Southampton Safeguarding Adult Board

Safeguarding Adult Review

SSAB

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Penny

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'Send me a full stop'

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1. Introduction

1.1 Penny was 35 years old when she tragically died in 2020 from hanging. She had experienced mental health trauma for many years and had a diagnosis of Emotionally Unstable Personality Disorder (EUPD). She was receiving support and care from adult community mental health services (AMHT). In the month prior to her death on Christmas Eve 2020 she came to the Emergency Department (ED) five times.

1.2 Over many years and increasingly so during 2020 she was in regular contact with health services, including her GP, ambulance services, crisis resolution team, adult mental health teams, University Hospital Southampton NHS Foundation Trust (UHS) Emergency Department (ED), the Liaison Psychiatry Team and a care coordinator. She was also in regular contact with the Lighthouse[1] and called 111.

1.3 Southampton Safeguarding Adult Board recommended that this case met the criteria for a discretionary Statutory Safeguarding Adult Review and identified that there was learning relating to how agencies worked together. There is much to learn from Penny's life and this review has tried to look at future learning from an understanding of Penny's experience.

1.4 We must not forget that Penny was part of a family who felt and witnessed her pain for many years and cared for her deeply. She was her sister's 'soul mate' and friend, sharing her struggles as well as her joys. They shared an understanding and had a unique way of communicating. At times when Penny could not even write a text message to her sister because of her distress she would simply be asked to '*send a full stop'*.

2. Context of Safeguarding Adults Reviews

2.1 The Care Act 2014 requires Safeguarding Adults Boards (SABs) to arrange a Safeguarding Adults Review (SAR) if an adult (for whom safeguarding duties apply) dies or experiences serious harm because of abuse or neglect and there is cause for concern about how agencies worked together. Southampton Safeguarding Adults Board (SSAB) commissioned an independent author, for the review. The author is independent of SSAB and its partner agencies.

[1] Informal, non-judgemental, out-of-hours mental health support for those in need of extra support in times of difficulty in Southampton.

3. Methodology

'What builds a relationship, what solves problems, what moves things forwards is asking the right questions' (Schein, 2013: 4)

3.1 This SAR was carried out using an appreciative inquiry approach. Information and learning were drawn from a combination of narrative reports and chronologies from each agency with a learning event of practitioners who had worked closely with Penny. The primary purpose is to learn lessons and to use the learning to drive and sustain change.

4. Key Lines of Enquiry

- Explore the EUPD pathway and the services provided, specifically whether they followed NICE (National Institute for Health and Care Excellence) guidelines for personality disorders
- Consider the effectiveness of multi-agency communication and decision-making – especially interactions between UHS and the police (was there a gap between UHS' request for a welfare check, and the police welfare check being carried out?)
- Evaluate the application of the Mental Capacity Act in practice.
- Did agencies capture Penny's voice and actively involve her in the care she received?
- Consider agencies' management of risk and quality of risk assessments, including the escalation process.
- Establish whether there are any frameworks or processes agencies have in place for frequent attenders to / users of their services. Why was a Multi-Agency Risk Management meeting (MARM) not considered in response to the increasing intensity and frequency of presentations?

5. Family Involvement

5.1 Penny's sister kindly agreed to share her thoughts and experiences with the author, and, with her permission, these have been integrated into the report. We offer our condolences to Penny's family as they still come to terms with her loss.

6. Reflection on Penny's life

6.1 As practitioners pointed out during this review, it is difficult to truly represent Penny's life in a report and capture the true essence of her life. What we do know is that Penny's life was impacted by terrible trauma and abuse as a child, and that this would continue to affect her whole life. We know that there was support from Child and Adolescent Mental Health Services (CAMHS) as a young person and that links with services continued into adulthood with support from Adult Mental Health services and several admissions, mainly voluntary, upto 2019.

6.2 Penny's life of course is so much more than professionals will ever know. We can only begin to imagine how she tried to deal with the pain she was experiencing. She started to train as a student midwife at the age of 18 years old but found this hard for many reasons and it was about this time that her sister described that she was perhaps drinking more than usual and was admitted to hospital because of increasing mental health concerns.

