

7-minute briefing: *Thematic Safeguarding Adult Review*

Out of area mental health admissions, delayed transfer of care and system oversight

1. Background

This review focuses on three young women, L, B and A, who died while receiving inpatient mental health care at a distance from their home area. The review is thematic, and respects each woman as an individual while examining what their experiences reveal about the mental health system, particularly when people are admitted a long distance from home. It has been completed to identify learning and improvement, not to apportion blame to any individual organisations involved in this review.

2. The three women

L, aged 22, had diagnoses of Emotionally Unstable Personality Disorder and Autistic Spectrum Disorder. B, aged 26, had a diagnosis of Emotionally Unstable Personality Disorder and complex physical and mental health needs. A, aged 20, had diagnoses including Emotionally Unstable Personality Disorder, Post Traumatic Stress Disorder and disordered eating. Each woman was detained under section 3 of the Mental Health Act. All three experienced increased or fluctuating risk during admission. The review found that each expressed concerns about the environment in which they were receiving care, but system barriers limited how far those concerns changed their care pathway.

3. Out of area care and delayed transfer

Out-of-area admission may sometimes provide access to specialist treatment that is not available locally. However, prolonged stays away from home can separate people from family, carers and familiar professional networks. For L and A, a short-term Psychiatric Intensive Care Unit placement became a prolonged admission after the clinical need for a different, less restrictive environment had been identified. The review found that delayed stays in restrictive settings contributed to deterioration and increased risk. Across the cases, discharge or transfer arrangements were affected by limited specialist provision and uncertainty about the right pathway.

4. Quality, patient safety and system oversight

The arrangements between the person's home area, the host area and the inpatient provider were not consistently clear or joined up. Factors included prolonged stays, increasing incidents, diagnostic complexity, and safeguarding concerns. Home teams did not always have timely awareness of incidents or the overall level of risk.

5. Safeguarding and recognising patterns of harm

There were many patient safety incidents, some of which led to safeguarding action. Thresholds and approaches were not applied consistently, and similar incidents did not always receive the same response. Not every incident of self-harm automatically requires a section 42 enquiry. However, repeated incidents, possible abuse or neglect, failures to follow care plans, and worsening patterns must be considered cumulatively. Clinical risk, patient safety, quality and safeguarding information should be brought together so the whole picture is visible and shared with the home team.

6. Voice, family involvement and advocacy

The women communicated distress, frustration and concerns about their care environments in different ways. Families and advocates also raised concerns. The review found that these voices did not always lead to sufficiently timely action.

Listening must be evidenced through decisions. The person's views should directly inform care planning, risk formulation, discharge planning and patient safety. Family involvement should reflect the person's wishes and confidentiality. Where family involvement is limited or views differ, effective independent advocacy is especially important

7. Links and further information.

Please read the full report on the Stockport Safeguarding Adults Partnership website
[Safeguarding Adult Reviews - Stockport Council](#)