requests to obtain these. Her legal advocate reported he provided the information and one of her mobile phones directly to the police when police officers subsequently attended her solicitor's office. The perpetrator was also interviewed that day under caution and denied the offence of rape. In conversation with the reviewers, the officers explained they had tried to pursue an investigation into the rape allegation. They had asked to review Una's phone records for any evidence, but did not receive a response. Una has since explained that she felt aggrieved that her phone was seized, leaving her unable to contact her support network when the perpetrator was unaffected by the police investigation. The police explained this was because the perpetrator's phone had been seized for another investigation (unconnected to this case). The officers investigating subsequent allegations explained those enquires were also frustrated as the Trust's documentation did not contain timings to evidence when the MHA assessment had taken place that day and her subsequent admission into hospital, so there was no objective evidence to corroborate her statement. However, they did question the perpetrator, he denied rape; repeating earlier complaints that she had capacity and was manipulative. They also recollected the assessing doctor's notes stating it was a voluntary admission. They did follow this up with the hospital who admitted her, requesting advice about her capacity to consent to sexual intercourse, but this was not forthcoming. Police officers understood that they would now use escalation pathways to challenge partner agencies who were not cooperating with enquiries, but felt that this is common when perpetrators or victims of crimes have mental health disorders as clinicians will often refuse to provide information on 'confidentiality' grounds.

4.30. A decision was taken in April 2019 for no further action on both offences by the Wigan District Crime Manager (Detective Chief Inspector) without referral to the CPS for charging decision as it was felt that the evidential threshold was not met for prosecution. It is understood that the delay in recording the crime when it was first reported by Una in 2017 was in breach of the National Crime Recording Standard.[43]

4.31. Contributors to this review acknowledged that, in 2016, there wasn't clear guidance for undertaking a strategy discussion for complex safeguarding enquiries, however there is no explanation as to why basic requirements of the WSAB policy were not complied with (e.g. commissioning for her an advocate[44] or assessing the risks to Una and others posed by this abuse). Attendees at that meeting confirmed to reviewers they remembered police clarifying that the issue of consent/ capacity was not relevant to the offence under s38 of the Sexual Offences Act, as this would only have been relevant to whether the correct charge would be rape. However, this theme of capacity/consent continued to influence decision making throughout this case, and featured heavily in the section 42 investigation, as social workers did not consider that Una had been sexually abused because they understood that the relationship had been consensual.

4.32. Neither the clinical journals of staff nor discussions captured with Una provide any reflection that Una was being considered as a victim of abuse. Rather, the clinical records assert that safeguarding concerns focused on her role within what was perceived as 'an inappropriate relationship'. Again, as evidence by the Court reports, the minimisation by the team providing her

[42] Under s127 MHA or s20 of the Criminal Justice and Courts Act 2015

[43] Where an allegation of crime is made and there is no credible evidence to the contrary, the crime should be recorded without delay, and in any event within 24 hour, unless exceptional circumstances prevail

[44] Required by s68 Care Act 2014 and 6.2 WSAB's safeguarding policy.

clinical care (e.g. her psychiatrist had chosen not to explore this with her on the 23.03.16 whether the disclosure had triggered self-injurious behaviours and the perception of victim blaming language used in this meeting) had a lasting impact on her recovery. It also undermined the therapeutic relationships and trust between her and clinical staff. Trust senior managers did not recognise that this abuse would adversely impact Una's mental health, nor that this would need to be carefully addressed therapeutically to avoid an increase in her self-harming behaviour. Far too little consideration was given to how this would impact on her ability to stay safe.

4.33. Within the WSAB safeguarding policy significant emphasis is placed on self-determination, consent and capacity to accept risk. It advises '*where the individual chooses to accept the risk, their wishes should be respected*' (7.6), The policy at that time, unhelpfully, provided no practical guidance in respect of allegations against professionals merely stating '*this is a grey area with possible tensions between safeguarding and disciplinary requirements… action taken within disciplinary procedures is aimed at the staff whilst action taken in respect of safeguarding is aimed at the adult at risk. One set of procedures should not compromise the other.'* (7.8). There is reference to a process for reviewing a critical incident which involved the WSAB's chair at the earliest opportunity (s.8 and appendix 2) but no definition of what constitutes a critical incident, this appears to be limited to criteria for a Safeguarding Adults Review under s44 Care Act (which of course was met in this case).

4.34. Even within the independent investigation report dated 17.03.17 by Niche commissioned by the Trust, the authors had to debate the use of the term 'abuse' when describing the perpetrator's actions "…*with various professionals at the Trust. To some professionals it is a term that indicates malicious intent or violence.",* although the authors took "…*advice from our associates and our expert by experience group"* and concluded that the term should be used as "…*the power differential between a healthcare professional and a vulnerable psychiatric patient is so great that any sexual contact between them cannot be a mutual act. The patient cannot give properly informed consent and the situation is abusive.*"[45] Handwritten notes (presumably written by an employee of the Trust as they provided the report) beneath this paragraph on the photocopy of the report provided to the reviewers note "*Capacity? Contradicts police position*."

4.35. It is deeply concerning that staff at the Trust, including the senior employee who would have had a copy of the report to write those handwritten notes at some point after March 2017, would question that Una had experienced abuse. It is equally concerning that safeguarding enquiry officers at the local authority did not understand that Una had been sexually abused, and that police focussed on this being a 'loving and consensual relationship'. Even the independent authors of the Niche report lacked confidence in respect of this issue, and had to take external advice. However, the report goes on to make a recommendation that "*The Trust should ensure that all future disclosures of inappropriate relationships between staff and services user (sic) are initially considered to be abusive until an investigation establishes otherwise*", which was accepted by senior managers in the Trust. This demonstrates a fundamental misunderstanding of the law, professional standards, and the nature of abusive relationships across the partnership. A sexual 'relationship' between a mental health patient and their care coordinator will always be an abuse. No investigation can lawfully conclude otherwise.

4.36. This lack of recognition and guidance to staff providing her treatment extended throughout the review period. Una reported[46] that when the perpetrator lived with her after the disclosure the two members of staff from the team who were providing joint care coordination took a different approach to whether she could speak about it, but neither explained the nature of the s38 offence or explained why her 'capacity' to consent to sex was irrelevant because of his professional role and the inherent power imbalance. One care coordinator refused to allow discussion of her private

[45] Paragraphs3.14-3.15 of the Niche report
[46] Within her Witness statement 3, dated 03.12.20 (pg 122-124)

life, whereas she reported the other was '*positively encouraging.'*[47] Case records (including reports to the first-tier tribunal) make references to Una's capacity to engage in a sexual relationship and, inexplicably, to the risk of exploitation she posed to staff. Senior managers at the Trust were also aware he had moved into her home and continued the abuse; one senior manager raised concerns internally that it '*didn't feel right to post (letters in respect of the ongoing disciplinary matter) to a patient's home*'[48] but made no attempts to agree with partner agencies safe interventions. In conversation with the reviewers, community safety staff explained, had they been consulted they would have advocated for use of closure powers to prevent the perpetrator moving into her home, they highlight that this case should also have been considered under the MARAC procedure. Una would then have likely benefitted from specialist Independent Domestic Violence Advocacy support. Actions to disrupt the perpetrator's behaviour and hold him to account needed also to be matched with high intensity support for Una to prevent self-injurious behaviours. The Duty of Candour obligations were not fulfilled.

4.37. Police officers reported that they had been very concerned that if they attempted to remove the perpetrator from Una's home or prosecute him, she would be more likely self-harm and they were very worried she would complete suicide. Police also reported that they were concerned that, despite the perpetrator's confession, the CPS would not support prosecution if they did not have Una's support. They explained they were anxious to ensure that the caution would show up in any Disclosure and Barring Service checks to ensure he could not obtain work with vulnerable adults in the future. In conversations with the reviewers, Una raised her concerns that the perpetrator could still be working with other vulnerable adults and that she had not received assurance at any point during the review period that this had been prevented. This continued to cause her distress.

4.38. Police officers described having lengthy discussions about the case, trying to balance the relative welfare and safeguarding issues. While officers may have been well-intentioned, this rationale was not recorded in any of the contemporaneous documentation provided, nor was this explained to Una at the time. Instead, the perpetrator's 'good character' and the fact Una had told police that this was a 'loving and consensual relationship' were identified as the 'exceptional circumstances' to justify the perpetrator being cautioned instead of prosecuted. As noted in section 3 above, a 'romantic' relationship between a victim and perpetrator is not a mitigating factor to a sexual offence and in the situation of a care worker abusing a patient, an ongoing relationship should be a very serious aggravating factor. This decision left Una feeling that the abuse she had experienced was not taken seriously, and she gained this impression that there had been a conspiracy between the Trust and police to protect the perpetrator.

4.39. The Care Act 2014 expects professionals with safeguarding responsibilities to consider the outcomes that matter to adults who have experienced abuse or neglect and ensure any interventions consider those wishes. This provision is intended to empower adults at risk and ensure proportionate responses. As was made clear in the LGA's framework[49] the 'making safeguarding personal' principles do not override professional duty of care, but can be integrated with those duties so that responses by relevant partners (especially those with statutory safeguarding responsibilities) promote the person's wellbeing, including long-term recovery goals as well as immediate risk. Statutory safeguarding partners should use their professional judgement to decipher what weight to place on a victim's desired outcome. Failure to take protective action, particularly where serious crimes have (as in this case) been admitted, cannot be justified by deferring that professional judgement onto a victim, particularly when (as in this case) necessary procedural steps have not been taken to evaluate their ability to recognise risk and keep themselves safe from abuse and exploitation. For others involved in this review, this

[47] Taken from Una's witness statement submitted within the civil proceedings
[48] Email from the Trust's senior leader investigating the allegation against the perpetrator on the 27.04.16, referenced within Court papers.
[49] Published in 2019 following national engagement events throughout 2018 and available : https://www.local.gov.uk/making-decisions-duty-carry-out-safeguarding-adults-enquiries

highlighted how significantly the need was for a change in culture to enable regard to the victim's voice, especially where violence is perpetrated against women and girls.

4.40. Further, as stated above, the Ministry of Justice guidance[50] stipulates that police are only permitted to issue a simple caution without authorisation from the CPS if there are exceptional circumstances, namely that on conviction, the perpetrator would be unlikely to receive a custodial sentence or high-level community order, having regard to mitigating and aggravating features. Based on the sentencing guidelines and his confession, it is highly likely the perpetrator would have received a custodial sentence for the offence. The perpetrator's mobile was already in the control of the police, having been removed under warrant for an unrelated matter, and a review of his messages with Una would have identified that serious aggravating features, including grooming behaviour, supplying Una with additional prescription medication, soliciting and storing sexual images of her. The serious nature of the offence warranted a full investigation of the crime, irrespective of whether Una supported a prosecution at that time, and the decision to issue a caution within just 5 weeks of the perpetrator's disclosure was dreadfully premature.

4.41. The decision was made by a single agency. Partners did not work collaboratively so crucial information pertinent to the nature of the offence, which was within the knowledge of the Trust, had not been sought or shared with relevant bodies to enable them to comply with their statutory investigations. Trust employees, rather than assert Una's capacity, should have provided opinion evidence of the nature of her condition, particularly the risks associated with cognitive distortions, transference and heightened risk of sexual re-victimisation to police colleagues undertaking the investigation. They should have been focused on how, collectively, they would work to protect her from future sexual abuse and from an immediate deterioration in her own mental health.

4.42. Failures to share pertinent information at the early strategy meeting were compounded when senior managers at the Trust also failed to report the abuse to their own patient safety panel or via StEIS to WCCG and CQC. The impact on Una's recovery is explored in more detail below, but reinforces that there was a systemwide misunderstanding of the serious nature of the offence and the harm this inflicted. Una's belief that Trust senior managers conspired to cover up the abuse is wholly understandable, particularly when senior Trust managers subsequently refused to share transcripts of the perpetrator's WhatsApp messages to her with NMC despite understanding that these were highly relevant to his fitness to practice proceedings. Nor were these forwarded to the police to support their investigation into subsequent allegations made by Una that he had raped her, provided her with other patients' medication and wilfully neglected other patients. As noted above, police officers explained those subsequent investigations were frustrated also by a lack of information from the Trust. The minimising of the serious nature of the offence continued throughout the review period, most notably within the civil litigation addressed below in response to KLOE 5.

4.43. There is sparsity of documentation regarding the response by the Trust to disclosure of abuse. While the Trust acknowledged in the civil proceedings that a decision was taken to avoid 'email trails', Mersey Care noted that on taking over her case that all recording on Una's file was very poor. This remains unexplained but falls far below expectations set out within the patient safety framework. At that time, the Trust lacked a specific policy to support managers and frontline practitioners who (having been part of a team around Una) had also known the perpetrator well. Very few senior decision makers working within the Trust at the time spoke with the reviewers, those that did asserted they worked within the safeguarding and disciplinary frameworks, but it is clear that insufficient thought was given to potential or perceived conflicts of interests. What information is available concurs with professionals' recollections to the reviewers, that they were instructed not to talk honestly with Una about her experience as abuse. A few individuals at senior executive level assumed responsibility for decision making, but this was outside of NHS usual safeguarding or patient safety processes. Within the multi-agency s42 strategy meeting there is

[50] Simple Cautions guidance (publishing.service.gov.uk)

no record of any discussion of the complexities of trying to safeguard Una or how her mental health needs would be met. There was no consideration of whether there could be other victims or if the Trust's actions should be investigated, to determine whether organisational neglect[51] contributed to the harm Una experienced. There was no obvious structure for this meeting, to support practitioners and ensure that all relevant considerations had been addressed. Nor was there any consideration during the case conference in July 2017 if the circumstances met the criteria for a review under s44 Care Act and who should make this referral.

4.44. Junior managers, Trust practitioners and local authority safeguarding practitioners advised that they were told by senior Trust managers that escalations they had made about their concerns would be acted on. They reflected, in conversation with reviewers, this was (with hindsight) overly optimistic. WSAB's safeguarding policy contains within it an appeal and escalation process. This was not used by any professionals involved in the original s42 enquiry despite all acknowledging to this review that they continue to feel deeply uncomfortable about the outcome. It highlights the need for clarity of the purpose that sits behind such policies and procedures and the interface between parallel processes. Widespread failures were not challenged by partner agencies, including the local authority responsible for providing oversight of safeguarding enquiries because they deferred to the Trust on crucial issues, thereby undermining the effectiveness of criminal, regulatory and disciplinary investigations. For the avoidance of doubt, safeguarding responsibilities are not subservient to those processes - they are the golden thread which runs through those legal frameworks.

4.45. Nationally, children's social services' response to sexual exploitation and complex sexual abuse is generally significantly more advanced than adult social services. Tools developed to support children's safeguarding enquiries can be adapted to provide structure for practitioner investigating adult safeguarding enquiries. Because this case involved a person in a position of trust, and at the time of the investigation it was unclear whether other patients could also have been subject of abuse, or neglect of their mental health needs, use of a complex safeguarding enquiry framework would have helped practitioners take a strategic approach to the s42, criminal, disciplinary and regulatory processes that needed to be addressed, while keeping a focus on Una's welfare, care and treatment. A good example is the London Children Procedures Organised and Complex Abuse procedure,[52] which prioritises the welfare of the victim and suggests setting up a strategic multi-agency management group to oversee the investigation, engage with regulators and ensure that resources such as legal advice are available to the investigation team. This advocates for an investigation team to be established with the necessary training, expertise and objectivity to manage and conduct the criminal investigation and/or safeguarding enquiry and explicitly states that "*line managers or colleagues of any person implicated in the investigation must not be involved and the involvement of any person from the workplace under investigation must be considered with particular care*".

4.46. The reviewers have not had sight of the concluded s42 report and the reasons for this are unclear. It is understood that this was very delayed and there is evidence that Una's solicitors wrote to Wigan's legal department raising concerns regarding the delays and procedural integrity of the s42 enquiry. They also highlighted the perpetrator had admitted the offences. Wigan's s42 process at that time required that a case conference was convened at the conclusion of the s42 process, when representatives from partner agencies considered the outcome of the investigation and voted as to whether they agreed that domestic, sexual, physical, psychological abuse or neglect had occurred. Both the subject of the enquiry and source of risk were expected to be invited to attend to make representations in respect of the allegations. This case conference did not take place until 06.06.17, whilst some delays were a consequence of Una's admission to hospital, it is unclear why this process was delayed by almost 15 months which was significantly longer than expected standards of a timely response and therefore poor practice.

[51] Repeated requests for an investigation into organisational abuse were raised to WSAB, but action wasn't taken to initiate an enquiry.
[52] CP8. Organised and Complex Abuse (londonsafeguardingchildrenprocedures.co.uk)

4.47. The minutes of the case conference were littered with overt victim blaming language. It was clear that the meeting was very fractious, with solicitors for Una, the local authority and Trust in attendance. At that time, the Council required case conferences to be chaired by an Independent Reviewing Officer who had understood that the structure set out within the local policy required very little flexibility. A large number of those involved in this conference spoke to reviewers, all expressed deep disquiet about how confrontational the meeting was and the minutes demonstrate very poor safeguarding practice. Although the social worker undertaking the s42 acknowledged that she had very little contact with Una, her decision remained inconclusive and that "…*even though (the perpetrator's) actions were inappropriate there was no offence under the S38 offences*". Police explained that they "…*established that (Una) has not been coerced in any way and was happy with the relationship. It fit the criteria in terms of a S38 however (Una) had the capacity to make her own decision …they looked at (the perpetrator)'s back ground and from this he was a good character and from this a proportionate decision was made to give (the perpetrator) a caution*"[53] It was (incorrectly) stated that this caution had been under s38(1) (for non-penetrative sexual offences) and an officer in attendance stated the CPS had not been consulted due to Una's wishes. This was challenged by Una's legal representative who was reminded "*this is a case conference arena and not a court of law*". They were advised the issues around the perpetrator inappropriately administering medication to Una and hiding incidents when she had seriously self-harmed had not formed part of the original allegations in March 2016 so had not been investigated. No explanation was provided as to why this would not require a further criminal investigation or s42 safeguarding enquiry.

4.48. Attendees of the case conference were advised that the perpetrator had been invited to attend but had elected to provide a statement, which was read out, where he gave graphic descriptions of incidents where Una had self-harmed, raising the impact on his own mental health saying that he felt '*tortured by (Una)*', and that she was '…*extremely manipulative, clever and calculated in how she conducts herself.*' The case conference decided that abuse had occurred under the categories of sexual abuse (albeit this was a split decision as some professionals did not consider that this was conclusively evidenced, and the chair took a decision that this finding should be made), psychological abuse and domestic violence. No further safeguarding measures were implemented as referrals had already been made to the Nursing and Midwifery Council and Disclosure and Barring Service and mental health support would be provided by the Trust.

4.49. So little regard was had to Una's needs and the impact of such a meeting that she self-harmed in a public reception area shortly before the conference. This was confirmed by NWAS, who were called following injuries to Una's arms and legs. In conversation with reviewers, the conference chair explained that, prior to the conference, she had no detailed knowledge of events, including disputes between statutory parties regarding issues of disclosure. There had been no risk assessment undertaken or recommendations made about reasonable adjustments that might be needed. She was aware, prior to the conference, that the local authority's solicitors had written to assert to Una's solicitors that the process would be fair, but had not met with the conference chair to provide her guidance on the nature of s38 offences, how to ensure Una's wellbeing in the process or consider waiving their usual practice of 'right to reply' for perpetrators given the offence was admitted. She explained, whilst the role of IRO was based on that role within child protection conferences, there was not the same level of respect at that time. Her experience when she had previously challenged local authority findings was that she had been removed from conferences and been subject to complaint investigations. She spoke of a toxic culture which left many isolated and unable to provide effective challenge.