6.3 There were several differing diagnoses such as Emotionally Unstable Personality disorder (EUPD), bi-polar and anxiety. Penny was most uncomfortable with the diagnosis of EUPD and asked on several occasions that it be removed from her records. More recently, she had discussions with different practitioners about post-traumatic stress disorder (PTSD).

6.4 Penny frequently cut herself as a means of managing her emotions, and on occasions when experiencing suicidal ideation and hearing voices; she took overdoses of her medication and said that it was to seek rest from her distress. This risk was compounded by frequent and increasing use of alcohol. Practitioners who knew Penny well said that she was often overcome with intense pain from the trauma in her life. She would experience a wave of emotions over short periods and then at other times she would be hopeful for the future. In October 2020 she was setting long term goals for the future but expressed how scared she was of addressing the past.

6.5 She had been reported as a missing person and a vulnerable adult on 13 occasions between 2006 and 2017. In July 2019 she was assessed under the Mental Health Act which resulted in her being detained under Section 2.

6.6 Penny disclosed to police three times between 2011 and 2014 that she had been abused as a child by a family member. Her sister and mother had been abused by the same person. The perpetrator served a prison sentence and sometime later because of homelessness and mental health issues it appears that he went to live with Penny's grandparents. Penny was living there at the time and therefore had to leave. Penny was in her 20's at this point. She had been very close to them but was no longer in a position to visit. As Christmas 2020 approached, she had been looking forward to seeing her grandparents as contact had been difficult during the first wave of COVID. In addition, her grandfather was on end-of-life care. All of this caused her great distress.

6.7 She was in contact with her mother and sister and had a close friend 'a soul friend' who lived nearby. Penny loved her cat and even when she was in great distress herself, she ensured that her cat was safe and well.

7 Findings and Learning

7.1 There are challenging themes from this review. Some are reflected in national priorities such as capacity and resource issues in mental health and emergency medicine. The perennial problem of the need to improve information sharing between agencies again rears its head, alongside the need for systems that communicate. However, this should force us to look deeper into practice and to explore the reasons behind some of these difficulties at a local level.

7.2 The findings of this review emphasise the intense nature of working with a person with Penny's experiences with such complex pain, and fluctuating needs and a high risk of suicide. At times, it was 'overwhelming' and emotional for practitioners. If we believe that 'well-being leads to well doing[2]' then we must surely invest more in our staff.

> Karen Treisman: My favourite quote about well-being is from the wellness project in Kenya "well-being leads to welldoing"; and the quote by Rachel Remen "the expectation that you can be immersed in suffering and loss on a daily basis and not be impacted by it is thinking you can walk through water and not get wet".

7.3 Practitioners demonstrated an awareness and acknowledgement of Penny's struggles and tried their best to ensure that her voice was at the heart of decision -making. All of those involved in this review worked to hear Penny's voice and yet at times struggled to fully understand what was happening in her life. Practitioners described how hard it was to 'gauge' Penny's state of mind as her presentation fluctuated so frequently between 'crises'.

7.4 Penny had her own struggles with services and would sometimes be frustrated by lack of reliability. For example, she would expect phone calls at a certain time from the Community Mental Health Team (CMHT) or crisis resolution teams, but this would happen a few hours later. If she was not available this was seen as 'non-engaging', and she and her family found this difficult.

[2] Dr Karen Treisman Mental wellbeing interviews

7.5 In conversations with her sister, Penny would comment over the years that these moments were not simply 'crises' for her, but her life, and such terms did not help her to trust services. For Penny, it was about living with pain from trauma, so much more than isolated crises or diagnoses.

7.6 Penny's experience highlights the challenges faced by health staff especially in the Emergency Department (ED) in assessing, understanding, and managing risk when people present in mental health distress. The resounding view of practitioners who participated in this review is that, for those people with mental health needs who are accessing services most frequently and most intensely, the systems do not fully work. This is acutely so in terms of the ability to exchange information across the community and hospital NHS systems and to build a collaborative approach.

