Safeguarding Adults Review - Learning from the death of Nevaeh

2026

Commissioned by Bolton Safeguarding Adults Board

Lead reviewer - Chris Hogben, Invigor Consulting Ltd

Date – May 2026

A tribute to Nevaeh

(Her mother's words)

Nevaeh was, and always will be, the best thing that ever happened to the Owen family. She was the first-born daughter of Lynda and Anthony Owen, and a wonderful role model to her younger siblings, Adam and Alisa.

Family meant everything to Nevaeh. She was endlessly supportive in everything they did—whether that meant cheering her sister on at gymnastics, giving up her weekends to be there, or caring for her grandad when he was unwell. She would do anything for anyone, no matter the personal cost.

It is difficult to put Nevaeh's life into words, especially as things became so dark after she struggled deeply during lockdown. But we do not want her to be remembered only for how she died, because she was so much more than that. We want people to remember how she made others feel—like when she would spend hours baking a cake, just to bring a smile to someone's face.

Nevaeh felt everything deeply and passionately. While this sometimes made life harder for her, it also made her incredibly compassionate. She was an empath in the truest sense, and we would not have changed that about her for anything.

She lit up every room she entered from the moment she was born. She had an amazing sense of humour and a loud, infectious laugh that people will never forget.

Nevaeh wasn't perfect - she had her diva moments—but she was also deeply caring and naturally nurturing. She always put others first and gave everything she had to those around her. She showed this time and again, whether it was supporting friends on the ward or insisting on taking her rabbit for walks around the Priory.

To our dearest Nevaeh, we will love you forever and always. You will not be forgotten for the person you truly were, and we will not stop fighting until the truth about your life is heard.



CONTENTS

1. Introduction 4
2. The Purpose of the SAR 5
3. Terms of Reference 5
4. Methodology 6
5. Key Lines of Enquiry (KLOEs) 7
6. Family Involvement 9
7. Narrative Chronology 10
8. Findings and Analysis 19
9. Conclusions and Recommendations 33
10. Appendix 1: Table of Recommendations 40
11. Appendix 2: Table of Single Agency Recommendations 41
12. Appendix 3: Table of Identified Good Practice 42
13. Appendix 4: Terms of Reference 44

1. INTRODUCTION

1.1 This safeguarding adults review (SAR) has been commissioned by the Bolton Safeguarding Adults Board (BASB) to extract the learning from the circumstances surrounding the death of Nevaeh in March 2024.

1.2 At the time of her death, Nevaeh was 18 years old. Nevaeh had been an inpatient with mental health services under Section 3 of the Mental Health Act 1983[1] since December 2021. Whilst an inpatient, Nevaeh's engagement with treatment was inconsistent and there were several occasions where she attempted to self-harm through swallowing objects, or by using ligatures.

1.3 In September 2023, one day after her eighteenth birthday, Nevaeh was transferred to the adult mental health ward at the Royal Bolton Hospital where she remained as an inpatient. On a date in mid-March 2024, Nevaeh was found in her room with a ligature tied around her neck. Despite the efforts of medical staff, Nevaeh sadly died.

1.4 Nevaeh's parents have requested that the review should use her true identity and not replace her name with pseudonyms. Whilst generally pseudonyms would be used in statutory review to maintain the anonymity of those involved, there are occasions where the relevant authority agree to such requests. In this case, the circumstances around Nevaeh's tragic death are relatively unique and would make Nevaeh, and her family, easily identifiable. On this basis, BSAB agreed to support this request, and Nevaeh's name has been used throughout the report.

1.5 Nevaeh was an adult who was known to have care and support needs and had died. There were reasonable grounds for concern about how agencies had worked together to safeguard her. Her death was therefore referred to the BSAB on 20 March 2024 for consideration of holding a SAR. The referral was considered by the BSAB SAR Sub Group, who determined that the criteria for a statutory review under Section 44 of the Care Act 2014, was met. The BSAB Independent Chair subsequently endorsed this decision.

1.6 Nevaeh had contact with a number of services prior to her death. Whilst this was primarily the Greater Manchester Mental Health Foundation Trust (GMMH), she also had contact with other health services, social care, and Greater Manchester Police (GMP).

1.7 Under Section 44 of the Care Act 2014, a Safeguarding Adults Board must arrange for there to be a review of a case involving an adult in its area with need of care and support, (whether or not the Local Authority has been meeting any of those needs), if:

- There is reasonable cause for concern about how the SAB, members of it, or other persons with relevant functions, worked together to safeguard the adult and

[1] Section 3 of the Mental Health Act is commonly known as treatment order, it allows for the detention of the service user for treatment in the hospital based on certain criteria and conditions being met. These are that the person is suffering from mental disorder and that the mental disorder warrants their care and treatment in hospital and also that there is risk to their health, safety of the service user or risk to others. It also requires that the treatment cannot be given without the order being in place and that appropriate treatment must be available in the setting where it is applied.

- the adult has died,
- and the SAB knows, or suspects that the death resulted from abuse or neglect, whether or not it knew about the abuse or neglect before the adult died, (neglect includes self-neglect).

Each member of the SAB must co-operate in, and contribute to, the carrying out of a review under this section with a view to:

i. identifying the lessons to be learned from the adult's case, and,
ii. applying those lessons to future cases.

2. THE PURPOSE OF THE SAR

2.1 The purpose of a SAR is to promote effective learning and improvement in order to prevent future deaths, or serious harm, from occurring again. The purpose is not to apportion blame to any agency or individual.

The objectives include establishing:

- lessons that can be learnt from how professionals and their agencies work together,
- how effective the safeguarding procedures are,
- learning and good practice,
- how to improve local inter-agency practice,
- service improvement or development needs for one or more services or agencies.

The lessons learned are shared by the partnership to maximise the opportunity to better safeguard adults with care and support needs who may be at risk of abuse or neglect.

3. TERMS OF REFERENCE

3.1 To use a full SAR methodology to identify any learning, including examples of good practice, from Nevaeh's case.

3.2 To consider the learning that emerges in light of what is understood already through national research or published SARs.

3.3 To work with the SAR panel to develop agreed multi-agency recommendations and key actions for the BSAB to consider.

4. METHODOLOGY

4.1 The Care Act 2014 guidance states that the process for undertaking a SAR should be determined locally according to the circumstances of an individual case, no one model will be appropriate in all cases. The focus should be on understanding what happened and why, what may need to change, and potentially, answers for the family and friends of the adult who has died or been seriously abused or neglected.

4.2 BSAB decided to use a full review methodology that engaged frontline practitioners and partner agency safeguarding leads. The review was facilitated by an Independent Chair and Overview Report Author. Chronologies collated during the initial scoping phase, together with other relevant information, were reviewed by the Independent Chair to determine the appropriate areas for enquiry. Partner agencies were then asked to review their own involvement with Nevaeh, and to provide a report detailing that involvement, good practice, learning, and suggested recommendations. A practitioner workshop was undertaken, which focussed on understanding the strengths of the current systems and sought to identify potential areas for further improvement.

4.3 The Independent Chair then worked with the SAR panel to develop agreed multi-agency recommendations and key actions for the BSAB consideration.

4.4 The timeline for the SAR was from 1 October 2021 until Nevaeh's death in mid-March 2024. However, agencies were also requested to provide a brief summary of any other historical information in relation to Nevaeh that was relevant to these terms of reference. Although the review was a SAR, it was recognised that Nevaeh was a child for most of the agreed timeline. Therefore the Children's Partnership were connected to the review.

4.5 The following agencies were identified as organisations who were involved in Nevaeh's care and support and as such, were expected to engage in the SAR process, including the completion of a single agency report and participation in the practitioner workshop event:

- Greater Manchester Police.
- Bolton Council Adult Social Care.
- Bolton Council Children's Social Care.
- Greater Manchester Mental Health Foundation Trust.
- NHS Greater Manchester Integrated Care Board.
- North West Ambulance Service Foundation Trust.
- Bolton NHS Foundation Trust.
- Education---School.
- Manchester University NHS Foundation Trust.
- Priory Hospital Cheadle Royal.
- Northern Care Alliance.

4.6 It was the responsibility of each participating agency to brief relevant managers and staff about the SAR, engaging them in the information gathering process, and once completed, to brief them on the outcomes of the review.

4.7 Each agency was asked to nominate a person to act as the single point of contact for the review and additionally, where required, a designated person to undertake the single agency report.

4.8 The workshop was structured to enable specific issues relating to Nevaeh's case to be considered and then, to allow time for focussing on broader themes identified in the review.

4.9 An important element of the SAR was to engage with Nevaeh's family, to encourage their contribution to the process and then, to share the findings with them prior to publication.

4.10 An Independent Chair has been commissioned, this is Chris Hogben, Invigor Consulting Ltd, who is completely independent from all of the agencies involved in this case.

5. KEY LINES OF ENQUIRY (KLOES)

5.1 The following KLOEs were examined as part of the review, they are not in any order of priority. Agencies were requested to complete a single agency report, using an agreed template, addressing each area covering good practice, learning and where appropriate, recommendations against each;

5.2 Multi-Agency Working/Safeguarding

How well did relevant agencies work together with a specific focus on:

- How risk management and safeguarding processes were applied?
- Were child/adult safeguarding referrals made?
- How effective was the safeguarding response?
- Was there evidence of multi-agency coordination?
- Was consideration given to using the Section 42 framework[2]?

5.3 Risk Management

- How effectively was risk identified by practitioners and what measures were taken to mitigate that risk?
- Were identified risks escalated appropriately?
- Were risk assessments completed in line with organisational expectation?
- Did any risk assessments fit with the risks identified and any decisions made?

[2] Section 42 Care Act 2014

- How effectively were risks communicated with other professionals and with Nevaeh's family?

5.4 Management of Home Leave (Section 17 MHA)

- Were Nevaeh's family involved in the risk planning for home leave?
- Were the appropriate agencies involved in risk planning around home leave?
- How effective was the risk management process in relation to the use of Section 17 MHA home leave in Nevaeh's case?
- Was any additional support offered to the family in advance of planned home leave?
- Please comment on the balance between safeguarding and therapeutic risk taking where appropriate.

5.5 Transitional Safeguarding

- Was there a clear transition plan in place for Nevaeh's transition from CAMHS[3] to adult mental health services?
- Was it appropriate for her to transfer to an adult inpatient ward at that time?
- Was it in her best interests to transfer to the adult inpatient ward at that time?
- Was the appropriate support in place to support Nevaeh's transition from Children's Social Care to Adult Social Care services?
- Were Nevaeh, her family and other professionals engaged in any transition plans?
- Was Nevaeh's voice heard and was she able to contribute to her care planning?

5.6 Deteriorating Health Conditions Including Mental Health

- How effectively were Nevaeh's mental and physical health needs met?
- Was the support/treatment provided in line with organisational expectations?
- To what extent were other professionals involved in supporting the treatment plan?
- To what extent were family members involved in understanding and engaged in, the treatment plan?
- Was Nevaeh's care managed in line with the NICE Self-Harm Pathway and the GMMH Trust Self-Harm Policy?
- Were Nevaeh's care and support needs assessed and appropriately met?

5.7 Information Sharing

- Did practitioners share information with partner agencies appropriately?
- Did practitioners pro-actively seek information from partner agencies, particularly to support the risk assessment process?

[3] Child and Adolescent Mental Health Service

5.8 Trauma Informed Practice

- Did practitioners understand the potential impact of previous trauma on Nevaeh's physical and mental health?
- If previous trauma was identified, how did this impact on practitioners' approach to supporting Nevaeh?
- Did previous trauma impact on Nevaeh's ability to engage with services?

5.9 Safeguarding Children

- Was consideration given to the young person being a child at risk of significant harm?
- At which point of their journey was this considered and what was the rationale/outcome of this?
- Were decisions reviewed?

6. FAMILY INVOLVEMENT

6.1 Letters explaining the review process, introducing the Independent Chair, and explaining how family members could contribute to the review were sent to Nevaeh's mother and father. Nevaeh's parents met with the Independent Chair and provided valuable information to support the process. The Independent Chair shared the terms of reference with them and undertook to share the findings of the review with them at the conclusion of the process.