4.50. The rebuke to her legal team's challenge of factual errors that this was 'not a Court of law' evidences a disregard for the public law obligations to meet statutory safeguarding duties in a

[53] Taken from the minutes of the meeting on 06.06.17

manner consistent with natural justice.[54] In addition, practitioners' arguing inexplicably, in front of Una, they believed it was inconclusive she had been sexually abused, suggests Una was required to 'prove' that she had been harmed, despite the perpetrator's admission of the sexual offence. The decision to read the perpetrator's lengthy statement in front of Una undoubtedly triggered distress for Una. Finally, the conclusion that a protection plan was deemed to be 'in situ' (as referrals had already been sent to the Nursing and Midwifery Council and Disclosure and Barring Service, and that Una's mental health support would continue to be provided by the Trust) is indefensible. That conference took place a year after the Care Act came into effect, despite that passage of time, practice had not made the required radical shift towards ensuring safety and away from simply determining if abuse had occurred. The minutes suggest a very high degree of poor legal and safeguarding literacy, which (arguably in our view) resulted in a process that in itself was abusive and is likely to have retraumatised Una, who had self-harmed in the waiting area before the meeting. From an objective view, it is difficult to see how Una could have perceived the safeguarding process as one intended to keep her safe.

4.51. In conversation with the reviewers, social care practitioners at the conference have, to their credit, spoken about how uncomfortable they were then and still remain at the way the conference was conducted and its findings. Senior operational staff involved reflected that they were deeply uncomfortable with policy expectations even at the time of the conference. Other attendees also reflected to the reviewers there were obvious errors of judgment, commenting that the way conferences were set up unhelpfully encouraged the focus to be on a finding about whether the allegations could be proven. This encouraged a blame rather than learning culture. At the time of the s42 enquiry, local policy dictated that locality teams would lead on safeguarding and, whilst that team had allocated someone from a mental health background, they accepted the complex nature of such an enquiry required more expertise and experience and that much more care should also have gone in to planning the conference. They explained that the focus of safeguarding had rightly changed considerably since, so the focus is now on the outcomes that matter to the person who has experienced harm, protection planning for them and wider public safety and if there are lessons to learn. They also spoke of valuing improved access to specialist safeguarding support and legal advice for complex safeguarding cases, especially if parallel legal processes run alongside.

4.52. Given that, prior to the sexual abuse, Una presented with significant treatment needs because of complex trauma, including trauma arising from sexual abuse she experienced as a child and in adolescence, the earlier strategy meeting, police investigation and case conference should have taken into consideration her needs and made reasonable adjustments or arranged for special measures to ensure best evidence. This is a legal requirement to ensure public bodies comply with duties under the Equality Act 2010. The Trust held important information about how her diagnosis may impact on her capacity to recognise the perpetrator's actions as abusive. Sharing this, rather than the erroneous opinions about capacity, with officers involved in the criminal and s42 investigations would have supported a proper understanding of the impact on grooming and coercion on her. A protection plan should have been agreed across the agencies, focusing on pursuing the perpetrator and protecting her, reflecting her strengths. The Trust knew, for example, she had previously engaged with and reported some benefits from a range of interventions to support her effectively manage her diagnosis of EUPD, PTSD with disassociation symptoms and complex PTSD.

4.53. A plan to secure sufficient evidence to prosecute should have been developed fully understanding how her psychological conditions might impact on her executive decision making. The onus should have been on professionals to support the gathering of information and not, as it did, wholly rely on Una's disclosures. When she subsequently made these, those should not have been dismissed. The Mental Capacity Act 2005 (MCA) sets down the right of a competent person (from the age of 16) to take decisions. Often, in safeguarding adult reviews, tensions arise

[54] *R (oao Davis & Davis) v West Sussex County Council* (2012) EWHC 2152

between respecting duties under s1 MCA designed to protect against unwarranted paternalism within statutory duties to promote health and wellbeing. As such, there is now a very clear evidence base advising professionals to consider the person's "executive capacity", which is the ability to implement decisions taken and to deal with the consequences. There is also an established body of caselaw, within the Inherent Jurisdiction of the High Court to assist practitioners weigh up the impact of undue influence on the decision-making process.[55] Mental capacity assessments should explore this carefully. NICE guidance[56] advises assessments should take into account observations of the person's ability to execute decisions in real life situations, highlighting the situational aspect of decision making. This should have been applied throughout the assessment, care planning and provision of support to Una. Where there is evidence that outside of an assessment environment the person is not able to understand or weigh up information to enact a decision, this should be thoroughly explored. The presumption of capacity under section 1 of the MCA does not override professional and statutory duties to ensure that adults with care and support needs are safe from abuse, neglect or exploitation. "*There is a difference between someone who has an appreciation of risk and yet goes on to take the risk – albeit unwisely – and someone who… lacked awareness of the risk and sufficient problem-solving ability*." [57] Una, whilst subject to the ongoing grooming behaviours of the perpetrator and without explicit advice and support to recognise the abuse, should have been identified as firmly in the latter category.

4.54. The flaws in the original s42 process were identified in the letter from WCCG's safeguarding lead to Wigan's Safeguarding Team manager dated 11.12.19, which raised serious concerns in respect of poor information sharing by the Trust, in particular in respect of the fact the perpetrator had moved in with Una during the police investigation which was known to senior managers at the Trust and police, the lack of knowledge around the provisions of section 38 of the Sexual Offences Act by managers at the Trust, the police and s42 investigators, giving rise to concerns about organisational failings. The safeguarding team manager took the view that the s42 should not be 'reopened', because the civil proceedings were ongoing, and considered that the court process was the most appropriate forum for these allegations to be addressed. This appears to have been predicated on a misunderstanding that the outcome of the previous s42 enquiry in respect of the perpetrator's actions, when in fact the referral sought a new s42 investigation into the actions of the Trust itself. A meeting to address these concerns with WCCG and the Trust was intended, but Wigan's safeguarding team manager has explained that following a period of unplanned leave, the Covid-19 pandemic took hold, placing unprecedented demand on safeguarding systems nationally and locally. Had this meeting taken place, the WCCG's assistant director of safeguarding would have had an opportunity to challenge the decision not to conduct a s42 enquiry, and if necessary, escalate this challenge to a more senior level. This was a significant missed opportunity to undertake a fresh s42 enquiry into allegations of organisational abuse which would have enabled senior managers within the Trust to have been held to account (outside of the civil proceedings). The fact that the letter requesting this enquiry was sent to the safeguarding team manager outside the usual safeguarding multi-agency safeguarding process meant that, when she went on leave unexpectedly, there was no tracking mechanism in place to ensure this request had been actioned. The decision to send the letter directly to the safeguarding team manager was appropriate given the sensitivity of the case and the nature and seriousness of the allegations. It is therefore essential that processes are put in place to track safeguarding concerns legitimately raised outside of the usual MASH procedure.

4.55. In May 2020, Greater Manchester Police ('GMP') launched the Adult at Risk Policy and Procedure. The policy aims to provide assistance to GMP officers and staff who have a responsibility to investigate and take action when an adult is believed to be at risk or experiencing abuse. The policy requires a 'care plan' should be submitted on every occasion where GMP responds to a person presenting with mental health related concerns. The policy explains a care

[55] SAR National Analysis 2019, available at: https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019
[56] NICE (2018) Decision Making and Mental Capacity. London: Overview | Decision-making and mental capacity | Guidance | NICE.
[57] Baker J, *GW v A Local Authority* (2014) EWCOP20, para. 45

plan allows for accurate recording of what occurred during the incident and action taken. Information officers have gathered during the incident is important to understanding the risk to that individual or others, and for making appropriate decisions on what further action may need to be taken. They also introduce an adult at risk vulnerability assessment framework (the A-G model) to record any relevant information about the person and incident. Officers are expected to document any advice from the Mental Health Tactical Advice Service (MHTAS), based within Operation Communications Branch (OCB), or information from other partners which has informed their decision making. Whilst this is to be welcomed, this action alone will not improve inter-agency cooperation to effectively identify, disrupt and pursue criminal sexual abuse by perpetrators working with vulnerable adults.

4.56. In September 2022 WSAB introduced a PiPoT policy.[58] This draws very heavily on the Care and Support guidance that accompanied the Care Act 2014 and would have been in place for practitioners, senior managers and strategic leaders to draw on at that time. Despite this, very little coordinated action was taken. Whilst those involved in this review reflected openly about how much more should have been done to protect Una and pursue the perpetrator, there is still a large gap in national and local policy guidance and practical support to ensure that those who exploit their positions of trust to perpetrate sexual abuse are bought to justice swiftly.

System findings

4.57. The perpetrator should have been charged and prosecuted for the s38(3) offence. The decision to offer a caution was taken in silo, without the authorisation from the CPS that was required by law, and on the misperception it may prevent a risk to Una's life. There was a widespread dismal understanding of the rationale behind the strict liability offence under s38 of the Sexual Offences Act 2003, adult sexual exploitation and grooming behaviours across all partners involved in the criminal, disciplinary and safeguarding investigations. There was also a lack of basic knowledge of criminal and civil law responsibilities to protect victims. The s42 safeguarding enquiry failed to involve all relevant safeguarding partners (in particular GMIC), convene a timely, properly skilled enquiry team, share pertinent information about the nature of the offence, the victim's needs for special measures and agree a strategy to manage parallel processes (i.e. the criminal investigation, organisational concerns, disciplinary processes and ongoing care and treatment duties owed to Una). Una's wellbeing was not prioritised during this process. This resulted in a breach to Una's human rights and amounted to organisational abuse.

KLOE 3: Supporting effective recovery for victims of grooming and sexual abuse

How was Una, as a victim and survivor of abuse that was admitted by the perpetrator, supported by all statutory agencies from March 2016 onwards? What systems were and are in place to facilitate and provide such support?

4.58. The Government's consultation on their proposed review of the Mental Health Act included a commitment to a safety improvement programme across all trusts whilst recognising that necessary changes to legislation and practice improvement regarding safety should not be at the expense of maintaining therapeutic environments that support people to recover. The consultation paper acknowledged a priority should be to shift the focus from reactive care to preventative measures.[59] Their proposal to embed principles of choice and autonomy, least restriction, therapeutic benefit and person-centred care reflects findings of earlier research which identified the '*dominance of risk of harm to self or others* (within the current MHA) *serves to more readily justify interventions that may restrict enjoyable activities or remove choice from patients, while intensive risk-monitoring can perpetuate stigma and isolation*'[60] felt by adults with poor mental health. Felton et al. explored how risk assessment tools and protocols often involve ranking an individual's behaviour and recording this process to ensure that information is passed on. Noting

[58] Available at: https://www.wigansafeguardingadults.org/Docs/Guidance/PIPOT-Policy.pdf
[59] Available at: https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-2-reforming-policy-and-practice-around-the-new-act-to-improve-patient-experience
[60] Felton, A., Wright, N., & Stacey, G. (2017). Therapeutic risk-taking: A justifiable choice. *BJPsych Advances*,*23*(2), 81-88. doi:10.1192/apt.bp.115.015701

that, throughout this process, the practitioner's view is dominant and the patient is a case to be studied and an object of care. They query whether judging individuals against the norm in this way promotes safety and recovery in the long term and highlight that cocooning patients in a risk-free environment does not support the person to develop skills in safer decision-making.

4.59. To overcome inherent risk adverse organisational behaviours, Felton advocates for a 'recovery concept' to protect against the view that mental ill health is an '*inevitable downward and deteriorating course'* but warn '*therapeutic risk-taking may be inhibited by organisational, professional and social constraints… Organisational processes that are committed to supporting rather than blaming professionals and to facilitating learning in the context of adverse events are essential. These are important features of developing a culture that is able to tolerate uncertainty, that values the patient's role in decision-making and that shares responsibility with the patient … When promoting autonomous decision-making and facilitating choices, people with mental illness should not be considered solely in terms of the dangers they present: recognising the full range of threats to their safety, alongside their strengths, successes and protective factors, can overturn their perceived identity as creators of risk*. This recovery concept also requires practitioners to ensure family/friends perspective on risk and safety are heard. Of fundamental importance to this model is to create safe places for professionals to hold uncertainty. '*Regular, inclusive and open* (multi-disciplinary) *discussion can promote shared responsibility, flexibility and creative decision-making…. Guidance from the Royal College of Psychiatrists (2016), Department of Health*[61] *(2007) and Implementing Recovery through Organisational Change*[62] *promotes therapeutic risk-taking and recognises that some of the current problems with risk assessment and management undermine autonomy and restrict opportunities for recovery. Recognising these values within policy and professional guidelines provides a framework to help justify therapeutic risk-taking*.'

4.60. The Trust accepted, within civil proceedings, that Una should have received '*predictable and reliable support. Those working with (her) must be very boundaried*'.[63] This is because they fully understood the way in which she responded to external pressures or inconsistent support was often to turn feelings of being let down or overwhelmed against herself triggering self-harming behaviours, substantially increasing her risk of accidental serious harm or death by suicide. Reports made available to this review explained that because in Una's early life core emotional needs[64] were unmet this led to the emergence of maladaptive schemas. Of relevance to Una and the terms of reference for this review are:

- Dysfunctional Child Mode: when the mistrust/abuse, emotional deprivation and abandonment schemas are triggered (i.e. via external events or internal triggers) she experiences others as uncaring and not helping her in the way she believes is best. She has talked about just "being a commodity...a pawn", someone who is "just there to be taken advantage of". The origins of this mode are the abuse, criticism, and lack of validation when expressing emotions that were a feature of her childhood.
- Critical Parent Mode: she has internalised voice of all the critical care givers she experienced growing up who criticised and punished her for all her perceived shortcomings. In this mode she will berate and criticise herself for all her perceived failures, saying things to herself such as "You're not good enough", "You've failed even more than XXX". She will also feel angry with herself and as if she deserves punishment for having or showing normal needs that she was not allowed to express growing up.
- Dysfunctional Coping Modes: describe states in which an individual overcompensates for, avoids or surrenders to the emotions connected to the parent and child modes. They are described as dysfunctional because in the short term, from a moment-to-moment perspective the individual will feel a sense of relief. However, in the longer term, coping modes create problems and stress too, due to their negative effect on the self and others.

[61] Department of Health (2007) Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services. Department of Health.
[62] Boardman, G, Roberts, G (2014) Risk, Safety and Recovery: A Briefing. Centre for Mental Health and Mental Health Network, NHS Confederation
[63] Taken from the Psychological formation prepared by Dr G, dated 27.11.19

- Needy and Dependent Mode: Because she rarely had safe and reliable care, she can present as needy and overly dependent. She can also be experienced as fragile and childlike. She appears overwhelmed and incapable of taking responsibility for herself.
- Putting on a Mask Mode: In this mode she will appear 'fine', passive and undemanding. Una talked about putting on a façade where she appears as if all is ok but she is just going "through the motions". She will put everyone else's needs before her own to reduce the chance of being let down or rejected.
- Detached Mode: This represents how she tries to supress or truncate emotional experience because they are painful. It is likely that the origins of this mode stem from her learning to 'switch off' when being sexually abused so as not to feel. When in this mode it can mean that she does not consider the possible consequences of her behaviour to herself or others.
- Healthy Adult Mode: This mode is the functional aspects of her personality, in this mode she is likeable, friendly and pleasant in her interactions. She is able to regulate her emotions appropriately. She is more accepting, understanding, and non-judgemental towards herself. She can be there for others but also able to recognise her own needs. She is able to ask for help and support when needed and is not avoidant. She can look after her more vulnerable side (i.e. vulnerable child mode) and doesn't let her critical mode take over. The Clinician responsible for her care towards the end of the period under review stated '*to her credit, Una spends considerable amounts of time in this mode which shows how hard she is working to control and regulate the other sides of herself*.'[65]

4.61. Prior to and during 2015, Una's care was delivered in line with the 'serenity integrated mentoring' ['SIM'] model which had been widely promoted by NHS England and NICE.[66] An alternative approach, the Structured Clinical Management Plan,[67] was introduced by Mersey Care in 2020 after concern was raised by several professional bodies discrediting the SIM model. Under the SIM model, Una received separate Community Psychiatric Nurse support (acting as her care coordinator) to monitor mental health and risk profile, medication compliance and support with comorbid symptoms such as mood and anxiety. Una was also expected to be reviewed by a consultant psychiatrist to prescribe and monitor the efficacy of medications on a quarterly basis. Additional crisis care plans included support in the community and at local urgent care centres/hospital A&E department.

4.62. Despite this policy expectation, Una was not seen (including for two medication reviews) by any other mental health professional other than the perpetrator between January and March 2016. Experts instructed by respective parties[68] in the civil proceedings reported there was '*no evidence of any meaningful care planning or reviews for several years prior to March 2016… there was no enhanced care plan, no coherent risk assessment and …overall an absence of any considered strategy and plan*' to meet Una's assessed needs. Trust staff accepted to this review that with hindsight the high frequency of self-injury and hospital admissions should have triggered a review. They explained that in 2016 it was common practice for CPNs/ Care coordinators to see patients at home and have high levels of autonomy in responding as the Care Programme Approach national guidance advocated a needs led and personalised approach. Every different CPN has different style, it was common practice to go from house to house and then write up their notes.

4.63. It is noteworthy that throughout the review period Una engaged positively with her GP and spoke highly of his expertise and the compassionate care he provided. He explained, in conversation with the reviewers, that he has a special interest in psychiatry and that,

[66] At this time, this was the approach recommended by NICE. However, since this time concerns have been raised that this model may have led to practitioners acting in ways that conflicted with their professional conduct and capabilities. The Royal College of Nursing's Mental health forum called therefore for the rollout of the programme to be halted in May 2021.

[67] This required her care be led by a practitioner trained in effective management of EUPD and supported by a clinical psychology team in a care plan that manages and reduces the impact of a personality disorder.

[68] Expert witnesses instructed by parties in civil proceedings are governed by part 35 of the Civil Procedure Rules which sets out their overriding duty is to the court to assist on matters within their expertise.

consequently, he was better placed than most GPs to assess and manage risks associated with her severe and frequent self-injurious behaviours that were a symptom of her EUPD and complex PTSD. Her GP understood that the most pressing issues presenting at the surgery or at A&E would be physical health needs arising from injuries. However, because she inflicted self-harm to alleviate internal distress, she would then usually present at low risk (insightful, remorseful and calmer) from a mental health perspective so be signposted for onward treatment via the Community Mental Health Team. Whilst he understood her presentations, he explained that these were extraordinary[69] because her needs changed so quickly. He explained that, in his view, the system didn't work for people with complex needs associated with PTSD and EUPD as, even those GP surgeries employing mental health practitioners are commissioned only to respond to those with low level of poor mental health or at the point of their first crisis.

4.64. Thereafter, GPs are expected to refer on to specialist or early intervention secondary Mental health services. Often those services are nurse or social care led, but for those with complex presentations with needs (like Una's) that sit outside usual treatments or protocols, what GP and CMHT services require is flexibility from hospital based psychiatric input to enable a reliable response to an agreed care plan. For Una, this meant a plan that reflected her maladaptive schemas. Her GP explained that crisis teams are commissioned to respond to those at high risk of suicide. All clinicians involved in Una's care understood that her self-injurious behaviours were not intended to end her life. She was not 'attention seeking', rather this was her way to regulate her emotions when she became overwhelmed. She had confided to her GP '*I get to such a level that I have to do something, I don't want to kill myself but I don't mind harming myself if it reduces stress*.' He explained, it was clear to him her distress that she felt this was the only way she could access support, but also explained to him that she recognised the frustrations from A&E consultants or surgeons who were responding to the physical health risks. She commented people had told her off for undoing their good work. He explained, the support Una received to address medical risks wasn't cathartic.