7.7 There was an escalating pattern of attendance at ED, with increasing intensity. This was not simply a matter of the number of attendances although they did increase in 2020 from 7 between July-November and 5 in December, but a rising constellation of symptoms and need. A change in risk was becoming clear and led the CMHT to escalate to the Crisis Resolution team. During the period July-December 2020, Penny had contacted the Lighthouse[3] 60 times and frequently called the 111 mental health triage service. In addition, there was decline in her appearance and an increase in use of alcohol which Penny said helped with flashbacks.

7.8 Penny's care plan was updated regularly in line with the EUPD pathway and reviewed on the 21st December with a crisis plan. However, this increased level of support was not communicated to ED.

7.9 The week of Penny's death was described as 'messy' by her sister. Penny was only communicating some of the time and then would withdraw. Contact was via text as at other times when Penny was in great distress. Christmas was a sad time for Penny as she could not visit her grandparents. Family had a number of other commitments due to COVID and therefore could not visit for Christmas. Some of the messiness was known by services and some only known by family. It was a week when she was increasingly unwell, and she only responded with a 'full stop'. The 'messiness' continued after Penny's death and there is learning for services in

[33] The Lighthouse is an informal, non-judgemental, out-of-hours mental health service for anyone over the age of 18 who requires short-term support with their mental health.

how family are notified of the death of a loved one. This was especially traumatic for Penny's sister who also had to inform her mother.

The impact of different diagnoses such as EUPD and PTSD

7.10. EUPD was first mentioned as a diagnosis for Penny in 2008 in mental health records. She was 21 years old. In 2020, Penny had been exploring a potential connection with post-traumatic stress disorder (PTSD) with her psychiatrist. She was not comfortable with the diagnosis of EUPD. According to some practitioners there were potential signs and overlapping symptoms of attention deficit hyperactivity disorder (ADHD), but this had not been explored fully. Her diagnosis is not clear and there are references to bi-polar, and PTSD with examples of disassociation.

7.11 Several research studies now link childhood abuse with the onset of early onset personality disorder (PD)and close correlation with symptoms of post-traumatic stress disorder (PTSD). For example, research in 2019 in Manchester [4]identified that people with personality disorder are 13 times more likely to report childhood trauma than people without any mental health problems. There is no mention in any known reports that Penny had disclosed childhood sexual abuse (CSA) before 2011, or that there had been any exploration of previous trauma. Neither is there any information about family involvement when her sister disclosed Child Sexual Abuse as a child.

7.12 Southampton Hospital Foundation Trust (SHFT) has a care pathway[5] to support people with a diagnosis of BPD/EUPD. This is based on a trauma informed approach and builds on national guidance[6] [7] It led to an initial delivery of training packages to enable staff to understand and have a more compassionate approach. This included an understanding of the guiding principle of the Mental Health Act Code of Practice (1983) which states that the most appropriate clinician should be responsible for the needs of the patient., and not necessarily a medical practitioner. A review of the pathway in Southampton is taking place. and has revealed gaps in understanding and awareness of translating the pathway into practice.

[4] borderline-personality-disorder-has-strongest-link-to-childhood-trauma/
[5] Treatment and Recovery from Borderline Personality Disorder Care Pathway, Narrative and Procedures 2016 Transform
[6] Personality Disorder: no longer a diagnosis of exclusion" (NIMHE, 2003a)
[7] Breaking the cycle of rejection: the personality disorder capabilities framework" (NIMHE, 2003b

7.13 The primary treatment for people with a diagnosis such as EUPD is psychological and therefore a clinical psychologist with expertise in working with people with such a diagnosis might be the most appropriate clinician to lead their care and treatment. Penny was working with a psychologist who was working with her to prepare her for more intensive therapy. However, even though she at times expressed hopefulness for the future and was engaging in work with a psychologist. In conversations with her sister, she would say that nothing was really helping her. Her fear of thinking through the trauma was such that she struggled to believe that she could trust the practitioners to 'hold her safely'[8] during therapy.