6.2 Nevaeh's parents had described Nevaeh as an amazing and often funny teenage girl who had a strong love of animals. This included a pet rabbit who they would often take into hospital to see Nevaeh. She had also been given a dachshund puppy for her eighteenth birthday. Her parents explained that Nevaeh had a real love for travel. She had loved going to America, in particular, Florida. She had also drawn up a list of the countries that she would like to visit, this was a list of about 25 countries, including China and Iceland. Her parents had booked a trip to New York for Nevaeh's eighteenth birthday, but sadly, this was a dream that she was unable to fulfil.

6.3 Prior to her admission to hospital, Nevaeh had lived at home with her parents and two siblings. She had worked hard at school, but had not been able to take her exams due to her hospital admission. Her parents informed the review that Nevaeh had not experienced any significant trauma during her childhood years. They did however, describe the challenges that Nevaeh had faced in coping with the COVID-19 pandemic restrictions, particularly the lock down periods.

6.4 Her parents spoke about the difficulties that Nevaeh seemed to have in dealing with her relationship with her sibling. Her parents believed that it was her inability to cope with her relationship with her sibling, exacerbated by the pressure and confinement of the COVID-19 lockdowns, that had caused Nevaeh's mental ill health.

6.5 Nevaeh's parents described Nevaeh as wanting to help and support people in the future. She was very keen to train to become a paramedic and in her mother's words, spoke about this constantly. They also described Nevaeh as being a very intelligent

young lady, who with the right support, could have achieved anything that she wanted to.

6.6 Nevaeh's parents provided a tribute to her which can be found at the beginning of the report (page 3). They requested that Nevaeh's true identity be used throughout the report and provided a picture of Nevaeh to be included within the report. This was agreed by the BSAB.

6.7 Following the SAR report being approved by BSAB, it was shared with Nevaeh's family.

7. NARRATIVE CHRONOLOGY

7.1 The Relevant Period

This is a summary of the narrative chronology:

7.2 1 October to 31 December 2021

In October, Nevaeh was referred to the CAMHS Rapid Response Team [4] (RRT) due to concerns about the level of risk of her self-harming. The review noted that she had previously been referred to the RRT in June 2021.

On 12 October, Nevaeh's mother contacted the GP by telephone to express concerns about Nevaeh. This included an escalation of her expressing suicidal ideation. She was advised by the GP to take Nevaeh to the Emergency Department (ED).

On 14 October, Nevaeh's mother spoke to the GP about her concerns for Nevaeh. She was advised to take Nevaeh to the ED. The GP also shared information with CAMHS.

On 15 October, Nevaeh was admitted to ED after refusing to eat/drink and expressing suicidal ideation. Nevaeh was discharged with planned follow up from the Home Based Treatment Team (HBTT).

On 17 October, Bolton Council Children's Social Care (CSC) received a referral from Nevaeh's school. They reported that there were concerns about Nevaeh's mental health, that she was refusing to eat, and she had been hospitalised. The referral also informed CSC that Early Help were supporting Nevaeh's family.

In late October, Nevaeh was assessed by the RRT and a decision made that the risk to Nevaeh could not be managed safely in the community. She was admitted to the Royal Bolton Hospital (RBH). Nevaeh was discharged at the end of October with a plan for her to be supported by the HBTT.

On 9 November, Nevaeh was reviewed by a CAMHS practitioner.

[4] The RRT are a service that forms part of the Children and Young People Greater Manchester Crisis Care Pathway. They can provide intensive support for a period of up to 72 hours, in a community setting, to children and young people who present with a mental health crisis and who are at risk of admission to ED or Tier 4 CAMHS inpatient services.

On 14 November, Nevaeh was admitted to the Critical Care Unit (CCU) after a reported overdose. Nevaeh was subsequently transferred to a tier 4[5] bed at the Priory Hospital Cheadle Royal (PHCR). Nevaeh would not accept treatment and was initially detained under Section 5(2) Mental Health Act (MHA) 1983[6]. Following a mental health assessment, it was decided to detain her under Section 2 MHA[7] .

Between 15 November and 14 December, Nevaeh remained very unwell in hospital and had been refusing treatment. This led to her being placed in an induced coma to enable her to be treated for the overdose.

On 15 November, the police submitted a safeguarding referral to CSC reporting that Nevaeh had taken an overdose involving 74 paracetamol and 8 Anadin tablets. She had also cut her wrists. Nevaeh remained open to CSC from this date until she turned 18 in September 2023.

On 17 November, CSC held a strategy meeting with relevant partner agencies. A decision was made that the significant harm threshold was not met as Nevaeh's immediate needs were being addressed. It was agreed that a Child in Need (CIN) plan would be initiated.

On 10 December, Nevaeh was assessed under the Mental Health Act. It was determined that she would now be detained for treatment under Section 3 MHA. She was initially transferred to a tier 4 bed at the PHCR. She was then transferred to the Wythenshawe Hospital[8] due to her physical health needs. Once her physical health was stabilised, she was returned to the PHCR for mental health care on 13 December.

On 29 December, Nevaeh was taken to the Wythenshawe Hospital ED after swallowing three batteries which were removed by a surgical intervention. The nursing staff submitted a safeguarding referral to CSC.

7.3 1 January to 31 December 2022

On 24 January, CSC completed a Child and Family Assessment. The assessment noted that Nevaeh had made what were recorded as six suicide attempts using clothing as a ligature since returning to the PHCR. Nevaeh had been refusing to comply with her medication, diet plan, or her schoolwork. It was decided that the only role for CSC was providing an overview for the CIN plan. It was accepted that this would change when Nevaeh was discharged from her Section 3 MHA detention.

---

[5] Tier 4 units provides highly specialised day and inpatient care where young people with more severe mental ill health can be assessed or treated. This can be as a voluntary admission or where the patient has been detained under the MHA.

[6] Section 5(2) MHA provides a power for doctors or other medical professionals to detain a person for up to 72 hours for the purpose of completing an assessment to enable a decision about possible further detention under Section 2 or 3 MHA.

[7] Section 2 allows for a person to be admitted to hospital, for up to 28 days, to complete an assessment of their mental health

[8] The Wythenshawe Hospital is part of the Manchester University NHS Foundation Trust

On 11 February, Nevaeh was brought to the Wythenshawe Hospital ED following an incident of self-harming with a ligature. As there were no clinical concerns, she was discharged back to the PHCR.

On 24 February, Nevaeh's siblings were closed to CSC as there were no concerns for them.

On the same day, Nevaeh had attended the Wythenshawe Urgent Care Centre having hurt her hand whilst punching a wall. She was treated appropriately and discharged back to PHCR.

On 1 April, Nevaeh was brought to the Wythenshawe Hospital ED with a head injury caused by deliberate self-harm. She was treated appropriately and discharged back to PHCR the following day.

On 5 April, Nevaeh went home on seven days home leave to assess whether she could be discharged home. The following day, a CSC social worker visited Nevaeh at home. Nevaeh reported that she was happy to be at home.

Later the same day, Nevaeh left her parents' home address and her mother informed CSC. CSC informed the police and relevant professionals. Nevaeh was found by the police and returned to the PHCR.

On 7 June, Nevaeh attended a GP appointment with her mother whilst on home leave. Nevaeh reported experiencing a tight chest during periods of high emotional stress. This was treated appropriately and information shared with staff at the PHCR.

On 22 June, CSC completed a second Child and Family Assessment. Having gathered information from Nevaeh's family, it was noted that there was no reason to believe that her decline in mental health was as a result of adverse childhood experiences (ACEs) or parental deficit. It was agreed that there were no reasons to prevent Nevaeh returning to her parent's home when her mental ill health allowed.

On 27 June, Nevaeh was admitted to the Stepping Hill Hospital (SHH)[9] ED following an overdose of co-codamol tablets. No medical treatment was required. Her mental health was not reviewed as she was being discharged back to the PHCR.

On 17 July, the police were called to Nevaeh's parents' home after Nevaeh suffered a mental health crisis. Nevaeh was threatening to self-harm. She was conveyed back to the PHCR by the attending police officers.

On 18 July, Nevaeh was brought to the Wythenshawe Hospital ED having said that she had swallowed a tin can lid. Her chest and abdomen were x-rayed and no object was identified. She was discharged back to PHCR.

On 29 July, whilst on home leave, Nevaeh attended an appointment with the GP Practice asthma nurse to assess her use of an inhaler. This was the last time the GP practice had contact with Nevaeh.

Later the same day, Nevaeh tried to leave her parents' home and stood in front of traffic. She was restrained by her father.

[9] The SHH is in Stockport

On 31 July, the police were called to Nevaeh's parents' home after a report that Nevaeh was on home leave and had tried to step in front of traffic. The attending police officers conveyed Nevaeh back to the PHCR.

On 10 August, CSC records documented that a professionals meeting determined that if Nevaeh's home leave was successful, and she was confirmed as medically fit for discharge, a therapeutic placement would be needed. The meeting documented that Nevaeh's case should be discussed at a complex case panel to seek funding to support the placement.

On 20 October, an Adolescent Resource Centre (ARC)[10] intervention was commenced with Nevaeh's mother. This was designed to support her in parenting for Nevaeh whilst on home leave and if the home leave had been successful, when Nevaeh was discharged to her parents' home.

On 30 October, Nevaeh was admitted to the SHH ED having swallowed 4 batteries. She was discharged from ED with a plan for a follow up x-ray to monitor the progress of the batteries through her intestines.

On 3 November, Nevaeh attended the SHH ED after inserting the inner part of a biro in her left forearm. She was discharged with advice provided to her carers about infection control.

On 8 November, Nevaeh attended the SHH ED after inserting a piece of plastic in her left wrist. The wound was infected. An appropriate dressing was applied and Nevaeh was provided with anti-biotic medication.

On 14 November, Nevaeh was brought to the Wythenshawe Hospital ED with an infected wound to her wrist. This was an injury caused a week previously. A surgical intervention was required. She was discharged back to PHCR three days later.

On 26 November, Nevaeh was brought to the Wythenshawe Hospital ED for a wound review. This was completed and no concerns were identified. She was discharged back to PHCR.

On 29 November, a CSC social worker completed a CIN visit to Nevaeh at the PHCR. Nevaeh was noted to be in very low mood. A residential placement was no longer thought appropriate, but there were no other options available.

7.4 1 January to 31 December 2023

On 14 January, Nevaeh was moved from the PHCR to Junction 17[11]. Nevaeh was visited by a CSC social worker at Junction 17. The CSC records noted that there had been several self-harm incidents involving swallowing items and the use of ligatures.

On 5 February, Nevaeh attended the Salford Royal Hospital (SRH) ED, accompanied by a carer from Junction 17. Nevaeh had inserted foreign bodies into a wound on her arm. She was then discharged back to Junction 17 with a plan for her to be admitted

[10] Adolescent Resource Centre, the ARC provides a range of services for young people and their families

[11] Junction 17 is a general adolescent unit provided by GMMH

to day surgery two days later. She was given infection advice and anti-biotic medication.

On 7 February, Nevaeh was admitted to the SRH Day Surgical Unit to have the foreign bodies removed. She was then discharged back to Junction 17. Information was shared with her GP with a request for a follow up appointment.

On 27 February, Nevaeh was noted to have tried to leave her parents' home whilst on home leave. She had been restrained by her parents in a nearby street. The police attended and conveyed Nevaeh back to Junction 17.

On 28 February, Nevaeh attended the SRH ED, accompanied by two carers from Junction 17. She had swallowed a number of metal objects and had caused superficial injuries to her forearms. She was discharged back to Junction 17 following the appropriate treatment.

On 17 March, the police were called by carers who had been escorting Nevaeh outside of the hospital premises. Nevaeh had made off from the carers and was believed to be heading for a motorway bridge. The police located Nevaeh at the bridge and detained her to prevent her from harming herself. She was conveyed back to Junction 17. Information was shared with CSC and CAMHS by the police.

On 23 March, Nevaeh was reported to the police as missing from Junction 17. The police located Nevaeh on a bridge over the M60 motorway. A police negotiator and GMMH staff supported Nevaeh to come back from the edge of the bridge. Nevaeh was conveyed to Junction 17 by North West Ambulance Service Foundation Trust (NWAS) staff. There was no safeguarding referral submitted as Nevaeh was an existing Section 3 MHA patient.