4.65. Everyone involved in the review understood and had significant empathy for those trying to keep her safe. The frequency and severity of Una's self-injurious behaviours from as early as 2010 suggested a strong need for multi-disciplinary assessment and shared care across physical health, social care and mental health with specialist input from experts in EUPD and complex PTSD so that her triggers and coping techniques could be better understood including within primary care and A&E departments. There is already established mechanisms for such shared assessment and care planning through the NHS Continuing Healthcare framework. It does not appear that framework was ever considered. This may be because it is often only applied for specific types of need, for example those requiring fast-track support due to end of life conditions or wrongly assumed by many to simply a mechanism for determining funding responsibility between health and social care commissioners. This is a shame, as it would have enabled practitioners to collectively consider the nature, complexity, unpredictability and frequency of her needs in a manner that wasn't limited to one specialism. Had the NHSCHC assessment framework been employed, it would not have necessitated waiting until after her mental health had deteriorated to such an extent that she required compulsory detention for treatment under the MHA. NHSCHC explores, by means of descriptors, levels of need across several domains including her cognition (enabling consideration of the impact for her of cognitive dissonance), behaviours, psychological needs as well as the impact these needs had on wound care. It is expected to sit alongside social care assessments under the Care Act so care plans can also consider wider wellbeing needs. Enabling medical staff to work more closely within this framework would protect against siloed working and open opportunities for health and social care professionals to learn from each other so that adapting the 'usual offers' (i.e. making reasonable adjustments to enable access to services given patient's known needs arising from their disabilities) could reduce anxiety in patients and make it less likely they become overwhelmed as

[69] He commented in his career he had only 2 other patients with similar presentations, both of which coincided with the time Una was on his patient case list

Una so frequently did. Sharing expertise across disciplines in treating trauma for those with EUPD could also protect against malignant alienation.

4.66. Given her complex conditions, high risk of harm and exploitation, there is no dispute that Una, following a detention under s3 MHA, should have been subject to s117 aftercare planning meetings and reviews on a regular basis. Reviews should have complied with the legal expectations detailed in section 3 above, but the reviewers could find no evidence of such a review taking place either prior to the disclosure of sexual abuse or in the months following.

4.67. In conversation with reviewers, Una reported that the perpetrator told her in December 2015 that another of his client's had died by suicide. He had explained to her that he had falsified his time recording with this client (including group sessions) in order to spend more time with Una. At that time she felt this was disclosed to her so that she could provide him comfort. This was, however, disclosed with complete disregard to the risks posed by transference. Una explained that she continued to experience guilt over this person's death.

4.68. Practitioners spoke of the steps they took, following disclosure of the sexual abuse, to support staff working directly with Una try to balance the issues of transference. They reported seeking assistance from other Trusts to transfer Una's care, but were turned down. Equally, they accept the language used in 2016 to describe the abuse was victim blaming and spoke of the work they had done locally to challenge such misperceptions. They explained, it was now widely understood that treating people in their own home is a position of trust, that there needs to be clear boundaries in place, but that because this is still an important part of any recovery plan it is important to find ways to mitigate risks associated with lone working. They gave an examples of using video-recording (of the worker, not the patient) in home settings. To address issues of countertransference, they reported far better oversight of supervision. They explained, it was not possible, because of staff shortages, to provide double-up care unless there is a known risk (usually of physical harm) to the practitioner. In addition, where requests are made for female worker, this is now granted. If a female patient has a history of male-perpetrated sexual abuse, they automatically allocate a female practitioners. It isn't clear, however, how as a system those improvements are measured, so that GMIC and WSAB can be assured that such improvements are sustained.

4.69. Una reported that she only became aware that there was a strategy meeting between the Trust, police and local authority following the disclosure of abuse in March 2016 much later as a consequence of disclosures within the civil proceedings. She explained she was not made aware, by anyone, of the protection plan put in place to support her as part of that investigation. Following her admission into hospital in May (after the perpetrator terminated contact with her) she reported being advised by a senior nurse that to discuss the abuse by the perpetrator '*with patients or members of staff could potentially compromise my care and treatment and could possibly also result in me not being able to stay on the Ward anymore…. that if I started to tell patients, that would likely make them uncomfortable. My immediate response was to ask the Nurse why I was in Hospital if I couldn't talk about what had happened to me. What was the purpose or benefit of me being detained if I couldn't rely on the staff to help and support me?*'[70]

4.70. Mersey Care's agency return for this review analysed the Trust's clinical records in respect of its response to Una's experience of abuse:

> "*The absence of any recorded clinical response to the direct impact of being abused by a staff member is astounding. When any survivor of abuse enters mental health services it is expected that they will receive care that allows them to feel safe and supported to speak about their experience of trauma, explore impact and develop effective ways of coping for the future. In Una's case there are examples of her being turned away from ward staff, advising Una that*

[70] Taken from Una's witness statement prepared for the purpose of the civil proceedings, dated 04.04.2016

she was not allowed to speak to ward staff about her experience of abuse- as advised by the Trust managers/leadership… From 2016 to 2020, safeguarding adult concerns are referenced throughout the care journey. Yet, at no point during the review is Una referred to as a victim of abuse from a person in a position of trust. Nor is there evidence to suggest that clinical services considered the possibility of Una experiencing controlling and coercive behaviour from (the perpetrator)."

4.71. Having appointed a solicitor, Una met with an independent expert clinical psychologist who reported the abuse '*had a profound and dramatic effect on (Una) and has yet again reinforced one of her dysfunctional core beliefs about trusting others. One of the many very significant and damaging consequence of this is that she will find it very difficult if not impossible to now trust any other care giver in the future and this will have the consequence of impeding and even denying her the ability to benefit from treatment and therapy to her own detriment*.' He advised '*she will need a completely new multi-disciplinary team... provided by an NHS Trust other than the Five Borough's Partnership… she requires a full psychiatric assessment as a matter of urgency and for all her care givers to be female'.* This advice, despite being made available to the Trust through the litigation, was not acted on.

4.72. Between the disclosure of sexual abuse in March 2016 and the interim judgment in July 2017 Una was seen by her NWBH psychiatrist, or admitted to a mental health ward on eight occasions.[71] In addition, she was referred by the crisis team for police welfare check a further five times[72] and either self-referred or been referred by friends/ her partner after self-injurious behaviours that required urgent medical care on fourteen further occasions.[73] Despite this, a written request from her legal team in April 2017, following serious incidents, for a strategy meeting was turned down by the local authority as the s42 enquiry was wrongly believed to have been concluded. Her request, that she receive a personal health budget so she could arrange her own care privately, away from the Trust appears to have been ignored. A review into her mental health care was finally arranged for the 02.06.17 after pressure from her legal representatives, though this was unsuccessful as her distress at written reports regarding the safeguarding enquiry into the sexual abuse had '*triggered emotional crisis that saw her swallow scalpel blades. Una was taken to A&E*'[74].

4.73. The review was undertaken on the 06.07.17 during which she confirmed she no longer wished to receive care from the Trust as she was '*emotionally impacted by information contained in reports from the safeguarding and legal processes she is the subject of.'* Follow further incidents of serious self-harm[75] she disclosed that the safeguarding and legal processes were triggers, that she felt unsafe in the care of the Trust and was aware that Greater Manchester Mental Health trust had refused to accept a transfer of her care. In early July 2017 at a care planning meeting with her legal advocate she requested a personal health budget rather than have the Trust decide the private psychotherapy. She also agreed to an in-patient stay to manage an acute crisis, but wished not to be accommodated by an in-patient unit managed by the Trust. She was offered a bed in Bristol, but as this was too far agreed a preferred plan of home treatment support whilst a bed was located more locally.

4.74. The High Court's interim judgment in July 2017 placed significant weight on expert testimonies as to Una's likely treatment needs. These advised Una would require a new treatment team to '*include a consultant psychiatrist and a primary nurse who would be available to see the claimant*

[71] 21.03.16 (for 1 week) the aftercare plan was reportedly 'support from crisis team', 04.05.16, 14.05-28.06.16,, 28.07.16, 06.09-28.11,16 aftercare plan was referral to St Helen's crisis and recovery teams, 08.04.17 (where she reported to have gone AWOL whilst waiting for an assessment), 14.04.17.
[72] 05.05.16, 12.06.16, 18.09.16, 07.04.17 and 12.04.17 (the referral on the 07.04.17 coincides with her legal team writing to request an urgent strategy discussion as she had required a police negotiator to avert imminent risk to her life in a public place.
[73] 28.07.16, 06.08.16, 30.08.16, 18.09.16- she was assessed in A&E by the RAID team, 29.12.16, 31.12.16, 11.01.17, 12.01.17, 28-31.01.17- discharged to St Helen's recovery team, 24.02.17, 02.03.17, 11.05.17, 24.06.17 and 28.06.18
[74] Taken from the combined chronology of case notes prepared by relevant partners for this review.
[75] On the 24.06.17 and 05.07.17 she was taken to hospital by NWAS (on the second occasion with police assistance as she required restraint to prevent further harm during transport) with a stab wound to her abdomen.

on a number of occasions during the working week. The claimant would require access to a crisis response team and will require some expert psychological help' Further expert evidence also proposed she would require '*treatment from a community psychiatric nurse, a clinical psychologist and a consultant psychiatrist… input from an occupational therapist and a case manager (and) ... from an independent mental health advocate*.[76] Whilst the Trust had accepted Una's therapeutic relationship had broken down and they had been unable to secure a transfer of her care to another NHS mental health Trust, they disputed the abuse and lack of care provided after the abuse was directly linked to an increase in her needs (causation). They argued she should not receive an interim payment to purchase privately funded care, proposing instead that any interim award should be limited to the cost of an assessment. The judgment records the Trust was unable to secure an independent expert medical report, so relied on her consultant clinical psychologist employed by the defendant. Una reported she had not understood that her treating psychologist would use information from the care planning meeting earlier that month to provide evidence within proceedings for the Trust and that, as a consequence, perceived this as further evidence that Trust staff would not put their duties to her first if a conflict of interest were to arise. Contrary to information reported within the judgment, it is understood that the Trust's solicitors had secured an independent expert report prior to the interim hearing. This does not appear to have been disclosed within proceedings, but it is understood to have supported the view that Una's care needs required more than the usual offer of crisis intervention. The Court ruled in Una's favour, concluding she suffered serious psychological harm as a result of the actions of the perpetrator. She was in need of expert treatment and care and was '*entitled to put in place a private care programme*'. Following that ruling, Una made clear she did not wish to be involved in arrangements for the funding of her private care package, but did wish to be involved in appointing professionals and agreeing the plan. Her solicitor gave an undertaking to the Court the interim payment would be held in a separate bank account and used only to meet her needs.

4.75. Following the interim payment, Una's recovery treatment and support was provided privately. When Una required crisis interventions, this remained the responsibility of local A&E services and the Trust's 'usual offer' from the St Helen's based crisis and home treatment team. Trust staff explained, they sought to provide consistency of care, including providing named workers to attend s117 aftercare review meetings. If she required emergency in-patient mental health admissions, this was usually some distance from her clinical and social support network.

4.76. In Spring 2018 Una, via her legal team, requested the Trust cease to provide oversight of her s117 aftercare support, so responsibility for this reverted to WCCG (now GMIC). In conversation with reviewers her legal team explained, they used their legal expertise to secure this new approach aware of the delay by Trust senior managers to engaging (through StEIS) with their duties of candour. They felt it was unlikely that other patients not in receipt of effective s117 aftercare would successfully be able to overturn the usual practice so that this was directly managed by GMIC, especially if (as in Una's experience) they lacked access to advocacy. They maintain, even now, too little regard is had of the need for a systematic and strategic oversight of s117 MHA aftercare provision.

4.77. In February 2019 a safeguarding enquiry was undertaken (and upheld) against her private provider who had sought to engage Una in discussions regarding payment of outstanding fees. Una reported this resulted in her '*feeling like a commodity*' and causing a breakdown in the therapeutic relationship. Thereafter, a new therapeutic team was established, with explicit instructions from her lawyers that they should ensure a clear separation of responsibility for payments from the therapeutic provision. The clinical team also secured agreement from the legal team and Una there would be a clear separation of roles, with her clinical team providing guidance of the support she would need to manage the ongoing legal proceedings in a way that enabled them to lead on safety planning and treatment. Care coordination was taken on by an independent

[76] Taken from the Interim Judgment in 2017

social worker ['ISW'] who had previously completed an independent assessment of Una's needs. The ISW assessed that it would be better for Una to have a multi-disciplinary mental health team who were jointly interviewed by Una, so that she could choose the right people to work with her. She recognised Una required professional boundaries in place so that she could self-regulate, but by a trusted team who could recognise when this was beyond her ability. The team consisted of a social worker, mental health nurse, psychotherapist, psychologist and consultant psychiatrist. The team would have monthly MDT meetings, including with her GP and kept a running chronology so that all involved in her care were aware on an ongoing basis of the any escalating and changing needs. Her CPN and GP met monthly to review the efficacy of her medication and build on the strength of this relationship. A local private hospital also provided a safe therapeutic space with 24/7 clinical supervision when Una felt too dysregulated to remain in her home, which minimised the risk of readmission to a psychiatric ward. This package of care continued to be overseen by WCCG assistant director for safeguarding via regular s117 MHA reviews. The Trust remained, however, responsible for sourcing crisis provision if an admission was required. There are no further incidents of self-harm reported by any parties between February- October 2019.

4.78. It is clear from the expert testimony and care plans provided to this review that her new private clinical team understood the impact the perpetrator's abuse had on Una's ability to form therapeutic relationships and how her maladjusted schemas may impact on her ability to maintain her wellbeing through periods of change. Understanding the importance for Una of trust, the need to provide local support and manage any change carefully so that Una did not view this as rejection, her independent social worker selected other appropriate skilled professionals who could provide local care, then offered Una an opportunity to interview and select who would be the right person to work with her. They explained, as Una was bright, insightful and articulate it was crucial for her and her treating team to understand she needed to know if she became so distressed she was unable to self-regulate, that her team would put in place agreed boundaries and would not be 'hoodwinked' by her articulate and persuasive manner. The risk, that Una's intelligence could 'mask' the level of risk if practitioners providing her care did not recognise her presentations as schemas, had previously been articulated by the CMHT's deputy team manager in 2016 when she urged senior managers to meet with Una to provide validation she had suffered harm from the abuse as, despite Una's assurances, she recognised Una was in acute distress.

4.79. Una explained to the reviewers, she really valued that she was involved throughout the care planning process, including interviewing prospective members of the team and agreed escalation routes for when she felt unable to keep herself safe. She was also able to rebuild trust in professionals because her clinical team and her legal team worked within clear boundaries to manage the separate legal and treatment process. Una described this care as '*responsible and reliable*'. Her partner credits the team for keeping Una alive during the later part of the review period and particularly in the run up to the final hearing in the civil proceedings, though of course he played a central role in promoting her safety and wellbeing throughout that period and beyond.

4.80. During this period, the frequency of her self-injurious behaviours decreased as Una gained greater insight and ability to moderate her maladjusted schemas. As a result, the nature of her support changed. For example, whilst initially she required advocacy support, this reduced as she became better able to regulate her anxiety in meetings and articulate her needs to professionals. However, her advocate remained available, such that he was able to support her (and the review panel) when the SAR process was initiated.

4.81. Her therapeutic team, post the interim payment, spoke of the significant change in approach after August 2019 when WCCG's assistant director for safeguarding took over direct responsibility for chairing s117 aftercare review meetings. It remained difficult to secure local resources for crisis intervention, but they felt confident his person-centred approach helped shift focus towards a more therapeutic, stable crisis offer. To build trust with Una, GMIC s117 chair held review meetings in two parts. The first included the Trust staff, Una, her independent social worker and legal team and, thereafter, met without the trust to review her support plan. He explained whilst he prioritised

re-building Una's trust as this was so vital to keeping her safe, managing it in this way made it more difficult for Trust staff to build consistency of care across the two treatment teams. There were practical barriers, which he felt should be possible to overcome, in providing more coordinated support to Una in that he could not compel another NHS provider to provide support, even crisis care, to Una.

4.82. Following the interim payment, Wigan social care also recognised that Una's partner was eligible for support (under s20 Care Act)[77] given the extensive support he provided to keep her safe and the impact this was having on his wellbeing. The worker assigned reported that providing a formal assessment and taking time to work with Una, her partner and the wider support team to understand what would have greatest positive impact was crucial. They were very respectful of the trust Una had for her ISW and CPN and felt confident to be guided by them and her. They also understood why it was important, especially at the start of their involvement, to respect Una's faith in her advocates and legal team- recognising that, for her, they provided a safer way to facilitate her choice and control over the care package as she was not comfortable accepting direct payments. In addition, the flexible approach taken by senior managers to deliver the carers package through support that would encourage Una's resilience and self-esteem, whilst lessening the burden of household tasks that could prove overwhelming, was hugely helpful in seeking to empower her partner to provide the high level of daily care and also in re-establishing her trust with public services. The importance of carers' support, should not, therefore be overlooked within care planning for complex needs.

4.83. Practitioners working within the Trust's St Helen's services remained unaware, until their involvement with this review, of her extensive trauma, the nature of her needs, triggers for Una's self-harming. Most were unaware of the sexual abuse perpetrated by her previous care coordinator. This was in accordance with Una's wishes, but made it more difficult for them to provide the therapeutic care she required. In addition, they were made aware from senior managers of strict rules about reporting who and why staff members were accessing her case notes. Many were unaware of the reasons for this, but reported it created genuine fear that they were making clinical decisions without full access to her notes or, if they sought this, that they would be subject to complaints regarding their professional conduct. Una and her lawyers explained they had asked senior Trust managers to provide details of who had accessed her records as they had concerns that her personal, private information was being used by Trust staff for reasons unconnected to her care and by people personally connected to the perpetrator. Again, that explanation was not passed to frontline workers or team managers, so they were left with a perception that Una (and her legal team) were excessively critical because they could not provide 'perfect care'. In conversations with the reviewer, the Trust's treating team explained they recognised Una had periods of disassociation, particularly when overwhelmed and would therefore find it more difficult to employ CBT techniques to avoid self-harm. However, having taken advice from a national lead psychiatrist they felt that the treatment plan needed to avoid hospitalisation whenever possible as this might delay her longer-term recovery. They accepted there were risks associated with this approach, but felt there were also risks to removing her self-agency. One clinician explained they had raised their concerns to her legal team that their interventions might adversely impact on Una's recovery and believed this resulted in him being removed from her treatment team. Again, with no explanation or challenge from senior management. They felt they were viewed as acting abusively or negligently by applying principles to try to develop her self-agency and coping mechanisms. Others also reported feeling intimidated by the presence of lawyers (both Una's and the Trust's) and the fractious nature of meetings such that it became very difficult, in the context they were working, to re-establish a positive therapeutic relationship. There was also concern that this fragmentation of care would lead to more risk averse behaviours by clinicians, resulting in more restrictive interventions (such as pro-longed hospital admissions) than would usually be clinically advised. Conversely, her legal team reported they felt

[77] This had not formed part of the interim payment or s117 MHA aftercare plan as this was a separate entitlement owed to Una's partner to enable him to provide the high level, consistent care she required but in a way that reduced any adverse impact on his wellbeing.

practitioners were unfairly criticising them for her poor mental health, when they raised her (and their) concerns that care needed to be reviewed and more effective crisis care implemented.

4.84. In 2020 Mersey Care published a Personality Disorder Policy, which reflects NICE clinical guidance, recognising the importance of setting clear boundaries and encouraging patients with EUPD to develop positive risk management coping schema/techniques so they develop greater self-reliance. The care plan developed by her privately funded team recognised, in line with Mersey care's personality disorder policy, that compulsory admission to hospital was not in her best interests but they were able to locate a local private hospital resource from October 2020 who offered a small, homely, safe space where Una could go to if she required a 'disruption' to intrusive thoughts. They also offered telephone support from a small well-established team who knew Una well and understood likely triggers and the steps they could take to support her to use techniques to de-escalate. Equally her CPN and social worker could make a referral, working with Una to help her recognise she required a higher level of support than her community team were able to provide. They explained, between 2020 until the end of the review period they did not need to use this resource often, usually it was sufficient for Una to know that it (and her wider support team) was there when she needed it. The commended the chair of Una's s117 aftercare review meetings for seeking to establish similar provision from an NHS provider locally, but explained that those 'safe spaces' were too often subsequently de-commissioned or be required to prioritise a very therapeutic focus which did not always work for patients, like Una, who needed the space to self-regulate. GMMH reported that, within their services they too wish to develop similar provision, at present this is specifically for women within the Edenfield site.