7.14 Penny's sister referred to a number of occasions when Penny's mental health had deteriorated but she was not admitted to hospital because of expressed confusion and inaccuracies about guidelines for EUPD. NICE guidance states that people with EUPD should only be admitted briefly in a crisis but does not completely rule out admission to a psychiatric inpatient unit. EUPD NICE guidance (2015)[9]9 also notes that the care that people with diagnoses of EUPD are given is often fragmented. The current narrative around standard 88 (NICE 2020)10 advises that '*Some mental health professionals may find working with people with borderline or antisocial personality disorder challenging. People with personality disorder can experience difficulties in communication, building trusting relationships and respecting boundaries. This can be stressful for staff and may sometimes result in negative attitudes*. NICE 2020[10]

7.15 The impact of negative attitudes may indeed be seen in busy ED departments, particularly towards people seen as 'frequent attenders' and who may invariably want to self-discharge after an initial presenting 'crises' with a pattern of follow-up from CMHT. It is possible that there is less use of professional curiosity and probing, and an underlying assumption of 'attention seeking'.

7.16 There is no sense that Penny's care was fragmented, except in terms of the need for improved interface between ED and mental health services. However, the review finds that there is insufficient understanding of the impact of a diagnosis such as EUPD on both the person's life and the view from services or full understanding of the meaning of emotional dysregulation.

[8] Penny's sister in conversation with the author
[9] NICE Guidance 2015
[10] NICE 2020 Organising and Planning Services for people with a personality disorder

7.17 The care pathway known as Transform in SHFT needs to be shared with other services, and more thought given to improving the connection and interface with other services to increase understanding.

7.18 There is a strong link between self-harm and suicide, with suicide more common in people with a diagnosis of personality disorder[11] and a higher prevalence of previous trauma and childhood abuse. The increase in use of alcohol added to clinical complexity and yet there was no referral for support or advice from alcohol services.

High intensity user group and definitions

7.19 A small proportion of patients referred to as 'frequent attenders' account for a large proportion of hospital activity such as ED attendances and admissions. It has been estimated in 2018 that 5% of all hospital emergency department (ED) attendances are primarily due to mental ill-health[12] The High-Intensity User Group is a small team seeking to understand the needs of the most high-risk people with mental health needs in the Southampton area.

7.20 Penny did not meet the threshold for referral to the High Intensity User Group (HIUG) until December 2020. (The threshold is 8 attendances in 3 months) Even when people do meet the threshold it is not uncommon for the HIUG to have to delay contact and care planning because of team capacity and workload. However, in Penny's case the referral was accepted, and a plan was in motion to develop a plan. Sadly, this was not to be implemented in time. The HIUG process would have initiated closer multi-disciplinary team (MDT) working and possibly initiation of the Multi-Agency Risk Management Framework (MARM).

7.21 There are some challenges to the current protocol and threshold for referral. It does not allow for flexibility in the process for people whose mental health deteriorates over a shorter period and, as in Penny's experience, have five high intensity admissions in one month. It is important to think of a way to trigger an escalation even when the numbers do not meet the threshold. The Royal College of Emergency Medicine (RCEM Guidelines 2017[13]) recommends that a best practice definition is someone who comes to a 'health care facility' five or more times per year.

[11] National Confidential Inquiry into Suicide 2022
[12] HSIB Provision of Mental Health in the ED
[13] RCEM Guidelines 2017.pdf

Use of Multi-Agency Risk Management Framework (MARM)

7.22 Multi-Agency Risk Management Framework (MARM**)** *designed to provide guidance on managing cases relating to adults where there is a high level of risk, but the circumstances may sit outside the statutory adult safeguarding framework but for which a multi-agency approach would be beneficial.*[14]

7.23 The benefits of a MARM were not realised in Penny's situation. The MARM framework would have guided services to consider the rising levels of risk and consider the need for statutory safeguarding, rather than exclude the statutory route. There was clear evidence of a deterioration in Penny's physical and mental health, yet insufficient understanding of the need to bring services together across community and acute hospital settings to agree a joint plan and review the risk. This would have a given a fuller picture including the high contact with 111 and the Lighthouse. The CMHT held their weekly 'risk' meetings and escalated their growing concerns to the crisis resolution team. Nevertheless, this remained contained and only shared within mental health teams.