Between April and December, NWAS conveyed Nevaeh to ED, (various hospital locations), on 18 occasions. Primarily this was from Junction 17, although there was one occasion in October, when she was conveyed from Oak Ward.

On 4 May, a CSC social worker completed a CIN visit to Nevaeh at Junction 17. Nevaeh was recorded as stating a determination to end her life and that she wanted to be at home so that she could carry this out. It was noted that the social worker discussed her transition to adult services with her as she was approaching 18 years of age.

On the same day, the North Manchester General Hospital (NMGH) Children's Safeguarding Team raised a safeguarding concern with CSC as Nevaeh had attended acute services four times within one month. These admissions were whilst she was in GMMH care under Section 3 MHA.

In July, a home leave plan was commenced. This involved short periods of four hours escorted leave. Progress was monitored through weekly reviews at multi-disciplinary team (MDT) meetings and regularly discussed with Nevaeh's family. It was also noted that the adult services CMHT allocated Nevaeh a care coordinator.

On 12 July, Junction 17 staff held an urgent meeting to discuss discharging Nevaeh to her home address as she was considered too high risk to remain on the ward. CSC were against this as Nevaeh was assessed as being too high risk when at home.

Nevaeh was documented as being on two person observations at this time due to her high risk of self-harming. Nevaeh was not discharged from Junction 17.

GMMH records documented that from mid-July, there were weekly professionals meetings to plan Nevaeh's transition to adult inpatient services. A referral was made to the Psychiatric Intensive Care Unit (PICU).

On 24 July, the GMMH records documented that Nevaeh's observation levels had been reduced to one to one supervision and that her home leave plan was going well. It was acknowledged that allowing overnight home leave was unrealistic due to the risk of self-harming. The consultant psychiatrist explained to Nevaeh why the one to one observations had to continue.

On 27 July, a CSC social worker completed a CIN visit to see Nevaeh whilst she was on home leave. Nevaeh was spoken to with her mother. Nevaeh informed the social worker that the plan to discharge her to her parent's home was putting too much pressure on her. She said that she was not ready for this. Her mother also raised a concern about Nevaeh's physical health as she appeared to have no energy.

On 8 August, GMMH records documented that the risk of self-harming remained, and that Nevaeh's mother was anxious about overnight leave. It was noted that Nevaeh had expressed concerns about being transferred to an adult inpatient ward if she was not deemed safe for a discharge to her parents' home. It was also recorded that although Nevaeh's risk level was suitable for a PICU admission, she did not meet the criteria for the PICU pathway due to the need for long term psychological work.

On 12 August, Nevaeh was admitted to the SRH ED with a reported self-inflicted head injury. She had x-rays and was then discharged back to Junction 17. Information was shared with CSC.

On 15 August, GMMH records documented that staff were struggling to manage Nevaeh's self-harming and that she was continuing to require restraint. Nevaeh had been requesting a medication change. It was agreed to trial the use of zuclopenthixol[12]. Practitioners recorded that although the long term plan to discharge Nevaeh to her parents' home remained, this was not going to be achieved in the short term. It was agreed that a referral would be made to an adult ward two or three weeks before Nevaeh's eighteenth birthday.

On 22 August, the GMMH records documented that Nevaeh had requested access to her medical records from her previous mental health provider. The MDT determined that it might be destabilising for her so close to her transfer to adult services and therefore, it was not in her best interests to have access to the records. This was explained to Nevaeh by GMMH staff.

On 29 August, the police were informed that Nevaeh had left Junction 17 without permission. She was located on a bridge over the M60 motorway in a very distressed condition. She had also been headbutting the bridge railings and cutting her wrists with a piece of metal. She was detained by the police and taken to the RBH by NWAS, to have her physical injuries treated prior to being returned to Junction 17.

[12] Zuclopenthixol is a medication used to treat schizophrenia and other forms of psychosis

On 4 September, a CSC social worker completed a CIN visit to see Nevaeh at Junction 17. The CSC records documented that there was a plan to manage Nevaeh's transition to adult services.

On 5 September, the GMMH records documented that Nevaeh's risk of self-harming continued. It was noted that Nevaeh's engagement with leave planning had been poor following her parents' return from holiday. Nevaeh had been refusing medication, and her home leave had been cancelled due to the ongoing incidents of self-harming.

On 12 September, the GMMH records noted a reduction in self-harming incidents and that Nevaeh was taking her medication. She was also engaging with her occupational therapist (OT) and completing her college work.

On 19 September, the GMMH clinical team agreed that a home discharge was not a suitable option for Nevaeh. The bed manager for adult inpatient in services confirmed that there was a bed available for Nevaeh. Her transfer to Oak ward was planned for the day after her eighteenth birthday.

On the same day, Nevaeh had been taken to the NMGH ED following a self-harming incident. It was noted that the previous seven attendances had not resulted in safeguarding concerns being raised. The NMGH Children's Safeguarding Team raised a safeguarding concern with CSC.

On a date in late September, Nevaeh was transferred to Oak Ward which is an adult inpatient mental health ward at the RBH. This was one day after her eighteenth birthday.

The Oak Ward records documented that they maintained the home leave plan initially, and with Nevaeh's family's consent, started to reduce the observation levels.

On 6 October, Nevaeh was admitted to ED after having swallowed a metal disc whilst an inpatient on Oak Ward. She was discharged back to Oak Ward after the appropriate treatment.

On 19 October, during an unescorted leave period, Nevaeh contacted the ward and informed them that she had taken an overdose of 64 paracetamol. She was located by the police and conveyed to RBH ED by NWAS. Nevaeh declined treatment whilst in ED and the clinical team completed a Mental Capacity Act assessment. Nevaeh was considered to not have the capacity to make decisions about her care and treatment. It was determined that it was in her best interests to be sedated and treated within the Intensive Care Unit (ICU).

On 3 November, Bolton Council Adult Social Care (ASC) received a safeguarding referral from the RBH. Concerns were raised about the appropriateness of the health care and support provided to Nevaeh by GMMH following her self-harming. Nevaeh had been admitted to the RBH Intensive Care Unit.

On the same day, an ASC social worker spoke to staff at the RBH to discuss concerns about how Nevaeh had obtained the tablets for an overdose. A Section 42 enquiry was opened by ASC.

On 16 November, Nevaeh was discharged back to Oak Ward. It was noted that Nevaeh told practitioners that the overdose was not planned. She stated that she was struggling when she was away from the ward on her own. It was also reported that

Nevaeh's mother had expressed concerns about Nevaeh returning to Oak Ward as she did not feel the plan for unescorted leave was safe. She requested that Nevaeh was moved to an alternative ward. The GMMH records documented that the Oak Ward manager spoke to another local female adult acute ward to explore a potential transfer on discharge from ICU. However, Nevaeh had reflected that she would prefer to transfer back to Oak Ward.

On 22 November, an MDT was informed by Nevaeh that she would like to be discharged to her parents' home rather than to supported accommodation. This was supported by her family. A plan was agreed to try and build up her home leave gradually in preparation for discharge.

On 27 November, practitioners from GMMH completed a carer's assessment[13] in line with the responsibility on GMMH under the Section 75 agreement[14] that was in place at that time.

On 8 December, Nevaeh was reported as having left her parents' home whilst on home leave. She was being followed by her care worker. The police located her in a woodland area. Nevaeh was adamant that she did not want to go back to Oak Ward. However, she was returned there by the police.

On 16 December, Nevaeh attempted to leave her parents' home whilst on home leave. Her parents struggled to stop her leaving and contacted the police for help. Police officers attended and after speaking to Nevaeh and to her mother, they conveyed Nevaeh to Oak Ward.

On 18 December, the RBH Safeguarding Lead contacted ASC to enquire about the progress of the Section 42 enquiry. It was noted that it had not been allocated.

On the same day, Nevaeh absconded from Oak Ward after attempting to harm herself with ligatures and then by swallowing batteries. She was located by the police and returned to Oak Ward.

On 22 December, Nevaeh tried an overnight home leave but she struggled to cope with this. Nevaeh was taken to ED having swallowed a battery. She subsequently left ED. This was reported to the police who located Nevaeh and returned her to ED. After being treated within ED, Nevaeh was discharged back to Oak Ward.

7.5 1 January to Mid-March 2024

In January, the MDT on Oak Ward continued to try and build relational security with Nevaeh through one to one time and engagement in activities on and off the ward. There were efforts to engage Nevaeh in psychology to help her gain insight into some of the drivers behind her risk behaviours, and to help her manage this differently. However, engagement with psychology was documented as being challenging and sporadic. It was noted that incidents of self-harming continued.

---

[13] Section 10 Care Act 2014

[14] Section 75 of the 2006 National Health Service Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

On 4 January, the staff at Oak Ward reported Nevaeh missing to the police. She had been given an hour's leave, but had telephoned the Ward to inform them that she had taken an overdose of 32 paracetamol tablets, and that she was now lost. The police located Nevaeh on a bus and returned her to Oak Ward.

On 6 February, ASC reviewed the Section 42 enquiry. It was noted that it had not been allocated after 8 weeks. ASC contacted the RBH to ascertain if Nevaeh had been returned to the care of GMMH as they had not been informed of Nevaeh's discharge from hospital in November 2023.

On the same day, a hospital manager's review of Nevaeh's ongoing detention under Section 3 MHA, noted that a recent Mental Health Review Tribunal recommended that the responsible clinician should consider referring Nevaeh to a unit specialising in the treatment of patients with personality disorders. Concerns were also raised by Nevaeh's family that Nevaeh had not been considered for a specialist personality disorder unit. However, the MDT at Oak Ward did not believe that this was an appropriate course of action for Nevaeh. This was because Nevaeh was consistently reporting a wish to work towards better management of her self-harming and her discharge back to her parents' home. It was also noted that such units are not evidence based in their approach and are therefore, unlikely to receive funding. The MDT continued to work towards building up leave, encouraging Nevaeh to engage in an occupational therapy assessment, and to develop her ability to manage her self-harming with a view to securing a supported accommodation placement within the local community.

On 5 March, Nevaeh was admitted to ED after a reported paracetamol overdose. The BFT records suggest Nevaeh declined treatment. However, Nevaeh's lack of consent for treatment was overridden and treatment was provided in line with Section 63 MHA 1983[15]. A safeguarding adults referral was made.

On the same day, ASC received the safeguarding referral, but there was no follow up with GMMH.

On a date in mid-March, NWAS conveyed Nevaeh from Oak Ward to ED after she was located with a ligature around her neck and she was then unresponsive. Advanced life support was undertaken. On arrival at ED, Nevaeh was presented to the Resuscitation Team and further attempts to resuscitate her were made. Sadly, Nevaeh was found to be deceased.

[15] Section 63 MHA 1983 enables a patient detained under the Mental Health Act to be compulsorily treated for any disorder from which they are suffering. (R (B) V Ashworth Hospital Authority (2005), UKHL 20

8. FINDINGS AND ANALYSIS

8.1 Multi-Agency Working/Adult Safeguarding

Although there were many examples of good information sharing between agencies, there was limited evidence of safeguarding referrals being used to raise concerns about the risks that Nevaeh faced.

The police had contact with Nevaeh on a number of occasions, primarily where she had either left from her parents' home and was at risk of self-harming, or where she had self-harmed whilst on leave from her Section 3 MHA detention. Officers would have been aware of her mental ill health and the risk of self-harm to Nevaeh, yet there was an inconsistent approach to child or adult safeguarding referrals being submitted to the relevant social care agency. There were also occasions where safeguarding referrals were created, but not submitted to the relevant social care agency. The review identified that there were management directions in some policing districts, that safeguarding referrals would not be submitted to partner agencies when the person has been received back by the relevant agency. This direction was not in line with the GMP force policy. The review recognised that the GMP Organisational Learning Board had, in August 2022, directed that the police Safeguarding Triage Team should refer mental health related safeguarding referrals to partner agencies even if the person has been taken to a health care setting, or transferred to NWAS. This decision had been included within triage training for district safeguarding teams.