4.85. This coordination of care extended to working closely as a clinical team to support her legal team understand the very real risks that the ongoing civil litigation presented. In discussion with reviewers, both her clinical team and legal team spoke of the work that went into ensuring Una would be suitably supported during the litigation. Importantly, they felt that (whilst they fully understood this risk), litigators and senior members of the Trust continued to pursue legal arguments without regard to the risks this posed. This is explored in more detail below in respect of KLOE 6.

4.86. There remains a lack of understanding across the wider system (including medical practitioners) of the impact that EUPD and complex trauma may have on executive functioning. Those who had met Una in a clinical context mirrored her GP's concerns that despite the unpredictability, severity and frequency of her self-injurious behaviours she was unable to secure consistent, trauma-informed specialist care. They questioned, even under the new personality disorder policy, if she would meet the criteria for high level personality disorder specialist input especially as, when her care became more predictable and designed around her needs, those needs were better managed and resulted in less self-injurious behaviours and crisis. In reality, given the scarcity of resources within NHS provision and the need to ration so as to meet rising demand reported nationally, there is a real risk that local secondary mental health provision cannot meet the principles which should underline provision but will remain overly restrictive, responsive only to crisis and without the continuity of care that enables therapeutic benefit.

System finding

4.87. Following the disclosure of sexual abuse in 2016, the Trust's response was inadequate to meet Una's increased needs and resulted in significant additional harm to her mental wellbeing. Within their IMR and chronology Mersey Care recognise there was a clear pattern of crisis whenever Una was involved in safeguarding or legal processes. Despite this, there is no evidence NWBH Trust actively reviewed to ensure her needs or risk assessments took into account those processes. There is no evidence of communication with the local authority, Una or her legal team to ensure that the s42 process could be managed in a way that considered Una's needs arising from PSTD, her EUPD or as the victim of sexual abuse. Nor is there evidence that expert assessments made available to the Trust by her legal team regarding her likely needs, were used to inform treating clinicians' care plans.

4.88. The High Court confirmed this directly impacted on her long-term ability to recover and amounted to a breach of her human rights. This therefore amounts to organisational abuse, for which the Trust senior leadership should have been investigated and held accountable. Failure to provide support to frontline practitioners, ensure timely review and appropriate care resulted in unnecessary disconnect between those providing ongoing daily support for Una's recovery and her crisis team and contributed to professional conflict. In short, the legal, safeguarding and welfare duties were conducted without regard to the intersectionality these would have on Una's immediate risks and long-term recovery goals.

4.89. The current arrangements for s117MHA aftercare do not provide sufficient opportunities for GMIC and local authority to fulfil their legal duties regarding oversight of the efficacy of care. There is also no established protocol for ICBs and local authorities to secure provision from alternative NHS providers if the therapeutic relationship is undermined by abuse perpetrated by an employee or arises from organisational abuse.

KLOE 4: Understanding and combatting unconscious bias

What is the understanding of unconscious bias across the professional network and what mechanisms are in place to prevent this impacting on the support provided to adults with care and support needs?

4.90. The relevance of the widespread stigma reported by those with personality disorders (detailed in section 3) is important when attempting to understand the position of NWBH Trust which perceived Una as a participant in an inappropriate relationship with a male, overlooking Una's status as the victim of abuse who had been groomed and exploited through her vulnerability by a staff member in a position of power and trust.

4.91. The term 'malignant alienation' describes a process common before suicide of psychiatric in-patients, which is "*characterised by a progressive deterioration in their relationship with others, including loss of sympathy and support from members of staff, who tended to construe these patients' behaviour as provocative, unreasonable, or overdependent."*.[78] One senior leader noted that malignant alienation had been a thematic issue that regularly arose during Serious Incident reports across their Trust, where high-need adults and in particular women with EUPD or substance users were dismissed as attention seeking and received superficial assessments and a lower standard of care than others, particularly in Emergency Departments. A series of learning events had been delivered to hundreds of Trust staff to address the issues identified in the Serious Incident reports, including one on malignant alienation which reinforced a message that EUPD was born from childhood trauma and was not a 'lifestyle choice'. As one of the experts in the court proceedings noted to the authors, "*empathy costs the NHS nothing."*

4.92. Una was well known to clinical services due to an extensive history of involvement with Community, Urgent Care, and Inpatient Services within Wigan for over a decade. Wigan's community safety team had also led on multi-agency planning to address risks to the public and emergency workers posed by her self-injurious behaviours. In June 2015, following a further incident when Una had been escorted by emergency workers from a bridge, the CPS gave authority to prosecute Una for causing danger to road users under s22A Road Traffic Act 1988. It is understood that this was a '*multiagency decision following multi agency agreement that Una had capacity in relation to an anti-social behaviour contract. GMP have to balance the needs of members of the public alongside Una's Mental Health. Concerns had been raised in 2014 and brought to the attention of GMP SLT and the Adult Safeguarding Board.*'[79] In the early hours of the 22.06.15 she was taken into custody following an arrest for causing danger to other road users

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

[79] Taken from the single agency report and chronology prepared by GMP for this review.

and, after a psychiatric evaluation, remanded in custody until the next court sitting. A previously agreed 'trigger plan' was followed, arrangements were made to ensure community safety staff were available to sit with her whilst she was in police custody. Una's complex dependency worker also attended the court hearing to assist her and reduce anxiety. This was outstanding practice. On the 23.06.15 Wigan Magistrates Court gave a 3-year conditional discharge with an indeterminate criminal behaviour order ['CBO'] which prohibited her from:

- engaging in conduct which causes or is likely to cause nuisance, annoyance, alarm or distress within sight or hearing of any person in England and Wales
- from going onto any bridge as a pedestrian
- from pouring petrol over yourself.

4.93. Such an approach was based on Serenity Integrated Mentoring ('SIM'), which was practice guidance adopted nationally at that time, but may also have been evidence that malignant alienation was impacting agencies responses to her care. One of the clinicians at the time reported that they had strongly opposed the CBO as they considered this to be overly punitive, and that the SIM model had since been widely discredited. During subsequent interactions with police when she was at high risk of suicide, she was never arrested as a result of breaching the CBO, rather officers sought medical assistance for her in the first instance. This demonstrates a compassionate approach from individual officers, but the approach adopted in 2015 conflicts with trauma-informed working methods e.g. overreliance on organisational cultures structured to encourage staff to use 'power-over' approaches[80] when engaging with service users. The CBO arguably reduced the public safety risk Una posed by reducing the incidents where she sought to self-harm in public places, but it did not reduce the risk to her from self-injurious behaviours. Instead, she continued to use these maladaptive coping strategies, but in private, making it more likely the injuries would have unintended fatal consequences. In discussions with the reviewers those involved in her care during this period explained that, though such approaches were then deemed to be acceptable behavioural managerial strategies, practice has moved to a different model of care.

4.94. In September 2022 NICE published an update to its Self-harm guidelines[81] which states: *"Do not use aversive treatment, punitive approaches or criminal justice approaches such as community protection notices, criminal behaviour orders or prosecution for high service use as an intervention for frequent self-harm episodes."* NICE states that this amounts to malpractice. However, it is of note that at the outset of this review in early 2022, the authors asked Greater Manchester Police to consider discharging the CBO against Una and this was declined. They subsequently explained the order could only be varied or discharged by the Court and that no parties had applied for this at that time. Previous learning from a local review had recommended consideration of these powers if they could be used as a protective factor. In January 2024, Wigan Community Safety Services also confirmed that CBOs remain a 'last resort' option, but that they have not employed this approach to assess risks associated with self-harm for adults with personality disorders since 2015. They explained that for every case referred for enforcement action they now complete an Equalities Impact Assessment and that this is provided to the Court to help inform those decisions.

4.95. In March 2023, NHS England published its position on SIM and similar models,[82] explicitly stating that this should not be used, and that three key elements should be eradicated from mental health services. Firstly, avoiding the involvement of police in delivery of therapeutic interventions in planned, non-emergency community mental health care. Secondly, that the NICE guidance against use of sanctions, withholding care or other punitive approaches must be followed. Thirdly prohibiting discriminatory practices and attitudes towards patients who express self-harm

[80] power-over' relationships replicate power and powerlessness by disregarding the experiences, views and preferences of the individual. *'There may be messages implicit in the manner or communication of care delivery that can also be triggering for a trauma survivor if he or she recapitulates aspects of the betrayal, boundary violation, objectification, powerlessness, vulnerability, and lack of agency experienced during the original trauma' (Butler **2011**).*
[81] Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE
[82] NHS England » NHS England position on serenity integrated mentoring (SIM) and similar models

behaviours, suicidality and/or those who are deemed 'high intensity users', including the labelling of patients by professionals as 'manipulative' and 'attention seeking'.

4.96. In 2020 Mersey Care published a Personality Disorder Policy, which reflects NICE clinical guidance, recognising the importance of setting clear boundaries and encouraging patients with EUPD to develop positive risk management coping schema/techniques so they develop greater self-reliance. In light of this new approach, practitioners reflected that the approach adopted in 2015 may have felt punitive to Una and could easily have reinforced her perceptions when in critical parent mode, triggering further anger directed towards herself, thus putting her at greater risk. The reviewers have not had sight of the assessments used to inform this decision that she had capacity to understand the contract and therefore make no finding in respect of this. However, it does reinforce a point made by a senior clinician of the importance of having an objective person to have oversight of individual care plans to ensure those working with a patient do not become overly punitive or overly caring, but rather manage any risks related to transference and counter-transference.[83] Adoption of the Personality Disorder Policy is likely to support practitioners to maintain an empathetic, if boundaried, approach and mitigate the risk of malignant alienation.

4.97. Another element of potential unconscious bias was the displaced anger and frustrations of the clinical health services workforce connected to Una and the perpetrator across Wigan. Review of Una's care journey through the clinical records does not provide any evidence that suggested staff within the Trust held an awareness of the relationship prior to disclosure on 21.03.16. Reports from initial safeguarding involvement at the Trust describe how staff working with the perpetrator expressed shock and anger towards him. If the perception of Trust staff was that Una was a consenting participant in an 'inappropriate relationship', this raised potential for staff to displace their frustration or emotions towards the perpetrator in their approach towards Una. Una's mother reportedly questioned this when Una was detained under the MHA two days after the perpetrator admitted the abuse, stating, "*It feels like you are closing ranks and penalising (Una) for what happened*."

4.98. More widely, throughout the time period of this review, frequent examples of victim blaming language were identified, by several of the agencies involved, comments which were often made directly to Una some of which were deeply concerning. Many have been outlined above, in particular the constant references to Una being in a 'loving and consensual relationship' (or variations of this) which were repeated throughout the papers by police, Adult Social Care, the Trust and their legal representatives. For example:

a. The minutes of the initial strategy meeting held on 23.03.16, which appears to have set the tone for the professional response to the abuse, recorded that "*this relationship had been consensual on both parts"* and that *"[Una] is aware of consequences and that she would have full capacity to consent to engage in this relationship and what impact and consequence this could have for both her and the alleged source of risk"* despite the fact that no investigation had taken place at that point, and that the perpetrator had admitted the abuse so this was an admission, not an allegation.

b. Una was interviewed by the local authority on the 14.09.16 as part of the s42 enquiry, during which prepared questions were put to her including: "*Did you think it was appropriate to start a relationship?*" and "*Why did you not report the incident straight away?*".

c. The report prepared by Una's treating psychiatrist to justify further detention to the Mental Health Review (first tier) Tribunal in October 2016, which referred to the sexual abuse as '*an inappropriate relationship*' which was '*quite stressful*' but went on to state '*there remains an unknown risk of exploitation particularly for the professionals involved in her*

[83] https://www.bps.org.uk/psychologist/what-passes-between-client-and-therapist

care. This is in the background of her previous inappropriate and sexual relationship with her CPN'.[84] Una reported to the reviewers that the minimalisation of the abuse and reframing of her as an abuser was insufferable.[85]

d. The independent investigation report dated 17.03.17 by Niche, commissioned by 5 Boroughs, repeatedly referred to the perpetrator as having "…*good character and was well respected by his colleagues'.*

e. During the s42 enquiry case conference on 06.06.17, Una was repeatedly questioned about her 'consent' to the abuse she experienced. A lengthy statement prepared by the perpetrator was read out to all of the professionals in front of Una, which spoke in disparaging terms of her character and mental health and included the following comments: "*I was included in an external review in February 2017 and the investigation officer who interviewed me agreed that the investigation against me had been unbalanced. …I can stand back and realise that I was tortured by (Una). I can see that over the space of approximately 2 years she has gradually reeled me in… She is extremely manipulative, clever and calculated in how she conducts herself… 5 Boroughs Partnership need to ensure that measures are in place to protect staff in future from this type of incident."*

4.99. It is to the credit of GMIC's assistant director for safeguarding that they challenged the language that was used during the case conference, and asked Una how the perpetrator's statement had impacted on her. It is vitally important that all practitioners are able to recognise and feel confident to challenge victim blaming language. This requires a culture shift across Wigan, with clear leadership from all layers of management.

4.100. The Trust's clinical records alerted professionals to a "*Lone Working Risk- 'Males Only'*" and when Una challenged this, the response was that the Trust would maintain this risk alert until disproved by investigations. Similarly, when she sought to challenge those assertions before the Tribunal, greater weight was placed on his views because of his professional standing, rather than a balanced approach which should have required that professional to back up his opinion to at least the civil evidential standard. Mersey Care's agency response for the review noted "*As such she could not feel validated as a victim of abuse, understood, or supported from the context of the abuse she had experienced. Littered throughout Una's chronology of involvement with NWBH Trust, there are references to 'not being believed' and 'feeling abandoned and rejected'. In all of the clinical and corporate records reviewed, there is not a single reflection that staff approached Una as the victim of abuse. Instead, this was referred to as 'issues with her care team' or her role 'in an inappropriate relationship'"*

4.101. The impact of this on Una was profound. She felt blamed and shamed by professionals and was very clear that she believed that these attitudes directly contributed to the failings in care she experienced. She felt that professionals viewed her as 'the other woman' rather than the victim of abuse, and a source of risk, rather than someone in need of protection.

4.102. As noted above, in November 2016 Una's legal team referred 7 members of staff from the Trust to the Nursing and Midwifery Council ['NMC']. In conversation with the reviewers, her legal team explained that prior to making this referral experts had confirmed failures by senior employees and managerial staff to comply with Trust policies could constitute misconduct in public office.[86] Expert Clinical Psychologist opinion was also provided to the High Court confirming that failures were '*not simply failures that could be considered as falling below a reasonable standard,*

[84] Taken from Una's witness statement, reporting contents of a Tribunal report prepared by the Trust's psychiatrist on the 13.10.16

[85] Una explained to reviewers that she had questioned the psychiatrist's assertion, asking for evidence for that statement. Her challenged was ignored by the Tribunal who gave this greater weight because of the psychiatrist's professional standing despite no offering any evidence to support the claim. She remained an inpatient and, whilst she was unwilling to take medication, was engaging well with ward staff and activities.

[86] Defined within CPS guidance available at: https://www.cps.gov.uk/legal-guidance/misconduct-public-office

but were of much greater severity."[87] The Trust took a decision that the senior managers referred would be recused from direct management of the case in the interim, while the outcome of the referral to the NMC was awaited. A practitioner reported that during a meeting with the WSAB independent chair that had been arranged to ensure WSAB had oversight of the ongoing safeguarding concerns, a senior leader from the Trust said that they were "*not going to let (Una) report any more of our staff to the Nursing and Midwifery Council*". While it is acknowledged that staff members found being referred to the NMC stressful, again, there is a sense that in her efforts to obtain justice, Una was perceived as the source of the problem.

4.103. The High Court gave final judgment on 15 October 2021, following mediation which resulted in a last-minute agreement between the Trust and Una's legal teams to settle the court proceedings. Prior to this, Una had been advised she would be expected to give evidence at a full trial and in light of her disabilities, written questions were provided in advance at the request of her legal team. The external solicitors acting for the Trust sought and obtained instructions directly from NHS Resolutions to provide these. It is understood that, despite a change in the Trust (from North West Boroughs to Mersey Care) instructions were not sought directly from the senior managers within Mersey Care Trust, specifically those leading on patient safety and safeguarding responsibilities. Those questions indicated that the Trust would seek to argue that the abuse she had experienced had not been harmful to Una. This included questions to Una that "*in the course of her relationship with (the perpetrator), she seemed happier and in better mental health*", "*whether (the perpetrator) gave her moral and emotional support*" and *"…that the allegations of coercion, control and manipulation are cognitive distortions, which do not represent how the Claimant viewed the relationship until after (the perpetrator) left her."* These questions were wholly inappropriate and were heavily criticised by one of the experts instructed on Una's behalf in the proceedings as "*an attempt to mitigate the actions of (the perpetrator)… One reading of these questions is that it is being put to (Una) that, in some way, she was the beneficiary of a grossly abusive relationship*."[88]

4.104. While it may be the role of the legal team to run a robust defence to the claim, it is frankly abhorrent for public bodies to run, as a serious argument, that a mental health patient being abused by her care coordinator was '*in better mental health*' as a consequence of the abuse. At an absolute minimum, earlier in the litigation process NWBH Trust should have acknowledged the fact that the perpetrator was constantly spending time with Una and intervening in her self-harm was directly contrary to the evidence-based approach recommended for patients with EUPD and would reduce the likelihood of her recovery. However, the Trust was also aware that the perpetrator had not been reporting all of the incidents when Una self-harmed, such as following her miscarriage in February 2016, likely due to his concerns that his abuse would be discovered.

4.105. To then argue that the fact Una has subsequently been able to recognise the coercive and controlling nature of the relationship is '*cognitive dissonance*' – essentially reimagining events in retrospect – demonstrates a deeply disturbing lack of understanding of the grooming process on the part of NWBH Trust managers who authorised this defence strategy. This also brings into question the understanding of senior managers within the Trust of the rationale behind the strict liability offence under s38. The law recognises that this is an inherently coercive and controlling situation. That is why the offence under s38 carries a similar sentence to a teacher sexually grooming a student. This defence strategy amounted to legal gaslighting and directly increased the risks that Una would become overwhelmed and self-harm in the run up to the trial. It does not appear that the impact of the proposed line of questioning had been risk assessed by them and this is considered further in response to KLOE 6. On becoming aware of the proposed line of questioning, her private treating team urgently revised her crisis care plan to seek to prevent Una further harm. Her legal team, supported by experts, also submitted arguments to challenge the clinical assumptions and the necessity given both parties to the proceedings had, by this time,

[87] Taken from the clinical psychologist's expert report, dated 20.11.20 disclosed within the Court papers
[88] Report of expert clinical psychologist, dated 21.09.21

already accepted that the abuse and subsequent failure by the Trust to provide the appropriate response left her '*in a very difficult situation, abandoned and alone and effectively discharged*.'[89]

4.106. This report has commented on the correlations between the sexual offence under s38, and child sexual offences. The Independent Inquiry into Child Sexual Abuse found that "*Victim-blaming attitudes and behaviours… obscure the seriousness of the crimes committed against them and may support a punitive approach which places responsibility for stopping sexual exploitation with the children. A victim-blaming culture and approach may result in inappropriate or ineffective interventions and support plans that lead children to feel that they are being punished for their own abuse*."[90]

4.107. Although discussions with frontline practitioners indicated that there had been some progress in understanding the impact of unconscious bias since 2016, the approach taken by NWBH Trust in its legal defence during the court proceedings demonstrates that this victim-blaming culture was embedded in its senior management. While it was not possible to speak with the managers involved in deciding the legal strategy during the course of this review, given that this was a corporate position, responsibility for those decisions is shared across the senior leadership team.

4.108. In Una's case, there is a very clear thread from the fundamental misunderstanding of the legal and practice frameworks in respect of both EUPD and the sexual abuse she experienced (KLOEs 1 and 3) to the use of victim blaming language and malignant alienation, leading to the failures of care identified (KLOEs 2 and 6).