The review noted that although NWAS had contact with Nevaeh on many occasions, most of which related to incidents of self-harming, their practitioners did not identify the need to raise safeguarding concerns in relation to the risks that Nevaeh faced. NWAS confirmed that their practitioners do not routinely raise safeguarding concerns when dealing with mental health presentations. NWAS encourage their staff to engage with the specialist local mental health teams in the patient's area to facilitate the right acute support or pathway of care, unless it is clear that robust specialist support is already in place.

The review recognised that NWAS practitioners, and police officers, undoubtedly encounter individuals experiencing mental ill health on a regular basis. However, the review determined that where a young person, either as a child or young adult, faces significant risk from an escalating pattern of self-harming, that services consider the safeguarding risk as a cumulative factor that may require a safeguarding referral to the relevant social care team for a safeguarding assessment. This should be regardless of the perceived involvement of other agencies where known. In Nevaeh's case, she clearly presented as a high risk of self-harm, and the fact that she was subject of a Section 3 MHA detention should not have excluded her from being the subject of safeguarding concerns.

The Section 75 agreement placed the responsibility for assessing and managing Nevaeh's care and support needs upon GMMH. The responsibility for this would sit with her care co-ordinator. The review has not seen evidence of any safeguarding referrals submitted by GMMH practitioners with respect to Nevaeh. The GMMH records have documented that a carer's assessment was completed with Nevaeh's mother in November 2023. However, the responsibility for adult safeguarding under

the Care Act 2014, would have remained with the local authority, despite the existence of the Section 75 agreement.

The review considered whether Nevaeh may have met the threshold for an enquiry under Section 42 of the Care Act 2014[16] whilst she was an adult inpatient. Section 42 of the Care Act places a statutory duty to cooperate on agencies, initiating cross-agency information sharing, a better-informed risk assessment, and enables a multi-agency risk management plan to be implemented.

The criteria for a Section 42 enquiry is:

- Were there reasonable grounds to suspect that the adult has care and support needs?
- Were they at risk of abuse or neglect? (Neglect would include self-neglect).
- Does the adult have ability to protect themselves from the abuse or neglect? (Where this relates to self-neglect, the statutory guidance is termed as 'the ability to protect themselves by controlling their own behaviour').

In Nevaeh's case, she had care and support needs, primarily relating to her mental ill health. She was not identified as being at risk of abuse but was vulnerable to self-neglect. The increased risk of self-harm represented an escalation from her usual presentation and was attributable to the complexity of her presentation, rather than the level of care provided. However, practitioners may have considered whether the available care was sufficient to respond to the heightened risks at that time. The review recognised that her mental ill health, and increasing level of risk due to the frequency and seriousness of self-harm in a secure setting, would have made it unlikely that she would have been able to protect herself from the risk of neglect or self-neglect.

In late 2023, practitioners at the RBH submitted an adult safeguarding referral to ASC after Nevaeh was admitted to ED and subsequently, to ICU, following an intentional overdose. Identifying the need to submit a safeguarding referral for Nevaeh to raise concerns about her health and care whilst subject to the Section 3 MHA detention was seen as good practice by the review.

Following the receipt of the safeguarding referral from staff at the RBH in late 2023, ASC initiated a Section 42 enquiry. The review recognised that the decision to initiate a Section 42 enquiry on the basis of an overdose, and the fact that Nevaeh had sustained a serious injury, was good practice. This decision was made, despite that fact that Nevaeh was in the care of GMMH and subject to Section 3 MHA.

However, although the decision making was identified by the review as good practice, it was noted that some eight weeks later, the Section 42 enquiry had not been allocated to a social worker to progress. There was no ASC involvement in the discharge planning when Nevaeh left RBH to return to Oak Ward in November 2023, and there had been no follow up with GMMH following Nevaeh's return to Oak Ward. This was a significant missed opportunity for ASC to understand how GMMH were supporting

[16] Section 42 of the Care Act 2014 states the duty of the local authority to cause enquiries to be conducted where an adult has care and/or support needs, is at risk of abuse or neglect, and is unable to protect themselves from that abuse or neglect.

Nevaeh, what her diagnosis was, and to better understand what was being done to mitigate the risks that Nevaeh faced.

The review noted that Bolton Council had an arrangement in place with GMMH under Section 75 of the National Health Service Act 2006. This agreement transferred the responsibility for adult social care in cases involving an adult aged 18 to 65 years old who had a mental health condition, to GMMH. The agreement had been in place for many years prior to the period subject to the review. The responsibility for adult social care returned to Bolton Council ASC in early December 2025. The review recognised that the responsibility for adult safeguarding under the Care Act 2014, would have remained with the local authority, despite the existence of the Section 75 agreement.

8.2 Risk Management

It was clear to the review that the risk to Nevaeh from self-harm was recognised by GMMH practitioners. There were risk management plans in place at both Junction 17 and Oak Ward. There was a significant challenge for the relevant MDT to balance the need for positive risk taking, using the least restrictive practice and where appropriate, enhanced observation. The use of therapeutic engagement[17] and observations are one of a range of interventions that can contribute to mitigating risk for the patient in their recovery journey. However, they are potentially highly intrusive and restrictive. They can therefore lead to harm and trauma if not used correctly. The review noted that the consultant psychiatrist had reported that increasing the observation levels would have been contrary to the overall plan, which was for Nevaeh to gain more independence and responsibility.

The internal Serious Incident Review (SIR)[18] completed by GMMH identified that Junction 17 and Oak Ward managed the risk of self-harm to Nevaeh in very similar ways. In particular, their risk management plans sought to empower Nevaeh to take responsibility for her self-harming. Both wards demonstrated collaborative safety planning and risk management planning, involving Nevaeh in the process. They also worked with Nevaeh to develop alternative coping strategies. However, they did have different thresholds for the use of more restrictive interventions.

Junction 17 used a more restrictive approach to managing Nevaeh's self-harming, although it was recognised that their staff provided a clearly documented rationale to record their clinical decision making. When Nevaeh was transferred to Oak Ward, her self-harm plan remained consistent with that used at Junction 17 initially. However, Oak Ward then worked with Nevaeh to reduce the therapeutic observation levels and developed their own risk management plan. The review noted that both wards had used good practice in the way that they had worked to manage the risk of self-harm.

---

[17] Effective therapeutic engagement is viewed as a partnership relationship between staff and patients, with shared decision making and recovery focussed goals. https://www.cqc.org.uk/guidance-providers/mhforum-ligature-guidance/overview/therapeutic-engagement

[18] Serious Incident Review.--- Serious incidents in health care are events 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 a review to ensure these incidents are identified correctly, investigated thoroughly and, most importantly, trigger actions that will prevent them from happening again. These reviews do not seek to assign blame or hold individuals to account.

There were clearly documented risk management plans in place, however, they could have been enhanced had GMMH adopted the self-harm tool kit within their risk management plans, that was guidance at the time.

The review recognised that GMMH have withdrawn their Self-Harm Tool Kit since 2024, as it was seen as being a stand-alone tool that was not linked to the full risk assessment. Staff are now expected to record all risk related information within a clinical risk and safety plan (CRASP). The CRASP has a section within it that specifically covers self-harm.

The review recognised the very clear challenge for mental health professionals in balancing the risk of self-harm to Nevaeh, and working towards helping Nevaeh to achieve her identified goal of being discharged to her parents' home. The GMMH practitioners looked to use escorted leave and where appropriate, unescorted home leave, as part of a longer term plan to support Nevaeh in being able to be safely discharged home. Generally, the home leave went well, however, there were occasions where there were incidents involving self-harming or Nevaeh would become distressed and sought to leave her parents' home. One incident led to Nevaeh's father having to restrain Nevaeh after she had left her parents' home and was at risk from on-coming road traffic. Following this incident, Nevaeh declined to see her parents for a period of time and her self-harming on the ward increased significantly.

During October 2023, Nevaeh was given unescorted leave for short periods, but on one occasion, she took an overdose. Home leave was considered, but Nevaeh's family had reported being unable to cope with her self-harming. The MDT determined that it was unreasonable to put her family in a position to manage the risk to Nevaeh when professionals had assessed the risk of self-harming to be high. As a result of this assessment, Nevaeh was not granted leave for a period of time. The review noted that Nevaeh had been given unescorted leave again in January 2024, but she had taken a further overdose. The review recognised that escorted leave was used for Nevaeh in order to build her confidence when she was away from the ward environment. Her response to escorted leave was then part of the risk assessment when considering unescorted leave.

The review identified that Nevaeh's family had complained to GMMH that the restricting of leave was, in their view, being used in a punitive way and as a bargaining tool. Her parents believed that this had caused Nevaeh distress. GMMH professionals had accepted that the restricting of leave may have appeared punitive, but had explained to her parents that it was necessary, due to the level of risk of self-harm that had to be managed.

The review recognised that risk planning and management was led and overseen through MDT meetings, which was seen as good practice. It was also noted that for much of the time that Nevaeh was an inpatient with GMMH services, her parents were involved in MDT meetings and ward assessments. Unfortunately, the relationship between Nevaeh's parents and professionals deteriorated towards the later stages of her admission, and their participation in decision making was less frequent.

8.3 Management of Home Leave (Section 17 MHA)

Home leave under Section 17 MHA 1983[19] enables the responsible clinician to authorise a patient who is detained under the Mental Health Act, to leave the hospital for an agreed period of time as part of their care and recovery. Conditions can be attached to this leave and the patient can be recalled to the hospital in certain circumstances. The home leave could involve the patient being escorted whilst away from the hospital. The use of home leave can be a tool for the responsible clinician to test the patient and to assess risk.

In Nevaeh's case, home leave was used on many occasions throughout the period of her detention under Section 3 MHA. The use of home leave to try and support Nevaeh in achieving her goal of being discharged to her parents' home, would be seen as good practice. However, the review recognised the very significant challenges that practitioners faced in balancing the use of leave, whether escorted or unescorted, against the risk of Nevaeh self-harming. The management of risk whilst actively seeking to develop and support Nevaeh's confidence when outside of the ward environment, is considered in detail within section 8.2 of this review.

The minutes of the multi-agency care planning meetings provide evidence of cross agency planning in relation to Nevaeh's home leave. The CSC files documented the concerns expressed by Nevaeh's mother about the home leave. The CSC social worker completed CIN visits to see Nevaeh at her parents' home during her periods of home leave. There was also additional support provided by the ARC from October 2022, to help Nevaeh's mother to manage Nevaeh's complex needs whilst on home leave. However, from the second ARC meeting onwards, it appears that the focus was on supporting Nevaeh's mother to manage crisis due to ongoing incidents that occurred during home leave periods.

8.4 Transition to Adult Services

The review has not been sighted on a plan for Nevaeh's transition to adult services. CSC records documented a planning meeting in August, just a month before her 18th birthday but there is no detail of any options considered or decisions made. There was no record of any social care input to her transition from Junction 17 to adult mental health services. It was noted that CSC had some input in July 2023 when Junction 17 were considering discharging Nevaeh back to her parents' home as she presented such a high risk of self-harming on the ward. However, the review recognised that the Section 75 agreement placed the responsibility for meeting Nevaeh's care and support needs as an adult, with GMMH services. Bolton Council ASC only became involved when a safeguarding requirement was identified.

The first references to Nevaeh's transition to adult services within CSC records began about four months before her eighteenth birthday. There was a referral made to ASC[20] and the CIN plan remained in place until Nevaeh actually turned 18. There was a record of a meeting that took place between CSC and ASC in August 2023, (about a

[19] https://www.legislation.gov.uk/ukpga/1983/20/section/17

[20] Although there is reference to a meeting with ASC within CSC records, it is unclear to the review if this was Bolton ASC, or adult social care services provided by GMMH.

month before Nevaeh's birthday). However, the review could not find any record of what was discussed, or any subsequent plan for her transition. The last CSC visit to Nevaeh was completed in September 2023. The CSC records stated that there was a plan for Nevaeh to transition to adult services, but there was no detail recorded.

The Serious Incident Review (SIR) carried out by GMMH in 2024 observed that *'locally, regionally and nationally, there is poor provision of age and developmentally appropriate in-patient services for children transitioning to adult services when they turn 18 years old'. The SIR further commented that 'Age is factored into the decision making and the need to transfer to an adult acute ward for long term care, it is uncertain whether this is the most appropriate environment as all 18-year olds present with varying degrees of developmental and emotional maturity'.*

It is likely that that lack of transitional provision impacted on the development of a plan to manage Nevaeh's transition from Junction 17 to adult services. Prior to Nevaeh's eighteenth birthday, GMMH practitioners appeared to have been discussing several options that differed significantly. This included a referral to PICU, a placement within a Low Secure Unit (LSU), as well as Nevaeh potentially returning to her family home. The review identified that CAMHS had referred Nevaeh to CMHT in May 2023 in preparation for her transition to adult mental health services. The review also noted that a recent Mental Health Review Tribunal had recommended that the responsible clinician should consider referring Nevaeh to a unit specialising in the treatment of patients with personality disorders.

The NICE guidance, (2023), states that a transition plan should not be based purely on an age threshold and that it should take place at a time of relative stability for the young person. The guidance further states that starting the planning process for the transition as early as possible can lead to a better experience for young people moving from child to adult services. It recognises that a sudden, unplanned move, to adult services, with no time for preparation or support, can cause the young person, and their family, to lose confidence in services. Early planning, led by health and social care practitioners, and with the involvement of the young person and their family, allows them more time to be involved in discussions, and to adjust to changes in their future care.

In Nevaeh's case, there is limited evidence of planning for her transition to adult services despite the fact that professionals had identified that it was unlikely that she would be discharged before turning eighteen years old. The review, (SAR), concluded that Nevaeh was moved to Oak Ward the day after her eighteenth birthday by default, i.e. there was no other agreed plan for her care provision. The review also recognised that Nevaeh's parents stated that they had not been involved in discussions about Nevaeh's transition to adult services, and had no choice but to accept her move to Oak Ward, as no other option had been offered to Nevaeh or explained to them. They were only informed of the transfer to adult services on the day that the move took place.

The review looked at the options considered by GMMH practitioners in Nevaeh's case. Discharging Nevaeh to her home address was viewed by the Oak Ward MDT as not being realistic, or appropriate, in the short term due to the high level of risk to Nevaeh through self-harming. It was also recognised that Nevaeh's mother was not supportive of a discharge to the family home address until the level of risk of serious harm to

Nevaeh was reduced. A PICU referral was unsuccessful as Nevaeh did not meet the criteria for the PICU pathway due to her need for long term psychological work. The MDT also determined that a referral to a specialist unit for the treatment of people with personality disorders was not appropriate for Nevaeh. This was because she had stated a wish to work towards better management of her self-harming, and to achieve a discharge to her family home.

Although a number of options were considered in relation to Nevaeh's future treatment, there was no clear record of a decision being made as to what option was most appropriate for Nevaeh. No alternative option was pursued, and effectively by default, Nevaeh transferred to Oak Ward on the day after her eighteenth birthday. The review noted that there was no GMMH Trust standard operating procedure for the transition between CAMHS and AOWA[21] when a young person was receiving inpatient care.

The review also identified that there was no formal handover of care between the consultant psychiatrists, (responsible clinicians). The review recognised that there was no standard process for formal handovers between consultants when planned transfers of care were taking place. This potentially increased the risk of information being missed, and potentially impacted on the continuity of care provided to the patients involved. There was also no documented record of practitioners from Oak Ward actually attending any pre-transfer MDT reviews in relation to Nevaeh.

Nevaeh was a high risk in-patient, one that caused such a high level of concern that Junction 17 practitioners had suggested that she presented as too high a risk of self-harming to remain on the ward just a few months before her transfer to Oak Ward. The fact that there was no formal handover between the responsible clinicians for such a high risk patient was a missed opportunity to provide a greater level of continuity of care for Nevaeh. The lack of documented involvement in the transition planning from Oak Ward practitioners, would suggest that they did not have input in the process. That a high risk young person could transition to Oak Ward, effectively by default, and with little planning input from Oak Ward, was also a concern to the review. It was a missed opportunity to better plan Nevaeh's transition to adult services, and for internal GMMH teams to plan effectively to mitigate the risks that Nevaeh faced.

8.5 Deteriorating Health Conditions including Mental Health

Nevaeh had a primary diagnosis of emotionally unstable personality disorder (EUPD) from a GMMH consultant child and adolescent psychiatrist in January 2023. The cause of the EUPD was not identified. She had a similar diagnosis following a previous assessment whilst she was an inpatient at the PHCR IN 2022. Nevaeh also had a history of self-harming, as well as non-compliance with medication and treatment.

The review noted the NICE Guidance (2015)[22], that advises that once in treatment, people with EUPD may build a strong attachment with practitioners and the services that support them. Any change to their familiar arrangements is likely to cause emotional dysregulation and may be associated with an increased risk of crisis. Self-harming behaviour and suicide attempts often occur at the time of such changes. The

[21] Adult of working age

[22] https://www.nice.org.uk/guidance/qs88/chapter/Quality-statement-5-Managing-transitions

guidance recommends discussing changes in advance, and that developing a structured plan that is acceptable to the service user, may give them a greater sense of control, and reduce the risk of emotional dysregulation.

Nevaeh's first contact with CAMHS was in October 2020. The referral referred to self-harming, low mood, anhedonia[23] , excessive sleeping, increased appetite and reduced energy. The stresses identified included a difficult home situation. Nevaeh was assessed by a mental health practitioner (MHP), who determined that the self-harming was non-suicidal self-injury. Her first episode of care with CAMHS was closed in February 2021.

In June 2021, Nevaeh had a further episode of care with CAMHS following a paracetamol overdose. Although the risk of self-harming was identified, it was documented that this did not involve suicidal intent. After being discharged from hospital, Nevaeh was supported by CAMHS.

Nevaeh was referred to the GMMH RRT in October 2021 due to increased concerns about her self-harming. She was assessed as not being suitable for treatment within the community, so she was admitted to hospital. Having been discharged from hospital under the care of the Bolton Home Based Treatment Team (HBTT), Nevaeh made limited progress, but was admitted to hospital again in December 2021 due to another paracetamol overdose. Following a Mental Health Act Assessment, she was detained under Section 2 MHA. Nevaeh was admitted to the PHCR, and following further assessment, she was detained further under Section 3 MHA. Nevaeh remained subject of Section 3 MHA detention until her sad death in March 2024.

Nevaeh had been admitted to PHCR in December 2021. She continued to be cared for there until her transfer to Junction 17 in January 2023. During her admission to PHCR, Nevaeh's engagement with her treatment was documented as sporadic. There were many incidents involving self-harming through swallowing items, or by tying ligatures. Attempts were made to support Nevaeh to increase her use of home leave as part of a plan to work towards a discharge to her parents' home, however, on each occasion, Nevaeh struggled with the transition and would self-harm. This prevented any realistic opportunity for Nevaeh to be discharged from her Section 3 MHA detention.

When Nevaeh was transferred to Junction 17 in January 2023, she was recorded as having struggled with the change. Nevaeh continued to self-harm through the use of ligatures. It was noted that Junction 17 staff tried to give Nevaeh ownership of her self-harming by getting her to undo them when it was safe to do so. Nevaeh was documented to have found this a challenge. However, it was identified that the number of self-harming incidents reduced.

[23] Anhedonia is the inability to experience joy or pleasure. The person may feel numb or less interested in things that they once enjoyed. It is a common symptom of many mental health conditions including depression

Whilst an in-patient at Junction 17, it was recognised that clinicians had reviewed her medication and cross titrated[24] her from haloperidol[25] to quetiapine[26]. Initially, Nevaeh appeared to respond well, leading to an increased use of home leave with the intention being to work towards a home discharge. However, Nevaeh became distressed during a period of home leave and left her parents' home. She also started to secrete medication leading to incidents where she was trying to crush and inhale her quetiapine tablets. As a result, her use of quetiapine was stopped. Nevaeh's self-harming increased, and as a result, she was transferred to ED on several occasions.

In July 2023, an increase in home leave was again tried and Nevaeh was able to manage short periods of leave up to about 4 hours, either at home, or escorted within the community. Nevaeh had indicated that she wanted to work towards a discharge to her parents' home. There was also a reduction in self-harm incidents. However, on her first overnight home leave, she became very distressed and attempted to leave her parents' home. This led to her father having to restrain her until the police arrived, and they conveyed Nevaeh back to Junction 17. Nevaeh was very distressed by this incident and refused to have contact with her family for a short time afterwards. Her self-harming escalated significantly after this incident, and never really reduced during her admission. The potential impact of those present at the family home during this period of home leave is explored further within section 8.7, (Trauma Informed Practice), of the report.

The review noted the use of the power under Section 63 MHA when Nevaeh was brought into ED following a reported overdose of paracetamol in March 2024. Nevaeh had declined treatment, but the clinician responsible for her care used the power under Section 63 to override the lack of consent and provide the required treatment. The medical assessment at the time, was that Nevaeh would have suffered significant harm had the intervention not been made. The review saw the use of the Section 63 MHA power as a good use of legislation and good clinical practice.

In terms of Nevaeh's physical health, there was documented evidence that the ward teams had consistently supported Nevaeh to attend any physical health appointments. The ward teams monitored her physical health in line with GMMH guidelines. If Nevaeh felt unwell, she would inform the nursing staff, and they would inform one of the doctors. Whilst on Oak Ward, Nevaeh reported chest pains on occasions. The doctor explained to Nevaeh that the pains were muscle pain caused by her tying ligatures. Nevaeh was able to get support for physical health concerns where required, this included being transferred to ED on relevant occasions. Nevaeh was provided with copies of her care plan, which included details of any physical health concerns and any interventions provided by the nursing team.

---

[24] Titration of a medicine means slowly increasing the dose of a medicine by small amounts over a given period of time to find the right dosage for the individual. This enables the clinician to see how the individual reacts to the medicine without causing excessive side effects.

[25] Haloperidol is an antipsychotic medication used to treat schizophrenia, acute psychosis, and mania in bi-polar disorder.

[26] Quetiapine is an atypical antipsychotic medication used to treat schizophrenia, bi-polar disorder and major depressive disorders

8.6 Information Sharing

The sharing of information between agencies is an important element of the risk assessment process. Without all of the available information, practitioners do not have the holistic understanding of the risks that an individual may face. If the risk is not properly understood, then it cannot be effectively mitigated. This is all the more important where the individual has complex care and support needs, and may be more challenging to engage with.

In Nevaeh's case, the information sharing between agencies was generally of a good standard. This included the information sharing between health services, including with the GP, and between GMMH and CSC. The review also noted that when Nevaeh had contact with RBH, primarily with ED, information was shared appropriately with the GP practice and where relevant, with mental health services. There were also occasions where RBH practitioners shared information with ASC, this included the submission of a safeguarding referral in late 2023.

The review noted some very good examples of information sharing between the GMMH practitioners within Junction 17 and CSC throughout 2023. The social worker within Junction 17, sent regular incident reports to CSC to ensure that CSC were sighted on the risks that Nevaeh faced. The review also recognised an occasion where Nevaeh had not consented to her information being shared with safeguarding partners, but the lack of consent was overridden by police decision makers, which would be seen as good practice.

There were other occasions where the information sharing could have been improved. The review identified that there were few safeguarding concerns raised by practitioners who came into contact with Nevaeh during what could be described as crisis periods for her. Police and NWAS practitioners had contact with Nevaeh following incidents where she had self-harmed, or was threatening to self-harm. Whilst there were some occasions where the police submitted a safeguarding referral, there were also occasions where concerns were not shared with safeguarding partners. NWAS practitioners did not raise safeguarding concerns as Nevaeh was already in the care of GMMH services. NWAS do not routinely submit safeguarding concerns to social services for all mental health presentations and will gauge current care and support provision, and any other available specialist mental health service, as a more targeted pathway for a patient's needs. NWAS accepted that in retrospect, Nevaeh's cumulative behaviours with repeat ambulance attendance as a 17-year-old patient in transition of services, made her additionally vulnerable, and raising safeguarding concerns would have been appropriate despite what their operational crews would have perceived as robust MH support being already in place. NWAS have agreed that the circumstances of this case will be discussed at their sectors regional learning forum to inform future learning.