Systems finding

4.109. Poor understanding of sexual exploitation and abuse of power across most partner agencies, including by senior leaders, resulted in Una being viewed as a source of risk rather than a victim of abuse. Use of victim blaming language was frequent and at time egregious, often directed towards Una directly and this is likely to have been retraumatising, resulted in practitioners being dismissive of the harm she experienced and undermined her treatment. At times this amounted to organisational abuse. Unconscious bias could also be seen in the response to Una's mental health needs, at times indicating that malignant alienation may have impacted decision making in respect of her care. However, the introduction of the Personality Disorder Policy across Mersey Care is likely to support practitioners and mitigate this risk, if supported through reflective practice and increased accessibility to hospital based or specialist PD consultants to support holistic care planning processes, including by contributing towards shared care planning undertaken within multi-agency s117 aftercare or NHSCHC processes.

KLOE 5: Oversight and Quality assurance of patient safety and safeguarding processes

What governance structures are in place in respect of reporting of safeguarding and serious incidents and how is adherence to these frameworks quality assured? How are staff supported to develop and maintain an open culture that promotes accountability, transparency and continual practice improvement? What oversight does, or should, the Safeguarding Adults Board and Regulator have into investigations of sexual abuse by professionals so that learning from the circumstances of this case is applied in the future?

4.110. The NHS England Serious Incident Framework 2013[91] (which updated the 2010 Framework introduced by the National Patient Safety Agency) details how all organisations providing NHS funded care should report, investigate and monitor serious incidents. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources

[89] Taken from the joint opinion (Dr A and Dr D)
[90] Child sexual exploitation by organised networks investigation report; E.3: Blaming child victims | IICSA Independent Inquiry into Child Sexual Abuse; paragraph 12
91 . http://www.england.nhs.uk/ourwork/patientsafety/

to mount a comprehensive response, which includes sexual abuse that occurred during the provision of NHS-funded care. The purpose of the serious incident reporting and learning process is to demonstrate assurance of good governance and safety for the most serious incidents; facilitate the wide sharing of learning; help prevent reoccurrence; and to support health service improvement by providing guidance and recommendations to support leaders in directing resources to improve quality and safety.

4.111. The Strategic Executive Information System ('StEIS) was the national reporting system that ensured compliance with the wider NHS Incident Framework during the period relevant for this review. The organisation where the Serious Incident occurred had overall responsibility for reporting the Serious Incident to StEIS, investigation and implementation of subsequent action plans. Lead commissioners are responsible for monitoring the management of serious incidents reported by providers of NHS funded care. At the time of the perpetrator's offences, Wigan Clinical Commissioning Group (since replaced by GMIC) was the lead commissioner for the Trust. WCCG's Quality Team held fortnightly Serious Incidents and Never Events (SINE) Panels during which Serious Incident reports were reviewed to ensure that they were accurate, robust and provided the necessary level of assurance to satisfy WCCG that the appropriate learning from each incident was identified, and an action plan developed to address necessary remedial action. This also gave WCCG an opportunity to challenge the provider trust in respect of any areas where they disagreed with the report. Further, bi-monthly meetings took place between WCCG and the Trust to review and monitor compliance against statutory safeguarding responsibilities, previously called the Quality Safety and Safeguarding Group (QSSG) meeting but now known as the Integrated Quality and Safeguarding Group (IQSG), relying on providers to submit a Safeguarding Assurance Proforma in advance of each meeting.

4.112. The National Framework required that a serious incident notification referral was completed within 48 hours of the incident and that a local root cause analysis or significant event type investigation should be undertaken no more than 45 working days from the date reported to the StEIS system. However, the Trust accepted within the court proceedings that it had failed to report the abuse after its disclosure on 21.03.2016 as a Serious Untoward Incident Review through StEIS until 13.07.17, consequently also failing to make timely notification of the abuse to the Care Quality Commission.

4.113. Unquestionably, the actions of the perpetrator met the criteria for StEIS reporting. Again, because so few of the Trust's senior leaders involved in this decision making were available to meet with the reviewers means that we have been unable to gain insight into their rationale for not reporting this at the time. At the QSSG meeting on 01.05.16 (over a month after the abuse had come to light), the Trust reported that a staff member had been reported to the NMC and that disciplinary action had commenced. Although the Trust was advised by WCCG to report the incident on StEIS "*due to the potential for adverse media interest"*, at the following QSSG meeting, the Trust advised that they had taken a decision not to do so. Although no rationale was given for this, at a subsequent meeting on 10.11.16, the Trust provided a 'timeline report' that indicated that they had been advised by a safeguarding lead at WCCG in July that the StEIS threshold was not met. However, this was disputed by WCCG's assistant director for safeguarding at the meeting and was inconsistent with the previous minutes. They were advised to reconsider their decision not to report. The decision of the Trust to ignore this clear advice is inexplicable and indicates a leadership culture at that time that lacked transparency or accountability. For the avoidance of doubt, the potential for adverse media attention is irrelevant to whether a case should be reported on StEIS, and the focus at all times should have been the sexual abuse, exploitation and resulting psychological harm experienced by Una.

4.114. Anonymised information from StEIS is also provided to the Care Quality Commission ('CQC'), to enable it to fulfil its duties as a regulator. The CQC is the independent regulator of health and social care in England, responsible for ensuring that essential quality standards are being met where care is provided and work towards the improvement of services. It promotes the rights and

interests of people who use care services and has a wide range of enforcement powers to take action on their behalf if services are unacceptably poor. CQC's records indicate that on 10.08.16, the Trust telephoned a CQC inspector to seek clarification on whether an incident was notifiable to CQC. No detail was recorded as being given about the incident other than it concerned an alleged inappropriate relationship with staff. The note records that the inspector informed the Trust this was not an incident that required notifying to the CQC under its statutory notifications guidance, but that they would expect safeguarding, the Police and the professional regulator to be informed as appropriate and for the Trust to investigate the allegation. The inspector also asked the Trust if the incident was evidence of a more systemic issue.

4.115. Regulation 18 of The Care Quality Commission (Registration) Regulations 2009 requires a statutory notice to be provided to CQC where there has been an allegation of abuse. However, there is an exception to that requirement under Regulation 18(4) where the service provider is a health service body if, and to the extent that, the registered person has reported the incident to the National Patient Safety Agency (NSPA). For clarity, all patient safety incidents should be reported to the NSPA's National Reporting and Learning System, but those which have resulted in serious harm must also be reported through StEIS. From the note of the conversation made by the inspector it appears they believed the exemption applied. In late 2016, Una's solicitors raised this issue with the CQC, resulting in a series of management review meetings to discuss the Trust's failure to notify the CQC without delay of any abuse or allegation of abuse in relation to a service user. However, a decision was taken that it was not in the public interest for CQC to take enforcement action regarding the delay to notify without seeking further information from the Trust in respect of the incident and decision not to notify them of the abuse. CQC met with Una and her legal team in July 2017 and her legal team subsequently requested CQC conduct an inspection of the Trust. Thereafter, they asked CQC to confirm they were willing to meet again to report the outcome of any inspection undertaken. From October 2017 to April 2018, a series of engagement meetings were held between the Trust and CQC, providing updates in respect of the legal proceedings and Una's ongoing care, but CQC did not report back to Una or her legal representatives.

4.116. During the reviewers' discussion with leaders from the CQC, they commented that even if a StEIS report had been made, the notifications they receive are very high level and give little context. Importantly, NHS England has given guidance to Trusts that when RAG rating Serious Incidents, sexual abuse should be rated low risk. Consequently, the CQC must rely on providers to self-report really serious incidents to enable them to distinguish them from the hundreds of lower level reports they receive annually. The minimising language during the initial contact made by the Trust appeared quite misleading, and again, the CQC relies on providers to make full and frank disclosures to enable it to take appropriate regulatory action. Although the existing CQC inspection framework allows some opportunity to identify inadequate providers, the fact that inspectors only examine a small number of randomly selected cases means that they may not gain insight into specific issues on individual processes through inspection alone. Further, changes to the CQC's inspection framework are likely to weaken oversight of providers, as Trusts will be able to nominate which cases inspectors will review, providing more opportunity to avoid any problematic cases.

4.117. The CQC acknowledged that the letter from Una's solicitors in late 2017 should have triggered consideration of a 'fit and proper' inquiry[92] in respect of the Trust's directors. Although it is unclear whether this would have resulted in a prosecution, as this must meet the criminal standard of proof, this may have challenged the Trust's directors in respect of meeting their duty of care and provided assurance to Una that her concerns in respect of a conspiracy by safeguarding partners had been taken seriously. Alternatively, the CQC could have triggered a themed inspection of the Trust, to provide assurance in respect of whether the sexual safety concerns identified were wide-spread or case-specific. The CQC noted that since 2016, communication channels with safeguarding

[92] Regulation 19: Fit and proper persons employed - Care Quality Commission (cqc.org.uk)

boards and safeguarding partners had strengthened. Wigan's Safeguarding Adults team now regularly invite the CQC to attend complex or high risk s42 enquiry meetings.

4.118. In August 2022, NHS England published a new Patient Serious Incident Response Framework (PSRIF),[93] which has replaced the Serious Incident Framework after a 12 month transition period. It removes the 'serious incident' threshold for investigation, instead requiring organisations to create a patient safety incident response plan that is jointly developed and agreed upon by a wide stakeholder group, including patient partners, front line staff, integrated care board members and Care Quality Commission inspectors. These plans are based on the organisation's local incident profile and existing improvement work, so that the resulting learning will have the most benefit for patient safety. StEIS has been replaced by the Learn from patient safety events ('LFPSE') system.

4.119. In September 2016 the Trust commissioned an investigation from an external firm Niche. A senior Trust manager explained that this decision was taken in light of the fact the StEIS process had not been followed, which had undermined Una's trust and confidence in their governance and was intended to provide impartiality and transparency. Whilst the decision to commission an independent provider to conduct the review was appropriate given the complexity of the case, as were some of the issues identified in the Terms of Reference, neither the WCCG nor the WSAB were consulted in respect of the report being commissioned and the report did not consider the organisational concerns raised by Una's solicitors on respect of the poor care she was receiving on an ongoing basis. Importantly, requests made by Una through her legal team for specific issues to be addressed through the terms of reference were not used to inform the terms of reference.

4.120. In March 2017 the Trust received a copy of Niche's report. Whilst the reviewers have had sight on that report, we do not accept the main findings that the abuse was not exploitative because this is based on a misunderstanding of the legal, criminal culpability (namely, that the perpetrator would have had to have financially gained). This is simply incorrect. Likewise, frequent use of victim blaming language and exculpatory language in respect of the perpetrator undermines, in our minds, the credibility of the findings. However, the report did make a number of recommendations for the Trust to action, including:

- The Trust further investigate whether other patients on the perpetrator's case list suffered as a result of his neglect of their care, specifically that he manipulated his time recording to spend time with Una, thereby not seeing other patients in high need and provided Una with their medication.
- The Trust report the abuse via the StEIS
- The police and local authority review their respective investigations as insufficient consideration had been given to whether others were complicit in the abuse.

4.121. We have seen no evidence that the first or third actions were ever undertaken.

4.122. It is of note that the Niche report was not shared on receipt with the senior managers who had been referred to the NMC by Una's legal representatives, as the NMC's decision was still outstanding. The Niche report was only subsequently submitted to WCCG at a 'QSSG' meeting on the 21.06.17 and it is unclear when this was shared with CQC, although CQC records indicate that they had received this by December 2017 and given feedback during an engagement meeting. The Niche report was not shared with WSAB until this SAR commenced. The fact that it was not shared with a number of senior leaders within the Trust who had been referred to the NMC by Una's legal representatives appears to have impacted both implementation of learning from the report and the report being shared with safeguarding partners.

4.123. On the 13.07.17 the Trust reported the sexual abuse as a Serious Untoward Incident on StEIS. On the same day the High Court gave an interim judgement, confirming '*as a result of the actions of the defendant's employee, (the perpetrator), the claimant has suffered serious psychological*

[93] NHS England » Patient Safety Incident Response Framework

harm causing a significant aggravation of her pre-existing personality disorder. The claimant has been and remains in need of expert treatment and care. She has repeatedly self-harmed and is a serious risk to herself. As acknowledged by [the Trust's clinician], the claimant's trust in the defendant's organisation has completely broken down. This is partly the result of the actions of an employee of the defendant, (the perpetrator), and partly due to the failure of the defendant to provide adequate treatment for the claimant once it became aware of the actions of (the perpetrator). This failure has been acknowledged by the chief executive of the defendant in evidence exhibited to the first statement of the solicitor for the claimant. The defendant has attempted to transfer the care of the claimant to another trust but this was unsuccessful. In these circumstances, private provision of care and treatment is required. In order for that to be achieved the claimant requires a substantial interim payment.'[94]

4.124. WCCG's Serious Incident Panel met on 03.11.17 to review the Niche report, and wrote to the Trust, asking for an explanation for why the abuse had not been immediately reported as a Serious Incident and the reasons for the delay in providing the report to WCCG. This was attributed to "*human error in relation to the initial internal fast track notification process.*" The Trust explained that the delays in circulating the report related to reviewing this for factual accuracy and supporting Una to receive a copy of the report in an "*appropriate and clinically safe way*."

4.125. As discussed, the s42 safeguarding response to the concern raised on the 02.04.16 was wholly inadequate and very delayed. Failings by the Trust, police and local authority are already documented above, but relevant to this KLOE was the minimisation of harm caused, as the perpetrator had been suspended and an assumption made (though no investigation had been undertaken) that no-one else was at risk. Care was not taken to ensure the full parameters of the police enquiry, patient safety and safeguarding responsibilities to Una and his other patients were met or how the parallel disciplinary proceedings or actions by the NMC and DBS would be progressed. In short, the legal obligation to determine what action would be required and by whom (s42(2) Care Act 2014) to ensure Una (or other adults with care needs) were protected from further abuse was not met by the local authority, police and Trust.

4.126. A further consequence of this was that the matter was not brought to the attention of Wigan's Safeguarding Adults Board ('WSAB') in a timely way. Section 43 of the Care Act 2014 requires each local authority to establish a SAB for its area, with the local authority, CCG (now GMIC), police and other local partners as members of the partnership, and overseen by a chair. Many SABs, including Wigan, appoint an independent chair to provide scrutiny and hold partners to account. Although hosted by the local authority, and with a Board manager and administrators employed through the council, the SAB is generally a separate legal entity (dependent on how it is established under its constitution).[95] The objective of a SAB is to "*help and protect adults in its area in (safeguarding) cases*", by "*co-ordinating and ensuring the effectiveness of what each of its members does.*"[96]

4.127. Una's case was first brought to the attention of WSAB's independent chair in September 2017, when a senior manager from the Trust requested a meeting with the chair and WCCG. Although this was over a month after the interim High Court judgment awarding Una substantive interim damages, on the basis she would require a private care programme, the request for the meeting resulted from police concerns about the Trust's management of the risks arising from Una's self-harm. The Board manager explained to the chair the outcome of the s42 enquiry, but the Board was not informed of the ongoing legal proceedings either in the email or the resulting the meeting on 02.10.17, when the Trust gave assurance that it would further develop a therapeutic care plan for Una in line with NICE guidelines that it would submit to WCCG and agreed to seek a second medical opinion in respect of her care. Whilst the meeting had been called due to concerns raised

[94] Taken from the Interim Judgement dated 13.07.17
[95] A Rough guide for Safeguarding Adult Board Chairs (local.gov.uk)
[96] Section 43(2) and (3) Care Act 2014

by police, the Trust's decision not to disclose that this meeting related to a case in proceedings, and that the judge had already indicated that the Trust was substantively at fault, was poor judgment. As noted, the Trust manager who had called the meeting had not had sight of the Niche report, so the learning from this was also not addressed. The chair was left with the impression that this related to a single-agency operational issue and was perplexed as to why the meeting had been called.

4.128. On 28.09.18 WCCG's assistant director of safeguarding notified WSAB that Una had made a further disclosure to the Trust that the perpetrator had sexual intercourse with her while taking her to hospital on the day she was assessed as being detainable under the MHA, and that this would be investigated by the police.

4.129. On 13.11.19, following a brief phone call the previous day, the WCCG's assistant director of safeguarding emailed the WSAB Board manager requesting a meeting to ascertain whether the safeguarding process and associated decision making had been robust due to his "*concerns regarding this case not least that it was largely presented as being the act of a rogue individual within a large organisation when it strikes to me that there were clear organisational failings that were never considered as part of the S42 Enquiry because they were never mentioned in the alert generated by the organisation*." He suggested a review to consider if organisational abuse should also be explored, given the Trust's failure to report in line with CQC/ SI framework. WSAB arranged to meet with the Local Authority Adult Safeguarding Manager and CCG's assistant director of safeguarding on the 18.11.19. The Local authority manager did not attend. During the subsequent discussion, the Board manager advised that as commissioning body, WCCG should make a new s42 referral and notify police of any new allegations. This was a missed opportunity for WSAB to fulfil its role to protect Una by ensuring the effectiveness of the s42 process and organisational response by the Trust. The fact that a senior safeguarding lead from one partner agency had raised serious concerns about organisational failings and non-disclosure by another partner agency required a proactive and robust response from the WSAB chair.

4.130. As discussed above, WCCG's assistant director of safeguarding wrote to the Head of Service for Wigan's Safeguarding Adults team on 11.12.19, setting out serious concerns in respect of organisation abuse that had not been fully disclosed to, or investigated by the original s42 inquiry. However, the Safeguarding team took a decision that it would not be appropriate to reopen the s42 as the civil proceedings were ongoing and this "*remained the appropriate measure… [and to] await further direction from the court."* It does not appear that this decision was fed back to the WCCG assistant director for safeguarding.

4.131. During this period, Wigan had a joint children and adults safeguarding board, and administrative staff were line managed through Wigan's Chief Executive's department, sitting on a different floor to Wigan's Safeguarding Adults team. Although this reflected that appropriate weight was being given to the strategic role of the Board and its independence, this also meant that supervision was provided by a leader who was very supportive, but was acknowledged they had no operational experience in safeguarding. When this was restructured, line management for the Board moved to the directorate for Children's Social Care. At the time, Wigan's Children's Social Care had been found inadequate by Ofsted, and the importance and urgency of this improvement journey pulled focus from the Board's joint role to safeguard adults, and placed overwhelming pressure on staff, who felt their response to adults was compromised. This was a particular challenge and concern during the pandemic, when priority needed to be given to supporting care homes and providers in their Covid-19 response. Consequently, in January 2021, a decision was taken to separate the Boards, with separate administrative teams to support each. Practitioners and leaders noted that this change had been positive, with better oversight and sub-group structures to support the Board's functions, and more comprehensive data collection and quality assurance.

4.132. In April 2021, WSAB and Wigan's Safeguarding Adults team held a meeting to discuss safety planning for Una and took a decision that as the court proceedings were still ongoing, learning in respect of any issues regarding the original s42 process should follow the conclusion of the case. By this time, Una was in receipt of a comprehensive package of care from her private team. The decision to wait until the end of the High Court proceedings to take a decision in respect of undertaking a safeguarding adult review was appropriate, given that the Trust's legal advisors would likely have advised them not to participate in the SAR process while proceedings were extant, and clear findings from the court would support the SAR process.

4.133. On 01.04.21, the Trust ceased to exist and responsibility for the mental health services in Wigan transferred to GMMH. On the 12.04.21 a meeting took place about Una's case between the local authority safeguarding team manager, GMP, GMMH and the WSAB board manager to discuss the original s42 enquiry and subsequent safety planning. WCCG's assistant director for safeguarding was invited but could not attend. They considered if original s42 enquiry should be re-opened but concluded, as the matter was within proceedings, any learning should follow that process. This pre-dated Mersey Care taking responsibility for Una's case, so they were not invited to this meeting.

4.134. On 06.07.21, Una's advocate (appointed in line with duties under MCA, but funded via the civil litigation interim payment) wrote to the local authority's safeguarding team manager, asking them to reconsider the decision not to reopen the s42 process, "*…not least because they are very concerned that information has come to light that there was a deliberate attempt by North West Boroughs to mislead the safeguarding process.*" Unfortunately, the safeguarding team manager was on compassionate leave at the time, so their response was delayed.