There were also some occasions where ED practitioners could have raised safeguarding concerns. Nevaeh was taken to the Wythenshawe Hospital ED, and the NMGH ED, on several occasions between December 2021 and late 2023. She was a child who had self-harmed and, on some occasions, had physical injuries that were consistent with the presenting concern. However, practitioners did not always submit safeguarding referrals reporting the escalating self-harm risk, or escalate concerns to

their trust safeguarding teams. The review noted that in December 2021 the Wythenshawe ED staff had raised a safeguarding concern with CSC. It was also recognised that in May and September 2023, the NMGH Children's Safeguarding Team had raised concerns about the high level of attendances that Nevaeh had made to acute services due to self-harming. However, in the majority of incidents, there were no concerns raised despite the frequency of similar incidents, and what appeared to be the risk of serious self-harm to Nevaeh.

8.7 Trauma Informed Practice

The review considered whether there was previous trauma in Nevaeh's life that may have impacted on her as she transitioned to adult services. The CSC records documented that this had been explored with Nevaeh's mother by the allocated social worker. Nevaeh's mother had told CSC that there had not been any trauma in Nevaeh's childhood and that she had started self-harming during the COVID-19 lockdown periods. Her mother reported that Nevaeh had been finding it difficult due to her home circumstances and relationships.

The practitioner event identified that Nevaeh had indicated to professionals that her parents' home had been crowded due to relatives living with them. She had reported that she found the lack of space and competing for her parents attention, difficult. It was recognised that after the unsuccessful home leave in July 2023, there was no professional curiosity from practitioners to better understand who was present at Nevaeh's parents' home and that if there were a number of people present, had this caused Nevaeh to react as she did. Practitioners agreed that these issues, and their impact on Nevaeh, could have been explored in greater depth.

The review recognised that GMMH, as with many health trusts nationally, have invested resources in working towards becoming a trauma informed service. GMMH have a trauma informed lead who leads work on researching best practice for a trauma informed organisation, benchmarking where the trust is currently in terms of delivering a trauma informed service, and preparing a trauma informed proposal for the trust to take forward. The trauma informed lead also manages the GMMH Trust's Trauma Informed Network, which is working to achieve best practice in this field. The review noted that GMMH has a dedicated intranet page for trauma informed practice and has recently held a practitioner learning event, (Trauma Informed Care-Making it Happen).

Trauma informed practice is a key part of social work training for qualified practitioners from both ASC and CSC. This is embedded within the Section 42 training for ASC social workers. The review noted that the Bolton Council Learning and Development Team were providing training that explains what ACEs are, how they affect people's lives, what can be done to support people who have experienced adversity and trauma. The training also covers what trauma informed practice looks like and how it can be implemented. This training is available to people who live or work in Bolton, including volunteers. This was seen as good practice.

The review noted the strategic and operational work being led by the Greater Manchester Combined Authority, (Trauma Responsive Greater Manchester[27]) to

[27] https://www.trgm.co.uk/

enable the region to become an ACE aware, trauma informed, and trauma responsive city by 2027. The programme seeks to deliver system wide cultural change. This aims to help every organisation, including health trusts, Schools, public services and community groups, to understand, recognise, and respond to trauma.

8.8 Safeguarding Children

An initial child safeguarding referral was made to CSC in November 2021. A strategy meeting was held within two days and a decision made that Nevaeh's immediate needs were being addressed. Therefore, the risk of serious harm was being appropriately mitigated. A Child and Family Assessment was completed for Nevaeh and her siblings within the required timescales. It was agreed that a child in need (CIN) plan would run alongside her hospital admission.

The CIN plan for Nevaeh remained in place until her eighteenth birthday in September 2023. Throughout the period that the CIN was in place, regular care planning meetings were held involving the allocated CSC social worker and relevant health professionals. As covered within section 8.6 of this report, the level of information sharing between Junction 17 and CSC was generally very good, ensuring that CSC were aware of the self-harming incidents and the risks that Nevaeh faced. Whilst the information sharing was generally good, it was noted that an urgent meeting was called at Junction 17 to discuss a plan to discharge Nevaeh back to her parents' home as the Junction 17 staff believed that the risks of Nevaeh self-harming on her ward were too high. This had not been raised with CSC in advance of the meeting. CSC strongly disagreed with this plan, as CSC considered the risks to Nevaeh, if living at home, were too high for her parents to manage. The review recognised that the proposal by Junction 17 staff, seemed to have been a decision made in isolation from other agencies. Nevaeh was subject of a CIN care planning meeting a few days later, which did not propose that Nevaeh should be discharged from Junction 17.

Although the strategy meeting in November 2021 had concluded that the risk of serious harm to Nevaeh had been addressed, the CSC records did document that in October 2022, a search for a placement for Nevaeh was underway. Had this been successfully completed, Nevaeh would have become a Looked After Child (LAC).This effectively recognised the risk of serious harm to Nevaeh. However, the search was unsuccessful and a suitable placement could not be found. It was also noted that Nevaeh's needs, and the very significant risk of self-harming, were increasing.

The review identified the very significant level of admissions to emergency departments following self-harming incidents during 2022 and 2023. Whilst on many occasions, practitioners within ED did not recognise the need to submit safeguarding referrals, there were occasions where safeguarding referrals were made to CSC. This included safeguarding referrals submitted by the NMGH Children's Safeguarding Team in May and September 2023. On both occasions, they raised concerns about the significant number of times Nevaeh was being brought into acute services.

Although Nevaeh was subject to a CIN plan, there was no consideration of initiating a Section 47 investigation under the Children's Act 1989[28] .

The review considered whether Nevaeh would have met the threshold for a Section 47 enquiry under the Children's Act. The panel recognised that Nevaeh was at risk of serious harm, but some panel members raised concerns about the fact that there was no deficit in parenting that led to the risk of serious harm. When a local authority takes protective action in relation to a child, it is usually on the basis of the parental care being sub-standard. However, this was not the case with Nevaeh's family. The panel noted that had a strategy meeting been held, it could have considered the provision within the Children's Act 1989 for children being beyond the control of their parent. The review concluded that a Section 47 enquiry may have been appropriate which would have enabled consideration as to whether a child protection plan was required. However, the panel also recognised that it was unlikely that any child protection plan would have included anything not already part of the CIN plan that was already in place.

CSC advised the panel of the introduction of the Young Person's Plans (YPP) that are now in place. These plans recognise that a young person is at risk of significant harm, but also recognise that the harm is extra-familial. The YPP process enables the level of intervention at the child protection threshold, but is managed differently as the parent is a partner in the process, rather than a 'harmer'. This process allows more creative practice in terms of young people contributing to the planning. It also provides the benefit of an independent reviewing officer to oversee the plan delivery. In circumstances similar to Nevaeh's case now, the YPP would be an option considered as part of a strategy meeting, or a Section 47 enquiry.

The review recognised the involvement of the school that Nevaeh had attended, in providing an appropriate safeguarding response when concerns were identified in relation to Nevaeh. The concerns were promptly referred to the school safeguarding lead, who initiated a multi-agency response, and facilitated an Early Help assessment to ensure that Nevaeh, and her family, received the timely support. However, whilst the overall response was seen to be effective and child centred, there was a gap in the consistency and clarity of the actions taken and the rationale for decision making. The review noted that the school leadership have taken steps to address this, and to ensure that all relevant staff understand the need to record decision making and actions taken, when dealing with child protection matters.

8.9 Practitioner Event

The review held a practitioner event in January 2026 which brought practitioners together from a range of agencies, to consider the identified themes, and the context surrounding the decisions and assessments made. It also enabled the review to understand what practice looks like now, and brought the practitioner's perspective to the process.

---

[28] Section 47 Children's Act 1989 requires a local authority to make or cause to be made, enquiries to enable them to decide if they should take action to safeguard or promote a child's welfare in circumstances that include---Where there is reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm.

Attendees at the practitioner event considered the themes identified by the review and provided their perspective, and additional information, to support the process. This has been included in the relevant sections of this report. As well as contributing to identifying learning within this review, the practitioners also recognised elements of good practice and, as some of the attendees had worked directly with Nevaeh, they were able to provide a better understanding of her perspective.

Attendees at the practitioner event considered issues around trauma informed practice and how that applied to Nevaeh's case. Whilst practitioners reported that there were no obvious ACEs in Nevaeh's life, practitioners recognised that Nevaeh had described sharing her family home with extended members of her family as being traumatic for her. Practitioners accepted that her care still required a trauma informed approach. Attendees informed the review, that trauma informed practice was not always captured within clinical notes which often tend to be fact based. This included a lot of MDT meeting discussions where the detail would not have been captured. They also suggested that the service design may not be trauma responsive with practitioners often lacking time, or capacity, to invest in delivering a service that would be described as trauma informed. As well as the level of demand, a lack of outreach capability for many agencies or teams, was identified as a significant issue.

The event acknowledged how important good information sharing is to support a trauma informed approach to supporting individuals. This helps to reduce the number of times a person who has experienced significant trauma, has to explain their history to practitioners. This was recognised as being particularly challenging for practitioners whose contact with Nevaeh was generally crisis driven.

The practitioners discussed when self-harming became a safeguarding concern that should be subject of a referral. Whilst there were some differing views, it was generally accepted that where there were repeated self-harming incidents, that should be identified as a safeguarding concern. In Nevaeh's case, with escalating numbers of self-harming incidents from mid-2023, the practitioner event recognised that this should have resulted in more safeguarding referrals being submitted.

Whilst the practitioners agreed that the decision to initiate a Section 42 enquiry following the safeguarding referral submitted by the RBH staff was good practice, there were concerns about the length of time it took for the enquiry to be allocated to a social worker. ASC attendees reported that there had been around 100 cases awaiting allocation in early 2024 and decision makers may have considered that Nevaeh was not a priority as she was an inpatient. It was also recognised that as the safeguarding referral was the first one that ASC had received, there would have been limited background information available to support the referral.

9. CONCLUSIONS AND RECOMMENDATIONS

9.1 Multi-Agency Working/Adult Safeguarding

The review identified that there was evidence of good information sharing between the agencies involved in Nevaeh's care. However, there was limited evidence of safeguarding referrals being submitted by professionals to raise concerns about the escalating risks that Nevaeh faced.

The review recognised that defining self-harming as a safeguarding issue was a grey area. The review noted the SCIE guidance, (2020), which states that '*self-harm could be considered as a form of self-neglect if an individual is unable to 'control their self-harm' or an 'inability to avoid self-harm'. This points to the importance of basing each case on its own merits.'* In Nevaeh's case, both the frequency and the escalating level of self-harming, would suggest that Nevaeh did not have the ability to control her self-harming or to avoid doing so. The review panel agreed that the escalating risk of Nevaeh's self-harming should be considered a safeguarding matter.

Although Nevaeh was subject of many self-harming incidents, and the frequency of those incidents escalated significantly in the second half of 2023, there were very few safeguarding concerns submitted by professionals.

Officers within some GMP districts had been instructed by their management teams to not submit safeguarding referrals where an individual was in the care of a relevant agency,and had been returned back to that partner agency. It was recognised that this direction was not in line with their force policy, and that this issue had now been rectified. The GMP Organisational Learning Board have advised MASH[29] Teams that safeguarding referrals should be submitted where there are concerns about people who have been taken to a health care setting, or transferred to NWAS.

The review identified that NWAS do not routinely raise safeguarding concerns when dealing with individuals who self-harm, for all incidents they attend. NWAS encourage practitioners to engage with the relevant specialist local mental health teams to facilitate the right acute support unless it is clear that specialist support is already in place.

The review recognised that Nevaeh had presented to ED on many occasions having self-harmed through overdoses, swallowing objects or through the use of ligatures. There were occasions where the need to submit a safeguarding concern was identified by practitioners and acted upon. There were also some occasions where there was no record of a safeguarding concern being raised.

The review acknowledged that there were some occasions where the police and ED staff identified the risks to Nevaeh and submitted safeguarding referrals. It was also noted that in May and September 2023, the NMGH Safeguarding Team had raised concerns about the level of Nevaeh's attendance at ED for self-harming. However, there were many occasions where concerns were not identified or acted upon. The review determined that where a child or adult faced significant escalating risk from frequent, or escalating, self-harming, the safeguarding risk should be identified by

29 Multi-Agency Safeguarding Hub

professionals and addressed accordingly. The fact that Nevaeh was in the care of GMMH as she was subject of Section 3 MHA detention, should not have excluded her from referral to appropriate safeguarding authorities.

The review noted that when ASC received an adult safeguarding referral from RBH, the need to initiate a Section 42 enquiry was identified and acted upon. This was seen by the review as good practice. However, having initiated the Section 42 enquiry, the enquiry had not been allocated to a social worker eight weeks later. Whilst the review accepted that the Section 42 safeguarding enquiry may not have changed the treatment plan or the tragic outcome in this case, it was a missed opportunity to bring additional scrutiny and professional challenge to the process.

Recommendation 1

The Bolton Safeguarding Adults Board should seek assurance regarding the management of the risk of self-harm and that the interface between escalating self-harm and safeguarding is recognised, and covered within any self-harm and risk management policies, with appropriate training provided within its member organisations.

Recommendation 2

ASC should ensure that section 42 safeguarding enquiries are allocated to an appropriate social worker within agreed timescales.

9.2 Risk Management

The level of risk to Nevaeh was identified by GMMH practitioners and there was evidence that risk management plans were in place at both Junction 17 and Oak Ward. The review recognised the very significant challenge for mental health decision makers in balancing the need for therapeutic risk taking to help a person like Nevaeh to achieve the intended outcome against the risk of self-harming in the short term. The fact that many self-harming incidents were reported to have happened on the hospital ward was clearly a concern, but the review also noted that the consultant psychiatrist had reported that increasing the observation levels would have been contrary to the overall plan, which was for Nevaeh to gain more independence and responsibility.

Both Junction 17 and Oak Ward had similar risk management plans in place for Nevaeh's care, although the Junction 17 plan would be described as more restrictive. Following her transfer to Oak Ward, GMMH practitioners worked with Nevaeh to reduce the therapeutic observation levels to give her a greater degree of independence and freedom. The review noted that both wards had used good practice in the way that they had worked to manage the risk of self-harm with clearly documented risk management plans in place.

Although neither ward had used the GMMH Self-Harm Tool Kit within their risk management plans, the tool kit has since been withdrawn. The use of the CRASP, which includes a section about self-harm, was noted as being better aligned with NICE

Guidance[30] and GMMH policy. The review noted that GMMH are currently completing an audit of completed CRASPs although the results of this audit are not available yet.

During October 2023, Nevaeh took an overdose having been given unescorted leave for short periods. Although home leave had been considered, Nevaeh's family had reported being unable to cope with her self-harming. The MDT assessed that the risk of self-harming was high and that it was therefore unreasonable to expect her family to manage the risk to Nevaeh. Nevaeh's family had complained to GMMH that restricting of leave was being used in a punitive way and as a bargaining tool which was causing distress to Nevaeh. However, the review recognised that that whilst it may have looked punitive, restricting leave was necessary due to the high risk of self-harm that needed to be managed.

The fact that risk management was delivered through regular MDT meetings which had involved input from both Nevaeh, and her parents, was seen as good practice by the review. It was unfortunate that the relationship between her family and professionals had deteriorated towards the last few months of Nevaeh's life, and as a result, the family's involvement with the MDT process was limited.

The review did not make a recommendation in relation to risk management.

9.3 Management of Home Leave (Section 17 MHA)

The review recognised that home leave was an important element of Nevaeh's treatment plan if her desired outcome of a discharge to her parents' home was to be achieved. However, the very significant challenge in balancing the use of leave with the high risk of self-harming was also noted.

There was documented involvement of partner agencies in the planning around Nevaeh's home leave, with support being provided to Nevaeh's mother to help her to manage Nevaeh's complex needs. However, it was identified that the focus of that support became more about crisis management, due to the frequency of incidents that occurred during home leave. It was also noted that CSC had completed CIN visits whilst Nevaeh was with her parents during home leave periods. The involvement of partner agencies in leave planning was seen by the review as good practice.

However, the review identified that Nevaeh found the potentially crowded household situation at her parents' home difficult to cope with. There was limited documented evidence that this was considered during the planning for home leave, or that most professionals were sighted on this potential source of trauma for Nevaeh.

The review did not make a recommendation with respect to home leave.

9.4 Transition to Adult Services

CSC records documented a referral being made for adult social care about four months before Nevaeh's eighteenth birthday, and there appears to have been a meeting between CSC and ASC in August 2023, just a month before she turned 18. It is likely that this meeting would have been with GMMH, as they would have had responsibility for meeting Nevaeh's care and support needs as an adult, as there was a Section 75

[30] NICE Guidance 225, (2022). https://www.nice.org.uk/guidance/ng225/chapter/Recommendations

agreement in place at that time. However, there was no record of any transition plan, or any detail of what may have been discussed by social care services at the meeting in August 2023.

The review noted the NICE guidance (2023), which advises that transition planning should not be based purely around age and that the transition should take place during a time of relative stability for the young person. The guidance also recommends that the planning for the transition should commence as early as possible as this may lead to a better outcome for the individual. It also identifies that an unplanned move to adult services can impact on the confidence that the young person, and their family, have in services.

Although there was documented evidence to suggest that a number of alternative options were considered in Nevaeh's case, there was no record of the rationale for the decision made to move her to Oak Ward. It was noted that Nevaeh's family were not involved in the decision making about her transition to adult services, and that she was moved to Oak Ward the day after her eighteenth birthday, effectively by default. Nevaeh's parents were only informed of her move to an adult ward on the day that it took place.

The review identified that there was no GMMH Trust standard operating procedure for the transition of patients from CAMHS to adult services when the child is receiving inpatient services. In Nevaeh's case, there was no documented involvement of Oak Ward staff being involved in any planning process prior to Nevaeh's move to the ward. It was also a concern to the review that although Nevaeh was a high risk patient, there was no formal handover of care between the consultant psychiatrists. Whilst this clearly increased the risk of information being missed, and certainly did not support the continuity of care for Nevaeh, the review noted that there was no standard process for the handover of care between consultants. This was a missed opportunity to better plan Nevaeh's transition to adult services, and for internal GMMH teams to plan to mitigate the risks that she faced.

The review recognised that the internal GMMH SIR had made a recommendation that the CAMHS Senior Leadership Team should develop a standard operating procedure for inpatient and community services, that covers admission, discharge and transition processes which should include a clinical handover between services.

Recommendation 3

The Bolton Safeguarding Adults Board should seek reassurance from GMMH that a standard operating procedure that covers admissions, discharge and transition processes, including a clinical handover process, has been implemented for inpatient and community services.

Recommendation 4

CSC should ensure that plans to support the transition of child service users to adult social care services are clearly documented within that child's record.

9.5 Deteriorating Health Conditions including Mental Health

Nevaeh had a primary diagnosis of EUPD from a GMMH consultant in January 2023. The review identified the NICE guidance that suggests that people with an EUPD diagnosis may develop a strong attachment with practitioners who support them. Any form of change to their familiar arrangements is likely to cause emotional dysregulation and may be associated with an increased risk of crisis. This would include self-harming and suicide attempts. The same guidance suggests that the risks can be reduced by discussing changes in advance, and by developing structured plans that are agreed with the patient.

The review recognised that as she had a diagnosis of EUPD, the risk of emotional dysregulation and self-harming behaviour may well have applied to Nevaeh. The importance of planning for her transition to adult services, and involving her in that planning process, may have been beneficial in helping her to cope with the move to Oak Ward.

The review noted that Nevaeh's physical health was monitored in line with GMMH guidelines. Where Nevaeh reported to be unwell, arrangements were made for her to see a doctor. She was also supported by ward staff to attend medical appointments. On the occasions where Nevaeh had self-harmed, she was appropriately transferred to ED for treatment.

The review decided not to make a recommendation with respect to planning for the transition between services, as this would be covered by recommendation four at section 9.4 of this report.

9.6 Information Sharing

Information sharing between agencies is important in supporting the holistic understanding of the risks faced by service users, particularly those with complex needs. In Nevaeh's case, the information sharing was generally of a good standard. The review identified many good examples of information between health services, including with the GP practice. Where Nevaeh had contact with RBH, primarily with ED, information relating to the attendance and any treatment was shared with Nevaeh's GP. The review also noted the information sharing between GMMH and CSC and between RBH and ASC.

As well as the information sharing between agencies in a general sense, the review identified occasions where police decision makers had overridden the lack of consent from Nevaeh to share information with relevant agencies. The sharing of safeguarding information in these circumstances was seen by the review as good practice.

The review identified that information could have been improved through the better identification of safeguarding concerns and the submission of safeguarding referrals, as detailed within section 9.1 of this report. There were a number of occasions where practitioners from several agencies, could have submitted safeguarding referrals to either CSC or ASC depending on Nevaeh's age at the time. This is subject to recommendation one within that section of the report.

The review panel did not make any separate recommendation with respect to the sharing of information between agencies.

9.7 Trauma Informed Practice

The review did not identify any specific trauma in Nevaeh's life. However, it was recognised that Nevaeh's mother had reported the potential impact of the COVID-19 restrictions on Nevaeh and that she had struggled to cope with her home circumstances. The review also noted the comments made by practitioners who had worked closely with Nevaeh. They reported that Nevaeh had often described struggling to cope with her crowded home. She had informed practitioners that her mother had taken on parental responsibility for her brother's three children which left her home over crowded. Whilst Nevaeh had accepted that this was done with the best of intentions, it had left her feeling that she did not have access to her mother, and that she had little space of her own.

The review recognised that GMMH, along with many other health trusts, have invested resources in working towards becoming a trauma informed service. Other agencies, particularly ASC and CSC, reported that trauma informed practice is a key element within their mandatory training for staff. The panel also noted the work being led by the Greater Manchester Combined Authority, to enable the Manchester area to become trauma informed by 2027.

The review panel did not believe that there was a requirement to make a recommendation with respect to trauma informed practice.

9.8 Child Safeguarding

Nevaeh had complex needs and the issue of child safeguarding was complicated by the fact that Nevaeh was subject to Section 3 MHA detention. The review considered whether Nevaeh should have been subject to a Section 47 enquiry under the Children's Act 1989. Primarily, this related to the significant level of ED admissions following self-harming incidents.

Whilst the review identified that Nevaeh would have met the threshold for a Section 47 enquiry, the panel recognised that CSC had completed Child and Family Assessments in 2021 and 2022, which resulted in Nevaeh being a CIN under Section 17 of the Children's Act 1989. As a result, the CSC social worker would have agreed a plan with Nevaeh's family, and other relevant practitioners, to ensure her safety and welfare. Therefore, the appropriate agencies were already working together to consider risk, and to agree if any safeguarding measures were required. In considering whether it was necessary, or proportionate, to move the CIN plan to Child Protection Procedures, and a Child Protection Plan, the review sought to understand what may have changed. Whilst a safeguarding enquiry may have brought additional scrutiny, in reality, it would have been the same practitioners meeting, with CAMHS taking the lead as the experts within the mental health field. Mental health planning, with the primary concerns being to keep Nevaeh safe and to provide a treatment plan to address her mental ill health, would have been the likely outcome.

As the expertise would have been provided by CAMHS, the decision making would primarily have remained with mental health services. CSC were involved, and had input to, MDT working with respect to Nevaeh which would have presented them with the opportunity to seek assurances, or professionally challenge decision making where it impacted on potential safeguarding issues. The review concluded that although

Nevaeh would have met the threshold for a Section 47 enquiry, it was reasonable and proportionate for CSC to manage the risk through a CIN plan.

The review also noted the introduction of YPP which would enable the level of intervention at the child protection threshold, but is managed differently as the risk of harm is extra-familial. As the YPP allows more creative practice through involving the family in planning, and the benefit of an independent reviewing officer to oversee the plan delivery, it may be an option for managing cases similar to Nevaeh's going forward.

The review did not make any recommendations with respect to child safeguarding.