4.135. While waiting for this response, on the 5.08.21 Una's advocate wrote to WSAB's independent chair, forwarding the letter to the local authority from 06.07.21 and seeking a response in the safeguarding team manager's absence. They advised '*there is significant further information that my client is willing to share*', and queried why a review under s44 Care Act had not been carried out. This is the first time any agency raised the need for a safeguarding adult review to the WSAB. A further letter was sent on the 23.08.21, from her independent advocate to WSAB's independent chair to request information regarding if and when a review would be undertaken and a response to substantive questions raised by Una in the previous correspondence to the local authority, commenting that "*matters in respect of [Una] have been blighted and plagued by a total lack of transparency and candour"*. Another chasing letter was sent on 25.08.21.

4.136. On returning from leave, the local authority safeguarding lead responded to the letter sent on the 06.07.21 by letter dated 26.08.21, stating '*On reading your correspondence and further consultation with our independent safeguarding chair … we are satisfied that initiating a brief learning review process will clarify if a Safeguarding Adults Review is required. The time frame will of course align with the High Court hearing to ensure we are furnished with all information … We await the outcome of the High Court proceedings in October 2021 as it is essential we have as much information as possible from the court proceedings to inform the statutory review process.*'[97]

4.137. Having received the response from the local authority safeguarding lead, on 26.08.21, the advocate wrote to the independent chair again on 16.09.21, continuing to chase a substantive response from him directly, noting that Una felt that WSAB and partners "…*have minimised the serious abuse they have suffered, and that WSAB are now colluding to cover this matter up further*"[98]. The independent chair responded to this on the 28.09.21 setting out the purpose of a SAR and stating '*the issues you outline within your correspondence will of course be considered within the case review process*' and asking for Una's availability to meet after 20.10.21.

[97] Taken from WSAB's single agency report prepared for this review.
[98] Taken from a letter dated 16.09.21 from the advocate to WSAB

4.138. On the 11.10.21 Una's independent advocate replied requesting in advance of any such meeting that WSAB provide clarity on (amongst other matters) when they have been advised by the Trust of the Niche report and by whom, if an explanation had been given for why that report had not been available for the safeguarding conference in July 2017, what they purpose of the meeting between the Trust and WSAB's independent chair in October 2017 and for a copy of any minutes and why there had been no action following concerns raised by WCCG's safeguarding lead in December 2019. They also asked the timeframe for the brief learning review and if this would then be followed by a SAR.

4.139. Although a meeting with the independent chair did not take place as his contract with WSAB ended in November 2021, the Board manager met with Una, her advocate and solicitor on 26.11.21 to explain the SAR process and discuss her involvement. It was agreed that this would await a decision from the High Court in respect of disclosure of key documents from the civil proceedings, which was handed down in December 2021. Thereafter, WSAB took advice from ADASS on the appointment of suitably experienced independent authors, following a recommendation from ADASS, Safeguarding Circle were formally commissioned as independent authors in February 2022.

4.140. WSAB has acknowledged that the delay in providing a substantive response was not best practice. This may in part have been due to some confusion arising from an apparent misunderstanding on the part of the advocate that the local authority's safeguarding team was part of the WSAB. As the substantive points raised in the letter of 6.7.21 were in relation to the local authority's response to WCCG's 2019 s42 safeguarding referral, the independent chair may have considered that the local authority's response on 25.08.21 had resolved the advocate's concerns. However, the additional points raised in correspondence in relation to the WSAB's actions, in particular why a s44 safeguarding adult review had not been initiated and whether the chair had been furnished with the Niche report should have been specifically and promptly addressed. Further, the WSAB should have forwarded the letter of 6.07.21 to the safeguarding team manager's line manager to respond in her absence.

4.141. Reflecting on the findings of this review, WSAB staff and panel members understood how further delays, with no clear explanation for why matters had not progressed, would have undoubtedly had a cumulative adverse impact for Una. She reported to reviewers feeling stonewalled, this reinforced her perception that '*within the care sector, no-one cared… no-one came to me to say we would like to learn from this*'.[99] The WSAB explained (but did not excuse) that the passing of time and only sporadic previous contact in respect of disparate issues on the case, a link was not made between the issues raised. WSAB staff do not have access to the Council's ICT system for individual service users and at that time, did not open files for cases when safeguarding partners contacted them for advice, which could happen over 20 times per week. This made it difficult to identify returning cases or patterns arising in referrals in respect of partner agencies, and the volume of referrals gave little time for reflective practice. WSAB has since introduced a Resolution Protocol, to support practitioners to resolve professional disagreements in relation to safeguarding issues in a timely manner. This reminds practitioners that the safety and wellbeing of the adult at risk is paramount, while setting out an escalation process culminating in resolution through the executive leads for WSAB. This has also created a process for logging advice requests, to enable these to be consistently tracked and provide greater oversight of cases where concerns continue to arise. Had this process been in place when the 2019 or 2021 correspondence was received, this would have been dealt with through this process and the concerns would have been discussed at WSAB's Executive group.

4.142. However, the issues raised within the correspondence, in particular querying whether the Niche report had been disclosed to WSAB by the Trust, should have prompted active enquiries

[99] Taken from conversation Una had with reviewers.

by WSAB's chair to the Trust to obtain a copy of the report and resulting learning action plan, together with an explanation as to why this had not been provided earlier. An important role of the chair is to hold partners to account to be open and transparent in respect of safeguarding matters. While positive working relationships are essential to effective functioning of a safeguarding board, it is important that this does not prevent collegiate challenge and, throughout this review, examples could be seen of senior leaders from different areas of the partnership or quality assurance framework showing a lack of professional curiosity as issues continued to arise.

System finding

4.143. Gaps in governance structures and weak leadership resulted in a culture of defensiveness, with a lack of transparency and candour. Decisions taken by NWBH Trust's senior executives, in particular, not complying with regulatory reporting requirements and sharing limited information in a manner that was misleading, prevented the CQC and WSAB from complying with their statutory duties in respect of oversight. Across the partnership, there was a systemic culture where organisations lacked curiosity and took inappropriate comfort from assurances given either by the Trust itself or from an expectation that action would be taken by other regulatory organisations.

KLOE 6: Safeguarding victims in civil litigation processes, balancing parallel obligations.

How did the civil litigation process impact on compliance with safeguarding procedures and the professional response to Una's needs and treatment under s117?

4.144. As noted above, the focus of this review is to learn lessons so that these can be applied to protect against similar harm occurring in the future. It is important to recognise that, during the review period NWBH Trust, responsible for much of the decision making, was dissolved. Many of the senior leadership responsible for the decisions taken in this case are no longer in post. However, failings identified above that gave rise to the breaches of Una's fundamental human rights and amounted to organisational abuse resonate with the findings of the Francis Inquiry in 2013. Arising from that inquiry was an expectation that senior leadership across all NHS trusts would work to embed a positive culture which, at its heart, held '*a relentless focus on the patient's interests and the obligation to keep patients safe and protected from substandard care… For a common culture to be shared throughout the system, these three characteristics are required:*

- *Openness: enabling concerns to be raised and disclosed freely without fear, and for questions to be answered;*
- *Transparency: allowing true information about performance and outcomes to be shared with staff, patients and the public;*
- *Candour: ensuring that patients harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it.*'[100]

The Inquiry recommended a legal duty of candour and '*where serious harm or death has resulted to a patient as a result of a breach of the fundamental standards, criminal liability should follow and failure to disclose breaches of these standards to the affected patient (or concerned relative) and a regulator should also attract regulatory consequences*.'[101]

4.145. Evidence disclosed as part of the civil litigation process and shared with this review suggests that the Trust's senior management sought external legal advice at the early stages of the enquiry. This advice was not shared with clinicians providing her care or to partner agencies responsible for investigating the subsequent safeguarding enquiry (s42 Care Act) or with agencies providing oversight of patient safety. The legal advice to Trust managers remains subject to legal professional privilege and, therefore understandably, has not be made available to this review. Whilst Una agreed to waive her legal advice privilege and permitted her privately commissioned clinicians and legal team to meet with reviewers, we have not met with legal advisors instructed

[100] Francis Inquiry executive findings 2013 available at: https://assets.publishing.service.gov.uk/media/5a7ba0faed915d13110607c8/0947.pdf
[101] Recommendation 28

by the Trust to explore the substantive issues.[102] We therefore make no findings in respect of that advice, but would have expected this to have highlighted to Trust managers the legal obligation to comply with the letter and spirit of the Francis Inquiry recommendations.

4.146. We have commented above about the lack of legal support afforded to frontline and safeguarding leads to ensure that, immediately following disclosure of the sexual abuse in March 2016, they were unaware of the multifaceted approach that would be needed so that the strategy discussion and protection planning for Una (and his wider client base/ public interest) met expected standards. Instead the strategy meeting concluded simply that police would lead. The Trust subsequently submitted (on the 02.04.16) a safeguarding concern to the local authority, which simply recorded there was no further risk as no one else had been involved. This was wholly inadequate.

4.147. Given the nature of the offence and what was known of Una's mental health conditions, Trust senior managers should have been acutely aware this could result in serious harm and therefore trigger multifarious legal obligations they owed to Una, to their commissioners and regulators and, as employees, to the perpetrator to ensure any disciplinary proceedings were conducted fairly. They should have sought immediate legal support (or advised the Local Authority to arrange legal support) to assist the initial safeguarding strategy meeting. If such legal support had been available, it should have been immediately apparent to all attendees that Una required an advocate to support her as a victim of abuse throughout the s42 enquiry and, thereafter, in any care or treatment reviews. Many involved in this review accepted there remains inconsistency of approach to people accessing advocacy support despite legal obligations and NICE guidance.[103] This is relevant to embedding a positive culture. The Francis Inquiry highlights how important it is for large organisations to openly explore complaints or other adverse or serious incidents as learning opportunities. Understanding patients have a right (and play an important role in enhancing patient safety) when raising complaints or concerns regarding negligence or abusive care.

4.148. The additional legal obligations and criminal sanctions for care providers introduced after the Francis inquiry were intended to prevent the onus being on patients to access justice through the courts. However, those changes did not prohibit victims from seeking civil redress if, as in Una's case, they had suffered avoidable harm. The failures to adhere to their own Trust policies, local and national safeguarding guidance and professional standards left Una with no support and inadequate treatment. An open and transparent culture would have recognised that instructing solicitors was reasonable in the circumstances; it should have been viewed not as a threat but as an access to justice issue. Una's legal team drew parallels with good practice within child protection where it is common practice to appoint a guardian to represent the best interest of a child subject to proceedings under the Children Act, recognising that whilst the local authority may view these as necessary to protect the child from harm, understands any intervention will require interference with other human rights and therefore the child's voice has a right to be heard and separately represented.

4.149. Parallels have already been drawn with lessons learned from organisational culpability in respect of child sexual abuse, but findings from the Independent Inquiry into Child Sexual Abuse ('IICSA') that '*institutional responses involved insincere apologies and inadequate provision of support and counselling, thereby compounding the harm…The protection of personal and institutions reputation above the protection of children was a frequent institutional reaction.* '[104] resonant strongly with the Trust's practice in this case. The IICSA report warned institutions should not rely on victims as the sole means of identifying and detecting sexual abuse, it called for no exception to a requirement that institutions be proactive and vigilant to signs of sexual abuse and

[102] We met briefly with the solicitor instructed by the Trust to seek agreement for disclosure of Court papers to inform this review.
[103] NG227, published 09.11.22 available at: https://www.nice.org.uk/guidance/ng227/chapter/Context
[104] Executive summary report, p3 available at: https://webarchive.nationalarchives.gov.uk/ukgwa/20221215051714/https://www.iicsa.org.uk/key-documents/31214/view/executive-summary-report-independent-inquiry-into-child-sexual-abuse-october-2022_0.pdf

that, if information about known or suspected sexual abuse is held by anyone, a proper investigation must take place. As with the changes introduced after the Francis report, IICSA recommended a national financial redress scheme and a guarantee of specialist therapeutic support for victims of sexual abuse is explicitly not intended as a substitution for access to criminal or civil justice schemes.

4.150. As noted above, from May 2016 Una sought to engage both the police and the Trust to investigate her concerns that she had been sexually abused, raped and that the perpetrator had used coercive and controlling behaviours, including falsifying her care records and providing her with other patients' medication as part of that abuse. She also made separate allegations, which still remain without investigation, that he wilfully neglected patients in his care. The perpetrator had admitted the s38(3) offence to his employer and there is no dispute that this was in clear violation of his duties as a nurse, an employee and that the Trust would be required to take steps in line with their disciplinary procedures. It is noted that he was suspended on the day of the admission, but he was never dismissed for gross misconduct because he resigned immediately before the disciplinary hearing. Formal dismissal would have sent a very clear message to Una (and the staff team) that what she had experienced was abuse. The Trust did, in line with legal duties, refer the matter to the Nursing and Midwifery Council, but could also have made an immediate referral to DBS so that he was prevented at the earliest opportunity from working in regulated activity with children and other vulnerable adults. Again, suitably experienced lawyers familiar with the legal safeguarding duties and regulatory legal obligations should have provided this advice to the team involved in the safeguarding investigation and senior Trust managers or relevant partner's safeguarding leads as soon as the disclosures were made.

4.151. Having failed in her attempts to secure appropriate responses from the police and Trust to undertake their duties and without appropriate advocacy support, understandably Una sought assistance from the solicitor instructed to represent her at the First Tier Mental Health Tribunal. Prior to this, despite being the subject of an ongoing s42 enquiry and detained under the mental Health Act, neither the Trust or the Local Authority had made arrangements for her to receive support via independent advocacy. We have already commented on unacceptable bias and victim blaming attitudes within this case, noting now that these attitudes directly impacted on Una's ability to access advocacy (an important procedural safeguard under Care Act, MCA and MHA) to protect adults uphold their legal rights and access justice. It was reasonable in the circumstances for the solicitor representing her at Tribunal to introduce her to a legal advocate. Likewise, the advocate and civil litigation solicitor took steps to ensure they acted in compliance with guidance issued by the Solicitors Regulatory Authority[105] and sought early advice from an independent psychiatrist to ascertain what reasonable adjustments they may need to take so as to safety secure her instructions (given the frequency of serious self-injurious behaviours). There is evidence that they followed clinical advice, ensuring that there was separation for her between any possible litigation (to be led by the solicitor) and the advocacy support she might need to during clinical reviews (provided by the legal advocate).

4.152. Conversely, NWBH Trust's case records (disclosed with Mersey Care's IMR) could not demonstrate senior managers actively considered how they would protect against possible tensions between their interlocking duties. There is no evidence that the Trust sought to separate out those functions or ensure that operational leads received legal advice in respect of the disciplinary issue, safeguarding enquiry or to that proper consideration was given to ongoing legal obligations for patient safety and their duty to support professionals providing care to meet their own professional standards and protect against possible conflicts of interest.

4.153. Whilst IICSA final report was only published in 2022, earlier reports had highlighted the need for a radical new approach to disclosures of sexual abuse by institutions. Given this and the Francis Inquiry recommendations, the Trust should have recognised the legal duty to secure

[105] Updated guidance issued 30.06.22 and available here: https://www.sra.org.uk/solicitors/guidance/accepting-instructions-vulnerable-clients/

several discreet outcomes and that the intersectionality of those outcomes required detailed and careful planning. Senior managers should have agreed within the strategy meeting an investigation plan (in line with s42(2) duty) which paid regard to their ongoing legal obligations to decide what needed to be done to prevent harm, including:

- Acknowledge to Una that she was the victim of sexual abuse, provide an apology on behalf of the institution and notify her of her right to civil redress;
- Review and revise Una's care plan, ensuring she was protected (in line with s42 Care Act) from foreseeable risk. This should have been done immediately after disclosure under the s117 MHA legal framework. Una should have been consulted, supported by an advocate and asked her preference of choice for a care co-ordinator, taking account of their duties as employers to protect Trust professionals involved in the disciplinary and criminal enquiry from a conflict of interest;
- Agree with police how to use sanctions (under criminal powers and disciplinary proceedings) to prevent the perpetrator from contacting Una whilst the investigation was outstanding;
- Report the abuse via the StEIS to GMIC and CQC;
- Review the care provided to all other patients provided on perpetrator's case list. A prudent approach, given models of offending, would have been to ensure no other patients exhibited presentations of sexual abuse. This should also have explored the therapeutic consequences for those who he had neglected (including by under-medicating) as part of the Trust's duty of care and in line with s42 obligations.

4.154. Further, the local authority (as lead agency under s42 Care Act) or (if this had been delegated under s42(2) Care Act to the Trust) and senior managers within the Trust should have clarified which relevant statutory partner[106] would lead on each parallel investigation and establish communication channels so that information pertinent to each enquiry could be swiftly and securely shared. Within the minutes, they should have recorded that the separation of functions was understood. Thereafter, the Trust should have identified a senior member of staff who could provide independent oversight of the enquiry and inform their Trust's Board so they could be assured the Trust had met with their public law functions throughout the enquiry process. This role is well established in other public bodies (for example, local authority monitoring officer). It is also common within law firms to protect against a perception of a conflict of interest.

4.155. The Trust's Board of Directors should also have been notified of the disclosure and that senior managers (ideally endorsed by the Board) were required to apologise for the abuse, offer Una counselling and set out her rights to compensation. Thereafter, a senior manager should have provided regular updates to the Board on her care, treatment and the progress of any litigation, so that the Board of Directors had oversight of the litigation strategy and could ensure this was consistent with their stated aims and public law obligations, including safeguarding duties.

4.156. The duty of candour obligations, to apologise, were not fully met. In October 2016 the Trust's Chief Executive and Director of Nursing "*expressed his sorrow to Una for what happened*", they also acknowledged they had focused on the disciplinary proceedings against perpetrator, rather than making a StEIS referral, they recognised she had not been listened to, had been let down and that her trust in her team needed to be rebuilt. The Trust offered to investigate the claims made within a tribunal report by a consultant that she posed a risk to staff, offered to assist Una facilitate a resumption of contact with her child and work with her to agree a future care plan. There is no evidence that such steps were taken. They also offered to arrange for a formal apology for the harm Una had suffered but asked that this was not done during a subsequent meeting with treating clinicians as they had not been made aware of the abuse. This is important from a clinical perspective as it frustrated practitioners' ability to ensure treatments were trauma-informed, i.e. those responsible for her care needed to understand where her trauma arose to provide her with safe coping mechanisms to respond to future triggers. Again, in discussions with Trust staff responsible for providing crisis care throughout this period, many commented that they were only

[106] Defined within s6-7 Care Act 2014

aware of the abuse and her previous history of childhood abuse when reading the case narrative prepared for this review. In an undated cover letter sent to Una with the 2017 Niche report, the Trust's medical director which states "*We would also want to once again apologise to the service user for the distress that has been caused to her following the action of our staff member.*" However, there is no further evidence within the extensive documentation submitted that the Trust provided an apology to Una for the Trust's corporate actions or inactions.

4.157. Clinicians employed by the Trust were also unaware of the need for a separation of roles, or that Una's legal team had this in place. Again, this should have been clarified at the earliest opportunity through an established communication route for the Trust and local authority legal teams to communicate directly with Una's lawyer. This would have ensured that further evidence which was made available to support disciplinary proceedings, NMC regulatory duties and the police prosecution were shared across the relevant agencies with clear accountability for further actions. It would also have allowed her advocate, separately, to continue in his role to support positive outcomes for her care and treatment during care and treatment reviews.

4.158. Had the relevant frontline practitioners benefitted earlier from legal advice and been able to refer Una's legal team to their own legal representatives, this could have prevented the significant professional conflict noted above. Reflecting on this with reviewers, senior safeguarding leaders involved in this review commended frontline staff for seeking to escalate their concerns regarding Una's safety and for highlighting there was a potential conflict of interest directly to her legal team, they accepted this took courage but, given the negative consequences for continuity of care in Una's treatment, should have been led by non-clinical directors or via their legal representatives. There are examples of Una's legal representative and advocate raising concerns, including to the local authority's lawyers, but they do not appear to have had a response including an acknowledgement and confirmation that their concerns would be investigated. Given the local authority's statutory role to oversee safeguarding functions (which, by virtue of s79 Care Act is non-delegable), this omission remains of concern. WCCG's assistant director for safeguarding explained that had Trust senior leaders involved him earlier with the safeguarding and patient safety processes, he could (as he later did) provide an objective voice to review and sought to have resolved concerns.

4.159. Una initiated civil proceedings only after protracted delays in securing a comprehensive review into her treatment needs. The urgency for a swift resolution was recognised by the High Court as an interim judgment was quickly secured. Within that judgment many of the substantive issues were concluded. The Trust conceded Una had suffered sexual abuse, that they had failed to adequately supervise the perpetrator and that this (as well as failures in care since the disclosure) meant Una could not establish a therapeutic relationship with Trust staff. The Court also gave a clear judgement that the sexual abuse and subsequent failings in care by the Trust had worsened her existing condition such that she would likely require specialist care for a significant period of time. The only remaining issue therefore was quantum (to both pay for her ongoing care and damages for the breach of her human rights). It remains unclear why those issues required such a protracted and invasive litigation strategy on behalf of NWBH Trust and NHS Resolutions.

4.160. Sadly, the adversarial nature of civil proceedings appears to have dominated too many of Una's treatment review meetings and directly impacted on delivery of safe care to Una. The impact on the therapeutic relations is documented clearly by all experts within the civil proceedings and elsewhere within this report, but there are two notable incidents when solicitors acting for the Trust were questioned on the appropriateness of their approach. The first, when a solicitor questioned Una directly in a meeting (on the 09.08.19) regarding her clinical needs in a meeting, the second when information was delayed regarding the treatment plan prior to the meeting on the 16.09.19 in order that the Trust could get legal input. This was raised as a safeguarding concern, but later referred to the Trust to address as a complaint. The outcome of that complaint was not shared with this review, nor were we advised of any action plan arising from that complaint investigation.

4.161. Senior safeguarding leads involved in this review raised concerns that the Trust prioritised reputational and financial risks associated with the civil litigation over Una's wellbeing and patient safety obligations more generally. Conversely, Trust safeguarding leads explained they had sought to have further strategy meetings with the local authority, but these requests were turned down, leaving them unsure how to progress. Again, many involved in this review, including frontline officers, court experts and safeguarding leads across partner agencies spoke of the difficulty in securing information to progress the investigations in this case and more generally when information is needed from Mental Health NHS trusts. They highlight, the primary focus (as identified by the Francis Inquiry and introduction of subsequent regulatory and criminal liability framework) should be patient safety- this includes minimising risk that further trauma results from legal strategy and defensiveness. The Solicitors Regulatory Authority provide guidance to solicitors taking instructions from vulnerable adults[107], however, there are no specific duties to solicitors instructed to defend public bodies to prioritise patient safety in line with the Francis Inquiry recommendations.

4.162. There are examples of practitioners, including her replacement care coordinator and senior clinicians, raising their concerns to senior management that the way in which proceedings were being conducted, including the secrecy surrounding the disclosure of sexual abuse, was adversely impacting on Una and escalating risks that she would suffer harm. Her care coordinator reported holding weekly MDT meetings to seek resolution across senior managers and clinicians of the heightened risks for Una following disclosure, but equally reported that over the weeks fewer people participated. Whilst staff were provided assurance by senior management they were aware of the risks, there was no evidence that steps were taken to seek agreement (with Una or with external agencies) on a plan which would support Una's recovery as a victim of abuse or progress the safeguarding enquiry in a timely manner in line with WSAB's policy. It was wholly unacceptable that (in a mistaken belief that this might reduce financial liability for the Trust within civil proceedings), staff were advised whilst there was an 'ongoing enquiry' they should not use the term 'abuse' when speaking to her of the actions by the perpetrator. Practitioners, to their credit, understood how this undermined a trauma-informed approach of therapeutic sessions. Practitioners explained to reviewers they understood Una's mistrust, but felt Trust senior leaders also overlooked their obligations to provide clinical and legal support to frontline staff involved. They also confirmed they had not had sight of expert reports as to Una's likely treatment needs, despite the obvious assistance this would have provided them when determining her care plan.

4.163. Practitioners also explained that, in the absence of a structured management approach to addressing the conflict between the civil litigation process and their duty of care to Una, they often felt intimidated by such detailed scrutiny because they rarely got direct guidance from Trust or local authority lawyers. Trust staff had sought to explain that it may not be safe to provide 'perfect care', because this might inevitably fail and therefore leave Una less resilient. Her legal team, explained during conversations with the reviewers they understood perfect care may not always be possible, but felt aggrieved that neither they nor Una were heard when they expressed any concerns within the proposed care plans. Una's legal team felt unjustly criticised for taking a robust approach to securing her treatment needs, highlighting that they were also criticised by the Trust's external solicitors who had intimated they would report them to their professional regulators. Una and many of the experts involved in the case commented that, if not for their diligent efforts to obtain clinical care for her, Una would likely have died in the months following disclosure of the abuse. However, some practitioners felt that decisions they took were perceived to be intended only as a defence in the litigation when their professional judgement was that the proposed course of action was in Una's best interests therapeutically. Others described feeling exhausted, overwhelmed or 'frozen' by the intensive scrutiny and criticism, including reciprocal threats to report lawyers and other professionals to regulatory bodies, leading to them second guessing their therapeutic care.

[107] Updated guidance issued 30.06.22 and available here: https://www.sra.org.uk/solicitors/guidance/accepting-instructions-vulnerable-clients/

4.164. Clear definition between the role of those involved in her clinical care and the managers involved in the litigation was important, both to prevent staff from facing a conflict of interest and to prevent Una from feeling that those involved in her care were her adversaries. An example of this was when the Trust used one of the clinicians involved in her care to write a report in response to an expert opinion on Una's care plan in the civil proceedings. While the reviewers have no doubt that the clinician's opinion on Una's therapeutic care was based on their professional judgment and in keeping with good practice, they were placed in an invidious position. Current guidance from the Royal College of Psychiatrists[108] warns it is inadvisable for the treating clinician to provide expert testimony within litigation involving their patients because of the negative effect upon the therapeutic relation and the risk of bias or perception of bias. The GMC's guidance 'Acting as an Expert Witness in Legal Proceedings' implies treating physicians should limit their role in proceedings to giving evidence as a witness of fact (as a professional witness) rather than provide expert testimony. The Trust's managers and legal representative should have sought to agree early the use of jointly appointed experts[109] or, failing that, independent experts in accordance with the Civil Procedure Rules, and this was commented on by the judge in the proceedings. Again, decisions made regarding the litigation strategy took too little regard to Una's needs as a vulnerable witness and undermined Una's trust in practitioners and may have contributed to the quantum of damages.

4.165. Another clear example arose in respect of managing concerns regarding Una's contact with her child at times when she was exhibiting serious self-injurious behaviours. Previously there had been an agreement with Una that, if she was unwell, her clinical team would notify the father of her child if contact could not take place with her child. Sometime around July 2016 the clinical team disclosed Una's health had deteriorated and, from that time, Una was required to seek legal orders to resume contact. Although Una had never self-harmed in front of her child, she had self-discharged from hospital against medical advice with infected wounds from self-harming and was highly emotionally dysregulated at this time. While the High Court's final order sets out that this was a consequence of the abuse by the perpetrator and therefore a breach of Una's Article 8 rights attributable to the Trust, the professional view that contact should be stopped on child protection grounds was appropriate. Although Una strongly disagreed with this decision, her child's safety and welfare was paramount. However, despite this disclosure being made in accordance with the existing agreement, this reinforces the problematic nature of the decision to keep providing Una's care and support through the same clinical team. Those practitioners acknowledged to the reviewers that, prior to his disclosure, they had been close friends with the perpetrator. Whilst they were appalled by his actions and felt this as a betrayal, they had been prohibited from discussing this with Una. Consequently, her perception was that the notification to her child's father was malicious. This further eroded the therapeutic relationship between Una and Trust employees and caused considerable and long-term distress.

4.166. Irrespective of any agreement in place, a more appropriate arrangement would have been for the clinical team to inform Children's Social Care of any concerns, and for a children's social worker to risk assess whether contact could safely occur and inform the father appropriately, with the level of information that was necessary and proportionate to the legitimate safeguarding concern. This would mitigate any potential conflict between the clinical team's therapeutic relationship with Una and their safeguarding duty to her child, minimise the amount of confidential health information it was necessary to share with the father and provide a clear audit trail of the information shared and rationale for this. Children's social care could also have supported the contact arrangements through indirect contact in the interim and to ensure that when Una's condition stabilised, contact could be reintroduced in a timely, child-focused manner, to promote both Una and her child's right to a private and family life in accordance with Article 8 EHCR.

[108] Responsibilities of Psychiatrist who provide expert evidence to courts and tribunals, published initially in 2015 and revised March 2023, available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr193.pdf?sfvrsn=c0381b24_2

[109] It is common practice within Family proceedings for parties to jointly appoint medical or other expert reports. Experts involved in this case reported in their extensive experience this was much less common in civil proceedings but where, as in May 2021 there was a joint experts reports, this brings a clarity to both parties and can substantially reduce the adversarial nature of proceedings.

4.167. Such an arrangement may also have reduced some of the control that the perpetrator was able to exert over Una while he was her care coordinator, as she was very conscious that he had been the person controlling whether she had contact with her child. This dynamic also raised a risk that the perpetrator would provide overly positive reports to the father to enable contact to take place when Una was unwell, undermining the safeguarding plan for Una's child, something she acknowledged had happened when she spoke to the authors of the Niche report. The fact that it was the perpetrator's actions which had contributed to Una becoming so unwell and consequently losing contact with her child was recognised by the High Court in awarding very substantial damages for the breach of their Article 8 rights.

4.168. The benefits of clear separation of roles could be seen when an independent social worker was instructed to develop Una's private care package in 2019. Due to their independence, they were able to build a trusting relationship with Una's legal team, enabling the solicitors to withdraw from attendance at multi-disciplinary team meetings, to ensure her treatment and care were not being driven by the court pathway. They were also able to develop a structured approach to support Una within the court proceedings, in particular preparing her witness statement, which was an ordeal for her, and in anticipation of giving evidence during the trial when the Trust had provided its questions for cross-examination which placed locus of responsibility for her abuse on Una.

4.169. The Trust's legal strategy to mitigate damages by arguing that Una had been in a consensual relationship with the perpetrator was extremely difficult for Una to understand. The lack of organisational disconnect between her treatment needs arising from the abuse and the civil litigation was not something Una could process. For her, this was a continuation of the organisational abuse and, as was clear as early as July 2017, that lack of validation of the harm contradicted the Trust's argument that she should continue to access local mental health services; it would be impossible to build a meaningful therapeutic relationship with employees or connected services of a Trust that was minimising her experience of abuse. To Una, the litigation strategy was indelibly connected to the service offer.

4.170. Following the dissolution of the Trust, Mersey Care assumed responsibility (alongside NHS Resolutions) for the conduct of proceedings in June 2021. Senior leaders responsible for patient safety and safeguarding reported to this review that they were briefed by their external solicitors on the litigation strategy at a meeting on the 03.09.21 shortly before mediation. They subsequently wrote to their external solicitors indicating that in this and all future 'high level' case the point of contact should be at deputy director of patient safety level so that they could ensure the Board and executives were fully sighted and able to make decision. Between April- September 2021 contact had remained with NWBH Trust's previous point of contact. Within their instructions for a change in process to manage future litigation strategy Mersey Care leads explained their rationale as they were '*conscious the MCFT oversight, governance and decision making is different to how NWB operated*.'[110]

4.171. It is understood that, whilst Mersey Care administrative staff were copied into the request in August 2021 from the external solicitors to NHS Resolutions for permission to disclose ahead of the trial the cross examination questions, this was not shared with Mersey Care's senior leaders and did not enable sufficient regard to the clinical impact for Una of the content and nature of those questions. Once briefed on the nature of the proceedings in October 2021 they confirmed their instructions, given the serious breaches of Una's human rights and their ongoing duty of care, was for a swift settlement. In conversation with reviewers, they explained whilst they understood and agreed with the decision to provide Una's legal team with cross-examination questions by way of reasonable adjustments to manage risks arising from her conditions, they

[110] Taken from Mersey Care case records made available to this review.

believed the nature and content of some of those questions could not be defended. Failure to check with the new trust's senior leadership prior to submitting the proposed cross examination questions that they supported the previous Trust's litigation strategy cause unnecessary further harm. Mersey Care explained that in cases where the likely quantum is lower than £10,000 trusts have autonomy to settle. Where this is higher, NHS Resolutions must authorise any settlement but usually decisions are made collaboratively. It is understood that, presently trusts have flexibility to determine how to work with NHS Resolutions and external solicitors. The circumstances of this case suggests there are strong grounds for developing consistency, particularly in the context of NHS restructuring or mergers. Ideally, working practices should provide the necessary separation of functions we have advocated, with trust's providing instructions on the likely consequences for patient safety (both generally and in each specific case).

4.172. In September 2023 the Solicitors Regulatory Authority published guidance[111] for solicitors instructed to represent employers where the employer becomes the subject of an external investigation. This was not available to solicitors instructed by the Trust in 2016, but is based on the Professional Code of Conduct and SRA Principles to ensure solicitors act in a way that upholds public trust and confidence in the solicitors' profession (Principle 2), with independence (Principle 3) and integrity (Principle 5) and in a way that upholds the constitutional principle of the rule of law, and the proper administration of justice (Principle 1). This reminds solicitors they must be certain for whom they are acting and mindful of unfair advantage being taken of third parties.

System Finding

4.173. NWBH Trust's response to the disclosure of serious sexual abuse by one of its staff members against a patient did not comply with the standards set out following the Francis Inquiry. Consequently, there was a failure to utilise information that was available to it to secure outcomes that would have made a meaningful difference both to ensuring the perpetrator was held to account and harm caused to Una was acknowledged in line with the Duty of Candour.

4.174. Adult safeguarding principles were poorly understood in 2016, such that partnership practice only superficially met expectations to work together. There was insufficient consideration of how safeguarding adult obligations should interface with disciplinary or patient safety functions. This weakness was not picked up at Trust or WSAB leadership level or addressed throughout the period under review. There were no mechanisms to challenge omissions, when frontline (even senior and experienced) clinicians highlighted heightened risk to Una's safety, if her clinical needs were ignored or the abuse she had suffered was not acknowledged. Instead, senior managers took an entrenched position to defend earlier poor safeguarding practice. Rather than supporting staff still responsible for Una's care, this left those staff exposed to criticism and uncertainty. For some it exposed them to allegations of misconduct and breaching their professional standards.

4.175. Greater awareness is needed of the dual role public bodies have to provide their substantive statutory functions in a way that upholds the rule of law, including human rights. The subsequent litigation strategy was overtly adversarial and failed to take into account their duties to act in the public interest and in the interest of patient safety. It demonstrated a defensiveness, not in line with a learning culture. In particularly, early failure by the Trust, local authority safeguarding officers and police to understand the parallel legal processes and interlocking outcomes were not corrected, even after the High Court gave Interim Judgement in Una's favour. The Trust failed to ensure legal proceedings were conducted in a way that adhered to these principles. Consequently, the length of time proceedings continued, when the only issue remaining was quantum, remain unexplained and this directly delayed Una's recovery. The approach taken to aggressively defend quantum following the interim judgment on the basis that the abuse had not been harmful to Una was dangerous. It showed a disregard for ongoing duties to protect life and protect against inhuman and degrading treatment.

[111] Available at: https://www.sra.org.uk/solicitors/guidance/supporting-client-interviews-external-investigations/

4.176. The adversarial litigation strategy adopted to defend proceedings likely caused further harm by delaying Una's recovery and retraumatising her. This also likely cost the Trust in additional quantum which should have been avoided had the approach recommended by Francis and the IICSA recommendations been adopted. The handover of conduct of the civil litigation to Mersey Care lacked clear governance and as a consequence, leaders initially lacked oversight of the litigation strategy, although steps were taken to remedy this as soon as this was identified.

4.177. There remains a lack of guidance on how to support vulnerable victims through civil proceedings to bring together safeguarding good practice guidance, legal obligations regarding the duty of Candour and professional ethics and standards across legal and clinical specialisms. This should urgently be rectified at a local, but preferably, national level. The Solicitors Regulatory Authority's ethics helpline have indicated interest in exploring if further guidance might improve future practice, drawing on the findings from their thematic review[112] in 2023 which identified potential risks for in-house lawyers having sufficient support to safeguard their independence, manage regulatory issues and obligations. WSAB should also consider sharing the review with NHS Resolutions' faculty of learning to help inform their training tools and operational practice when conducting litigation.

KLOE 7: Practice improvements since the review period

In respect of each of these issues, how has practice developed over time and would that reduce the risk of similar issues arising in the future?

4.178. As noted above, NWBH Trust ceased to exist in June 2021 and no members of the executive team transferred to Mersey Care NHS Foundation Trust. Constant reorganisations of NHS structures across the period under consideration in this review may have contributed to a loss of corporate memory and accountability, with organisational structures and functions becoming opaque over time. The Trust grew from Five Boroughs to North West Boroughs and has now been dismantled and redistributed between GMMC and Mersey Care. We have also commented above that, throughout the review period, the Trust did have in place effective policies to support practitioners and senior managers to address the perpetrator's poor work practices and subsequent legal obligations arising from the sexual abuse. What remains unexplained is why these were not followed by senior Trust managers and what lay behind the intentional decision not to keep records of decisions or report the matter via StEIS in accordance with national policy.

4.179. It is important to acknowledge, the agency response provided by Mersey Care to this review was insightful and reflective. It recognised the harm Una experienced, both as a consequence of the abuse she experienced and the failures of the Trust to provide a clinical response to this abuse, or provide assurance to Una that she was seen as a victim, leading to her inability to trust those responsible for her care. This is a positive development, and indicates a shift in culture.

4.180. Nationally too, there is recognition that more focus is needed in respect of sexual safety. Work started in 2020 by CQC to explore systematic issues to address sexual safety within mental health provider services and by the National SAB Chairs network to take forward recommendations from the Newcastle SAB's thematic review (referenced above) provides a base upon which WSAB and partner agencies can develop.

4.181. It is important to clarify, this will require a whole system approach. For the reasons detailed above it would be dangerous to presume this can be addressed solely by provider Trusts or their regulator. Since that review CQC's remit has widened considerably such that they have published a new approach to assessment clarifying that the frequency of assessments may change. This could adversely impact on embedding improvements if there is not agreement locally on how the system will work collectively to monitor quality of care and triangulate with safeguarding or employment law duties. Currently, the system relies heavily on the integrity of senior managers to

[112] Available at: https://www.sra.org.uk/sra/research-publications/in-house-solicitors-thematic-review/

adhere to good standards of governance. The importance of a transparent, open culture and one rooted in learning from adverse events was clearly made by both the Francis and IISCA inquiries.

4.182. Further changes to health commissioning with the introduction of ICBs widening the geographical footprint, coupled with significant rises in demand across mental health, critical risks in workforce (widely documented across the country) and unprecedented reductions in public funding for health and social care could, without concerted political and organisational support, cause an erosion of patient safety.

4.183. Responsibility for the system overview of patient safety and quality of care within the health economy sits primarily with local System Quality Groups (SQG). Their role is to focus *'engagement and intelligence- sharing for improvement, the discussions and decisions from SQGs will feed into the designated assurance functions of both ICB and local authorities; shaping assurance around relevant matters (eg safeguarding, pathways). SQGs will also escalate any risks or concerns to ICB, local authority assurance and regional NHS England and NHS Improvement teams where response and support is required.'*[113]

4.184. Following the interim judgment in 2017 the Trust's involvement was limited to making payments to enable the privately arranged treatment, facilitating crisis care- including in-patient admissions if required and conducting the litigation. In June 2021, on the dissolution of the Trust, Mersey Care NHS Foundation Trust ['MCFT'] assumed responsibility for the majority of its clinical services, including responsibility for the legal proceedings in respect of Una. However, Wigan-based services, where Una's abuse was perpetrated, were transferred to Greater Manchester Mental Health Trust. In conversations with the reviewers, practitioners and safeguarding leads reported there has been improvements across both Trusts since that time. Safeguarding leads spoke of greater confidence to provide respectful challenge across the partnership to enable improved assurance of safer systems.