10. APPENDIX 1: TABLE OF RECOMMENDATIONS

No	Recommendation	Theme	Agency
1	The Bolton Safeguarding Adults Board should seek assurance regarding the management of the risk of escalating self-harm and that the interface between self-harm and safeguarding is recognised, and covered within any self-harm and risk management policies, with appropriate training provided within its member organisations.	Multi-Agency Working/Adult Safeguarding	Bolton Safeguarding Adults Board
2	Bolton Adult Social Care should ensure that section 42 safeguarding enquiries are allocated to an appropriate social worker within agreed timescales.	Multi-Agency Working/Adult Safeguarding	Bolton Adult Social Care
3	The Bolton Safeguarding Adults Board should seek reassurance from GMMH that a standard operating procedure that covers admissions, discharge and transition processes, including a clinical handover process, has been implemented for inpatient and community services.	Transition to Adult Services	Bolton Safeguarding Adults Board
4	CSC should ensure that plans to support the transition of child service users to adult social care services are clearly documented within that child's record.	Transition to Adult Services	Bolton Children's Social Care

11. APPENDIX 2: TABLE OF SINGLE AGENCY RECOMMENDATIONS

A number of agencies had identified potential single agency recommendations whilst preparing their IMRs. These recommendations are not necessarily evidenced within the report, but will be actioned internally by the agency concerned. They are listed within appendix 2 for the information of the Bolton Safeguarding Adults Board.

No.	Recommendation.	Agency.	Intended outcome
1	Review compliance with Therapeutic Observations Policy and training to ensure that this has been embedded across the organisation in line with best practice guidance.	GMMH	1. Professionals check immediately prior to home leave being granted in respect of home circumstances and anything which could negatively impact on that leave. 2. To mitigate the risk of patients self-harming appropriately.
2	The provision of ILS and BLS training to be reviewed by the Trust in line with national guidance via an established Task and Finish Group led by the Deputy Chief Nurse.	GMMH	To ensure that staff have the skills and confidence to respond effectively to emergency situations.
3	Develop a flow chart to provide clearer guidance on post suspended ligature physical health intervention including review of, and rationale for, observation levels in line with best practice and least restrictive options.	GMMH	1. To ensure that staff respond in line with Trust expectation to incidents involving ligatures. 2. To mitigate the risk from self-harming incidents appropriately.
4	The School to ensure that all actions taken in response to a safeguarding incident are recorded with a clear rationale for those actions documented.	School	All safeguarding incidents should be properly recorded and the rationale for all actions taken should be appropriately documented.
5	Bolton FT to provide training for frontline staff on trauma informed approaches including de-escalation techniques and ensuring psychological safety.	Bolton FT	Trauma informed practice should be embedded in all interactions to support engagement and to reduce distress.
6	Bolton FT to provide refresher training on the legal and ethical application of MHA Sections, especially in high risk scenarios.	Bolton FT	To ensure that staff understand the interface between physical health care and patients detained under the MHA.

12. APPENDIX 3: TABLE OF IDENTIFIED GOOD PRACTICE

No	Agency	Item of Good Practice	Theme
1	BFT	Identifying the need to submit a safeguarding referral for Nevaeh to raise concerns about her health and care whilst subject to the Section 3 MHA detention.	Multi-Agency Working/Adult Safeguarding
2	ASC	Decision to initiate a Section 42 enquiry following notification of Nevaeh self-harming and having sustained a serious injury.	Multi-Agency Working/Adult Safeguarding
3	GMMH	Both Junction 17 and Oak Ward had worked to manage the risk of self-harm with clearly documented risk management plans in place.	Risk Management
4	GMMH	Risk planning and management was led and overseen through MDT meetings.	Risk Management
5	GMMH	The use of home leave to try and support Nevaeh in achieving her goal of being discharged to her parents' home.	Management of Home Leave (Section 17 MHA)
6	GMMH	The involvement of partner agencies in the planning around home leave for Nevaeh.	Management of Home Leave (Section 17 MHA)
7	BFT	The use of the Section 63 MHA power to override the service user's lack of consent and to provide appropriate treatment within ED.	Deteriorating Health Conditions including Mental Health
8	Police	Overriding the lack of consent to share relevant information with safeguarding partners.	Information Sharing
9	Manchester University NHS Foundation Trust	Wythenshawe Hospital ED staff had identified the need to submit a safeguarding concern to CSC.	Information Sharing
10	NMGH	The Safeguarding Team had identified the high level of attendances that Nevaeh had made to acute services due to self-harming and had raised concerns with CSC.	Information Sharing

No	Agency	Item of Good Practice	Theme
11	1. ASC 2. CSC	The review noted that Bolton Council ASC and CSC were jointly delivering training that explains what ACEs are, how they affect people's lives, what can be done to support people who have experienced adversity and trauma, and what trauma informed practice looks like and how it can be implemented. This training is available to people who live or work in Bolton, including volunteers.	Trauma Informed Practice

13. APPENDIX 4: TERMS OF REFERENCE

A Safeguarding Adult Review (SAR) is a multi-agency review required by Section 44 of the Care Act 2014 and conducted by a local Safeguarding Adults Board (SAB). In Bolton, the Bolton Safeguarding Adults Board (BSAB) are the responsible SAB. Local SABs have a statutory duty to arrange a SAR when:

a) an adult with care and support needs has died, and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive, and the SAB knows or suspects that they have experienced serious abuse or neglect,
b) and when there is reasonable cause for concern about how the SAB, its members or others worked together to safeguard the adult.

A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

SAB members must co-operate with and contribute to the SAR to identify lessons learnt and ensure that learning is shared and applied in the future.

1. Subject Details

This SAR is commissioned with due regard to the Care Act 2014, in response to the death/serious incident of:

Subject name.	Nevaeh
Also known as:	N/A
Date of incident:	Mid-March 2024
Date of Death:	Mid-March 2024
Home Address:	Bolton.

Chris Hogben, Invigor Consulting Ltd, has been appointed as the Independent Chair and Author of the review panel.

2. Purpose and Aim of the SAR

The purpose of a SAR is to promote effective learning and improvement to prevent future deaths or serious harm from occurring again. The purpose is not to apportion blame to any agency or individual.

The objectives include establishing:

- lessons that can be learnt from how professionals and their agencies work together
- how effective the safeguarding procedures are
- learning and good practice
- how to improve local inter-agency practice
- service improvement or development needs for one or more services or agencies

The lessons learnt are shared by the SAB to maximise the opportunity to better safeguard adults with care and support needs who may be at risk of abuse or neglect.

3. Methodology

The review will be facilitated by an Independent Chair and Reviewer. Chronologies collated during the initial scoping phase, together with other relevant information, will be reviewed by the Independent Chair to determine the appropriate areas for enquiry. Partner agencies will be asked to review their own involvement with Nevaeh, and to provide a report detailing that involvement, good practice, learning and suggested recommendations. A practitioner workshop will be undertaken to focus on understanding the strengths of the current systems and seeking to identify potential areas for further improvement.

The Independent Chair will then work with the SAR sub group to develop agreed multi-agency recommendations and key actions for BSAB consideration.

4. Period Under Review

The panel agreed that the review should focus on the time period between 01/10/2021 and Nevaeh's death in mid-March 2024. Any relevant information relating to Nevaeh from before this time period would also be considered.

5. Panel membership

The following agencies and individuals constitute the SAR panel:

Name	**Agency**
Chris Hogben.	Independent Chair/report author
Michelle Hulme	Bolton Safeguarding Adults Board.
Karen Kenyon	Bolton Council
Derek Dempster	Manchester Fire & Rescue Service
Alison Kelly	Legal Advisor to Bolton Safeguarding Adults Board.
Kaleel Khan	NHS Greater Manchester Integrated Care Board
Simon Johns	Greater Manchester Mental Health Foundation Trust
Sheila Mooney	Bolton Foundation Trust
Louise McWalters	Greater Manchester Police
Michael Lloyd	North West Ambulance Service Foundation Trust
Jane Barber	Greater Manchester Mental Health Foundation Trust
Mark Aspin	Bolton Council
Lizzy Lacey	Bolton Council Adult Social Care
Nick Libell	Bolton Council Children's Social Care

6. Chronologies, Individual Management Reviews (IMR) and Other Reports

An Individual management review (IMR) and chronology of contact will be requested from the following organisations:

- Greater Manchester Police.
- Bolton Council Adult Social Care.
- Bolton Council Children's Social Care.
- Greater Manchester Mental Health Foundation Trust.
- NHS Greater Manchester Integrated Care Board.
- North West Ambulance Service Foundation Trust.
- Bolton NHS Foundation Trust.
- Education---School.
- Manchester University NHS Foundation Trust.
- Priory Hospital Cheadle Royal.
- Northern Care Alliance.

7. Key Lines of Enquiry (KLOE)

The following KLOEs will be examined as part of the review, they are not in any order of priority. Agencies will be requested to complete an IMR using an agreed template, addressing each area covering good practice, learning and recommendations where relevant against each;

7.1 Multi-Agency Working/Safeguarding

How well did relevant agencies work together with a specific focus on:

- How risk management and safeguarding processes were applied?
- Were child/adult safeguarding referrals made?
- How effective was the safeguarding response?
- Was there evidence of multi-agency coordination?
- Was consideration given to using the Section 42 framework?[31]

7.2 Risk Management

- How effectively was risk identified by practitioners and what measures were taken to mitigate that risk?
- Were identified risks escalated appropriately?
- Were risk assessments completed in line with organisational expectation?
- Did any risk assessments fit with the risks identified and any decisions made?
- How effectively were risks communicated with other professionals and with Nevaeh's family?

[31] Section 42 Care Act 2014

7.3 Management of Home Leave (Section 17 MHA).

- Were Nevaeh's family involved in the risk planning for home leave?
- Were the appropriate agencies involved in risk planning around home leave?
- How effective was the risk management process in relation to the use of Section 17 MHA home leave in Nevaeh's case?
- Was any additional support offered to the family in advance of planned home leave?
- Please comment on the balance between safeguarding and therapeutic risk taking where appropriate.

7.4 Transitional Safeguarding

- Was there a clear transition plan in place for Nevaeh's transition from CAMHS to adult mental health services?
- Was it appropriate for her to transfer to an adult inpatient ward at that time?
- Was it in her best interests to transfer to the adult inpatient ward at that time?
- Was the appropriate support in place to support Nevaeh's transition from Children's Social Care to Adult Social Care services?
- Were Nevaeh, her family and other professionals engaged in any transition plans?
- Was Nevaeh's voice heard and was she able to contribute to her care planning?

7.5 Deteriorating health conditions including mental health

- How effectively were Nevaeh's mental and physical health needs met?
- Was the support/treatment provided in line with organisational expectations?
- To what extent were other professionals involved in supporting the treatment plan?
- To what extent were family members involved in understanding and engaged in, the treatment plan?
- Was Nevaeh's care managed in line with the NICE Self-Harm Pathway and the GMMH Trust Self-Harm Policy?
- Were Nevaeh's care and support needs assessed and appropriately met?

7.6 Information Sharing

- Did practitioners share information with partner agencies appropriately?
- Did practitioners pro-actively seek information from partner agencies, particularly to support the risk assessment process?

7.7 Trauma Informed Practice

- Did practitioners understand the potential impact of previous trauma on Nevaeh's physical and mental health?
- If previous trauma was identified, how did this impact on practitioners approach to supporting Nevaeh?
- Did previous trauma impact on Nevaeh's ability to engage with services?

7.8 Safeguarding Children

- Was consideration given to the young person being a child at risk of significant harm?
- At which point of their journey was this considered and what was the rationale/outcome of this?
- Were decisions reviewed?

8. Subject/ Family Involvement

Nevaeh's family/next of kin will be contacted by the Independent Chair at the earliest opportunity. The Independent Chair will seek to encourage Nevaeh's family to contribute to the SAR process to bring their voice, and where possible, Nevaeh's voice to the review.

9. Parallel Reviews

GMMH Foundation Trust have completed a Serious Incident Review with respect to Nevaeh's death. The review has been shared with the Independent Chair and will contribute to the information supporting the SAR.

10. Media and Communications

All media enquiries will be managed by the BSAB in consultation with the BSAB Independent Chair.

Following an information governance review, the final report will be published on the BSAB Website.

11. Terms of Reference Agreed

The SAR panel agreed these terms of reference on 9 July 2025.

The terms of reference will be kept under review by the panel throughout the review.

Amendments made	Agreed by	Date