4.185. For Una, the most significant improvement to practice was the coming together of her treating team under the coordination of an independent social worker but with the pro-active engagement of the whole treatment team, ensuring not only that Una and her partner were involved in the care planning process, but that the GP, CPN, local authority social worker responsible for Una's partner's carers support package, clinical psychologist and psychiatrist meet and reviewed her progress, adapting the treatment plan accordingly. In particular, the pro-active frequent communication between her CPN and GP enabled those she had contact with most frequently to plan for when, because of external pressures, Una may need more support. This was acute in the run up to the final hearing. Her GP explained, for him the holistic approach helped him to understand better Una's strengths and how far she had come in her recovery. He understood her needs more generally because he had access to how she was managing when not in a crisis, something he had not been afforded when her care was provided more directly through the NHS.

4.186. Many involved in this review spoke of the significant strains across the NHS and how this too often resulted in limiting interventions to when someone was in acute crisis. A wider application and dissemination of the NHS Continuing Healthcare framework to support coordinated, integrated care across physical and mental health and between primary, secondary health care and social care offers the tools to practitioners. However, many involved in this review working within secondary mental health spoke of barriers to this approach because of the high thresholds employed to get access to specialist clinical psychology or psychiatry to address complex presentations associated with repeat trauma and/or sexual abuse. The value of a recovery concept model[114] is recognised, but will require significant political and organisational change to

[113] National Quality Board's guidance on system quality groups published by NHSE in 2022 and available at: https://www.england.nhs.uk/wp-content/uploads/2022/01/B0894-nqb-guidance-on-system-quality-groups.pdf

[114] As advocated by the Department of Health (2007) Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services. Department of Health and Boardman, G, Roberts, G (2014) Risk, Safety and Recovery: A Briefing. Centre for Mental Health and Mental Health Network, NHS Confederation

empower clinicians, practitioners, patients and their carers to benefit from such a framework of therapeutic risk-taking, centred on the person's abilities and strengths rather than merely the risks perceived. Key to this will be mechanisms for measuring service user engagement with care planning, as well as evidence of shared ownership across disciplines of risks associated with building up someone's psychological resilience.

4.187. In addition, Una's treatment was, contrary to usual practice, subject to regular oversight by GMIC to ensure her s117 MHA aftercare plan was in accordance with her needs and reducing risks associated with serious self-injurious behaviours. As a consequence of that intervention, she felt empowered to resume self-advocacy thereby enabling a much clearer separation between her ongoing treatment and the continued civil litigation. Una was not only able to resume advocating on her own behalf, but (through her work with CQC) improved her self-esteem and wellbeing so became able to advocate more widely for systematic change to improve patient outcomes. In short, during the later part of the review period, her care and treatment provides a blue- print for the recovery-based model promoted by Felton et al.

4.188. Mersey Care's personality disorder policy, in line with the NICE clinical guidelines, should also support the development of such an approach not as an exception, secured only through civil litigation, but available to patients experiencing personality disorders and at high risk due to complex PTSD following sexual abuse. In addition, GMMH staff reported that, since the review period, they have completed a thematic review of their SI reports and recognised malignant alienation, either consciously or unconsciously, continues to undermine policy objectives to improve outcomes for patients with personality disorders, especially women with EUPD who too often experience a lower standard of service, particularly in A&E. Their findings (that judgements are made based on pre-conceptions of the diagnosis without adequate assessments), demonstrates that this will require a strategic approach and improvement is not confined to one organisation or across one discipline. GMMH reported that, following their review they have hosted a series of learning events across the year to several hundred of their staff. In respect of Malignant alienation the session was scenario based and reinforced an understanding that EUPD is born from childhood trauma, not a choice. They have also improved the training officer within the women's service, so all nurses have training in complex needs, to encourage a compassionate, therapeutic environment where patients feel believed, their experiences validated and not judged.

4.189. The recent rapid review into mental health in-patient safety data sets out starkly the challenge to understanding the systematic issues. Both Mersey Care and GMMH colleagues spoke of the urgent need to move away from the 'usual offer' of short-term compulsory admissions for adults who, like Una, require a therapeutic approach. They accepted currently secondary mental health provision is focused on psychosis and that, once someone is well enough for discharge to the community it can become increasingly more difficult for those with maladjusted schemas to make productive use of community-based services designed to be reactive and insular, in that they only seek to engage across disciplines by way of referral to alternative support, rather than co-producing a holistic care plan across disciplines and with specialist clinical PTSD or personality disorder input.

4.190. The potential for improved outcomes (for patients as well as costs and demand management) was not lost on everyone we spoke to as part of this review. Many recognised that those with the most complex needs were usually already in receipt of s117MHA aftercare support, but a lack of process to enable oversight by the local authority and GMIC commissioners means that for a small cohort of people with the most complex needs they remain in receipt of services (either as in-patients under s3 MHA or subject to s117 MHA aftercare) for years with little therapeutic recovery.

4.191. Exemplary practice could be observed from the assistant director for safeguarding at the WCCG/GMIC, who consistently challenged poor practice and raised concerns in respect of the Trust's actions throughout his involvement in the case. He was clear when speaking with reviewers that he was not acting in the role of a whistleblower, but rather in the context of his

statutory duty to challenge safeguarding concerns in respect of provider trusts. Others interviewed as part of this review praised his approach in acting as an intermediary between Una's legal team and other statutory partners, in an effort to ensure that her therapeutic needs were met, describing him as compassionate and unwavering in his commitment to her wellbeing. In a safeguarding culture that was reported by many spoken to in the course of this review to be toxic, oppressive or unsupportive, it takes courage to speak out about widespread poor practice, even for those who hold a statutory role.

4.192. These high standards have translated into improved safeguarding practice more widely across the partnership, as GMIC's Quality Assurance team is, in its role as the commissioner of services from GMMH and Mersey Care, challenging those providers in respect of their own assurance processes. However, for those assurance processes to be effective, the system still relies on self-reporting by agencies which, in respect of concerns around organisational abuse or failings, requires understanding of the rationale behind the safeguarding framework, and a desire on the part of leaders to have a culture of continuous improvement.

4.193. Mersey Care introduced a revised 'Freedom to Speak Up' policy in 2022, which sets out the organisation's aim to 'celebrate' those who speak up about their concerns in the workplace, ensure that lessons identified are actioned, and that colleagues who raise concerns in good faith should not experience any consequential adverse or detrimental treatment. It also sets out the principles of a Public Interest Disclosure, and legal protections afforded to those who whistle blow. As previously discussed, while this is a good quality policy, it will only be effective if properly implemented.

4.194. Recent developments, such as the re-establishment of the WSAB as a separate entity, strengthening of Wigan's Safeguarding Adults team, more robust oversight from GMIC as commissioner of partner trusts and the insight shown by Mersey Care within the review process indicate a positive shift in this culture, but it is essential that this becomes embedded across the leadership of partner agencies more widely, and is not merely seen to sit with safeguarding leads.

System Finding

4.195. Increasingly, Wigan has developed co-located or joint multi-disciplinary safeguarding services to provide a more holistic response to adults with care and support needs. Police have a mental health practitioner embedded in their call centre triaging Thrive[115] assessments, as well as a specialist mental health response car with another mental health practitioner in a first response unit, although it remains to be seen how these will be impacted by the national roll out of the 'Right Person Right Care' approach due to be implemented in Wigan in the Spring of 2024. Wigan's Adult Safeguarding Hub comprises safeguarding social workers, approved mental health professionals, police and independent domestic violence advocates, complex dependency and complex key workers who can be assigned to individuals. This is supported by weekly risk meetings, which provides a strategic response to repeat and high-risk referrals. Wigan's Safeguarding Adults team now has a principal social worker for adults, and those interviewed for the review commented on the resulting practice improvements.

4.196. WSAB partners may wish to reflect on practitioners input into this review, they articulated the need to prioritise education across all staff within primary and secondary health and social care so adults at risk with a diagnosis of personality disorder receive empathetic, trauma-informed care. This will require a more comprehensive offer to staff, working with patients at higher risk, so that they are able to access real time advice and guidance from clinical psychology to ensure that care and treatment plans remain recovery focused, rather than preoccupied to manage organisational risk.

[115] A model used to assess the right initial police response to a call for service. It allows a judgement to be made of the relative risk posed by the call and places the individual needs of the victim at the centre of that decision

4.197. Given the significant organisational change and resource pressures, however, WSAB should seek to engage with the SQG to agree a memorandum of understanding over how, collectively, they could gain assurance that NHS providers understand safeguarding and public law obligations and that good practice is firmly embedded at both operational and strategic levels.

Conclusion and recommendations for future practice improvement

5.1 This review has highlighted how difficult it can be for those impacted by sexual abuse to be heard and thereafter to secure justice for the harms suffered. It also demonstrates flaws within the current system to provide safe, well-coordinated, therapeutic care to victims of sexual abuse. All too often, victims experience bias which impedes their recovery.

5.2 The widespread significant harm caused by the perpetrator was remarkable. Of course, primarily this was felt most acutely by Una, but ramifications continue for her family and professionals. The challenges faced by public and private sector health, social care and criminal justice agencies to identify, disrupt and prosecute a perpetrator of sexual abuse are undoubtedly complex, but resolve is needed to ensure that adults at risk or who have experienced such harms are offered safe therapeutic environments and that safeguarding partners utilise the civil powers and criminal sanctions to hold perpetrators to account. This obligation must be understood to apply to every level of each relevant partner organisations.

5.3 The recommendations below are intended to compliment the recommendations arising from national reviews into sexual safety referenced in this review. They are intended as a starting point for the WSAB and partners to build on over time, engaging with their local Healthwatch, experts by experience and patient safety groups. We have grouped recommendations to enable partners to incorporate this into their own organisational strategic priorities recognising this will need wider ownership than the WSAB alone.

Safeguarding Policy and Procedures

1) WSAB update their safeguarding policy and procedures to include a detailed definition of adult sexual exploitation with explicit reference to s38 Sexual Offences Act and the ethos behind this.

2) The policy should also provide guidance on expectations regarding parallel processes, such as disciplinary proceedings, criminal investigations, referrals to DBS and obligations to report in line with the NHS Patient Safety Incident Reporting Framework and referrals to regulatory bodies for health and social care professionals.

3) The policy should also provide guidance on the Duty of Candour, including how failure to adhere may constitute organisational abuse or professional misconduct. It should set out a shared view on the provision of written apologies for organisational failings that may have given rise to abuse or neglect and support available to victims to access civil or criminal redress. This should include agreements to conduct regular multi-agency audits or case reviews to ensure internal HR processes, criminal investigations and safeguarding enquiries are aligned with this policy objective.

4) WSAB policy should confirm a presumption that advocacy be involved whenever investigations involve adults at risk of exploitation, grooming or coercive offences, particularly where this is against a person in a position of trust. Mersey Care and GMMH should work with commissioned advocacy groups to ensure patients newly admitted or detained for further periods are introduced to that service. Advocates should be routinely invited onto wards as part of an in-reach culture to promote a rights-based, safe care environments.

5) There should be greater clarity within the local safeguarding procedures of the steps organisations should take to ensure parallel processes are coordinated across relevant partners and establish communication channels across relevant partners, but also with legal representative and advocates as well as clear reporting expectations to partner organisations' Boards of Directors. Where concerns are raised by relevant partners outside of the usual MASH process, the procedure should detail how those will be recorded and tracked to ensure actions are completed in accordance with legal duties. In addition, the procedure should make clear that allegations of sexual abuse against professionals or persons in a position of trust ('PiPoT') require input from specialist trained police officers in sexual offences. Police officers, s42 enquiry officers and Trust safeguarding leads investigating allegations against PiPoT should have mandatory training in respect of sexual exploitation, coercion and control and the relevant criminal offences. They should not be tasked with undertaking investigations into sexual abuse allegations until they can demonstrate competency at Level 3 with this additional expertise or, in the case of police officers, that they have successfully completed the Professionalising Investigation Programme level 2- complex investigations.

6) WSAB should consider how to adapt existing safeguarding tools to support an urgent strategic multi-agency response to allegations of sexual abuse against professionals. Specialist safeguarding legal advice should be sought at an early stage (including from the CPS)[116] and shared with partners as part of the protection plan. The adult safeguarding policy should be revised to clearly set out expectations that place the victim at the heart of any response. This should include guidance on providing written apologies and advice on next steps for victims, including the availability of psychological support and compensation.

7) WSAB should undertake an audit of the Resolution Protocol to ensure that this is successfully identifying high risk cases and that where relevant, organisations have made the appropriate referrals to StEIS/ LFPSE, the CQC, safeguarding and any other notifications required under the relevant regulatory frameworks.

Managing Allegations against People in Positions of Trust

8) GMMH and Mersey Care (but, ideally, all relevant partner agencies) provide assurance to WSAB they have reviewed their employee disciplinary policy and phone/ IT use policies to make clear that this forms part of case records and therefore subject to managerial oversight to ensure practice standards are met within professional/ client relationships.

9) Relevant partners, including GMMH, Mersey Care, GMP and the local authority should work with WSAB to review their PiPoT policies and understand how those policies have been socialised within each organisation, particularly with reference to the identification, disruption and prosecution of sexual abuse. This should be a comprehensive exercise, involving practitioner surveys to ascertain their level of knowledge, a review of in-house training material, internal organisational policies to ensure that they comply with expectations of SCIE's guidance on sexual safety and DBS best practice. Board partners should be asked to confirm the governance oversight of s42 responsibilities and disciplinary processes internally.

System oversight of patient safety and quality of care issues

10) Mersey Care, GMMH, GMIC and local authority should provide assurance to WSAB that they have reviewed their internal policies and socialised within staff guidance so that staff are clear how to raise concerns where their duties as employees may conflict with their professional

[116] https://www.cps.gov.uk/rasso-guide/how-we-work-police-they-build-their-case

standards. The local authority's legal team should also review their standard operating procedure to ensure that where external complaints or concerns are raised in respect of adults at risk, these are responded to in line with s42 overarching obligations.

11) Wigan Council, GMIC and GMMH should conduct an urgent audit of s117 MHA aftercare plans, including for patients admitted to private hospitals and provide assurance to WSAB that those subject to s117 MHA have access to person-centred support that takes into account their needs in a manner that supports recovery. This audit should focus not on whether there is a s117 agreed aftercare plan, but the quality of those plans. The audit activity should explore if they have been co-produced with the patient, if friends/ family have been involved and if multi-agency input has facilitated recovery-based practice.

12) GMIC and local authority, working with GMMH should provide assurance to WSAB that they now have established governance in place to provide oversight of s117 aftercare planning duties. This should include establishing mechanisms for responsible clinicians and other practitioners involved in recovery work to reports gaps in current service provision to support patients with complex needs and co-occurring conditions.

13) To avoid duplication, WSAB should agree a local memorandum of understanding that the SQGs will provide regular quality assurance reports on the emerging concerns and steps taken to ensure services for adults at risk are safe. NHSE should be a party to that MOU, clarifying what role they will take particularly for complex care in out of borough placements.

14) Working with NHSE, CQC, GMIC, local authority and NHS providers should develop a local protocol to support the oversight of recovery/ support plans for patients subject to s42 safeguarding enquiries where the perpetrator of abuse is involved in care (including where there are concerns regarding organisational abuse). This should set out the circumstances where a patient can receive personal health budgets and/ or the transfer of care of patients to another NHS provider. The protocol will also need to address how, as this provision may be out of area, local services retain oversight of the efficacy of s117 aftercare provision.

15) GMMH and Mersey Care should present evidence to WSAB in respect of the actions they have taken to address cultural issues regarding accountability and transparency and how they encourage and ensure an open, transparent culture alongside the accountability framework.

16) All partner agencies have signalled ambitions to develop a culture where victim blaming language is avoided and challenged when used. WSAB should seek assurance from partners detailing how this will be realised, for example through incorporating this into guidance, training, supervision and audit processes with clear role modelling across senior leadership.

17) Health and social care partners should confirm to WSAB the steps they have taken to monitor use by staff of reflective clinical supervision to support trauma-informed practice, avoid burn out or desensitisation in complex cases involving chronic high-risk, and to minimise the risk of secondary trauma or malignant alienation. Given that generous leadership is required to ensure that staff have time to engage with this support, inclusion by relevant partners of this as a strategy priority would indicate strong commitment.

18) WSAB should seek assurance from all agencies involved in this review that NHS England and NICE guidance prohibiting use of criminal and other punitive sanctions and discriminatory practice and attitudes against mental health patients has been incorporated into organisations' policies, including GMP and Wigan Community Safety Services. WSAB should make the Chairs of relevant Boards, (including the Community Safety Partnership, Health and Wellbeing Board and Healthier Wigan Partnership) aware of the findings of this review so that recommendations can also inform the strategic priorities and assurance work of those boards going forward.

System oversight of access to justice issues for ‘adults at risk’

19) Mersey Care, GMMH, GMIC and the local authority should work with leads responsible for implementing the new PSIRF framework to agree how learning arising from complaints, litigation and patient safety incidents, involving organisational abuse or neglect against adults at risk should be routinely reported to the WSAB.

20) WSAB should consider referring this report to the attention of regional and, if appropriate, national SAB chairs through the National Escalation Protocol, NHS Resolution and to the Solicitors Regulatory Authority as an issue that may require joint work to ensure there is suitable guidance available to enable litigation to place the wellbeing of vulnerable parties as a principle within civil procedure rules as it is within cases conducted under the Family Procedure Rules and Court of Protection Rules.

21) WSAB should also write to NHS England to provide binding guidelines to Trust boards to ensure that where they are defending civil litigation against a vulnerable patient of the Trust, appropriate steps are taken to ensure active consideration is given to safeguarding, protecting the therapeutic/ clinical relationship and human rights obligations.

22) Mersey Care and GMMH, working with WSAB partners, should develop a policy to support patients and staff involved in civil proceedings understand how to balance competing outcomes and ensure separation of functions so that primacy is given to wellbeing and safeguarding obligations. This could draw on lessons learned following the Francis report and by organisations working to support victim survivors of historical sexual abuse so that it is widely understood across the organisational that offering an apology for wrongdoing and seeking to support recovery is likely to enhance the organisations reputation and minimise legal and financial risk. This should highlight the importance of ongoing reflective and respectful use of expert opinion, witness testimonies and advocates concerns to influence ongoing care planning and therapeutic responses.

Glossary

A&E	Accident and Emergency department
CBO	Criminal Behaviour Order
CPS	Crown Prosecution Service
CQC	Care Quality Commission
CRHT	Crisis Resolution Home Treatment Team
DBS	Disclosure and Barring Service
EUPD	Emotional Unstable Personality Disorder (also sometimes known as Borderline Personality Disorder
ECHR	European Convention on Human Rights
GMC	General Medical Council
GMIC	NHS Greater Manchester Integrated Care Board
GMMH	Greater Manchester Mental Health NHS Trust
GMP	Greater Manchester Police
HCPC	Health and Care Professions Council
IICSA	Independent Inquiry into Child Sexual Abuse
IMR	Independent Management Review
KLOE	Key Line of Enquiry
LFPSE	Learn from patient safety events
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
NSPA	National Patient Safety Agency
NWAS	North West Ambulance Service
NWBH	North West Borough Mental Health Trust
MARAC	Multi-Agency Risk Assessment Conference
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983
PSIRF	Patient Serious Incident Response Framework
PTSD	Post Traumatic Stress Disorder
PiPoT	Persons in a Position of Trust
SAR	Safeguarding Adult Review
SCIE	Social care institute of excellence
SIM	Serenity Integrated Mentoring
StEIS	Strategic Executive Information System
WCCG	Wigan Clinical Commissioning Group
WSAB	Wigan Safeguarding Adults Board