7.24 The Transform pathway states that: *For a minority of service users there may be exceptional circumstances in which it may be appropriate to involve and liaise with other agencies, such as the Police, Accident and Emergency Departments (As per Trust Policy Guidance for staff practice guidelines for confidentiality and information sharing guidelines).* Findings from this review suggest that it is imperative that a Multi-Disciplinary Team meeting (MDT) includes all relevant professionals and most specifically in this case staff from ED and liaison psychiatry. There should be consideration of the involvement of carers and family, with the consent of the subject of the meetings. In Penny's case she did not want her family to be always involved.

7.25 There was limited understanding of the benefits and purpose of a MARM with added confusion about the interface with statutory adult safeguarding. This is further compounded by a Section 75 partnership arrangement between Southampton City Council and the Southampton Division of SHFT adult mental health teams. This has implications for statutory safeguarding processes and a safeguarding standard operating procedure (SOP) between SHFT and Southampton City Council was developed in November 2021[15]. The SOP is designed to complement and not replace

[14] 4LSAB-MARM-Multi-Agency-Risk-Management-Framework-June-2020

[15] Southampton Mental Health Standard Operating Procedure for Safeguarding Adults

the Multi-Agency Policies and Procedures of Local Safeguarding Children Partnerships and Local Safeguarding Adults Boards.

> In practice this is a joint agreement made between Southampton City Council and Southampton Adult Mental Health Division and means that some of the duties usually performed by the local authority are undertaken by SHFT by staff working within the integrated community mental health teams or AMHT, safeguarding is one of the functions. (Standard Mental Health Operating Procedure 2021)

7.26 For statutory adult safeguarding, concerns are redirected back to community mental health teams in Southampton to complete the section 42 enquiry. The partnership arrangement should not prevent the use of the MARM Framework. The MARM was a necessary and vital intervention. The plethora of risks identified required a collaborative approach across ED, liaison psychiatry, HIUG, and mental health. In addition, housing might have been a useful addition to explore safety of the tenancy. A MARM should always in any similar case be considered when risks become heightened.

Interface between CMHT and ED

7.27 The CMHT and care coordinator had concerns about Penny's deterioration in her mental health. For example, in December there was an escalation to the Crisis Resolution team. This is the 'step up' service from the CMHTs for people becoming more unwell and needing a more intensive service. All admissions must go through the crisis team.

7.28 The CMHT and Crisis Resolution team were aware that Christmas would be a difficult time and trigger point for Penny and had updated safety plans. However, Clinicians in ED were only aware of a young woman who was attending ED more frequently with suicidal thoughts and self-harm, and that she was invariably discharged. It is possible that there was some unconscious bias operating in terms of diagnosis and perhaps some fatigue when a person presents frequently in ED. The increasing risk was not shared across the services and consequently the escalating presentation of increase in alcohol intake, decline in her appearance, flashbacks, and suicidal ideation was not understood. In a busy ED it is possible that information is not as accessible or visible as it should be. The process does not appear to be sufficiently robust as ED staff were not

aware of the full extent of the concerns being flagged by the liaison team. New information and changes in the safety plan in late December were not communicated by CMHT to ED staff.

7.29 The standard process for the liaison psychiatry team (based within the ED) is to provide a summary of all contacts on SHFT'S electronic system of record keeping (not the same as UHS) and this will provide them with access to information about the person. As a safety net, the liaison psychiatry team record a summary of their assessments in the paper records held in ED. The lack of interoperability across systems raises some serious questions and concerns. The review found that different electronic medical record systems are in place which are unable to effectively share information. The use of paper records is a complex issue in the NHS and yet the challenge is far greater in terms of working with fragmented systems enable to share data and information.

7.30 A pressing theme to be urgently addressed is further integration of liaison psychiatry and mental health services into ED. The Southampton division of mental health services and ED are employed by different organisations with, very often, separate policies and certainly with distinct systems.

Liaison Psychiatry

7.31 The liaison team in UHS is one of the largest teams in the UK, operates a 24/7 facility and covers the whole organisation. Team members are not based in ED but in a separate unit 10 minutes walking distance. Plans are being considered to co-locate team members.

7.32 At most attendances Penny was referred to the liaison psychiatry team. Referral to the liaison psychiatry does not take place until after a person has been 'triaged' in the' pitstop[16]' and assessed at initial presentation. This assessment does not always involve mental capacity or an assessment of mental health risk. People who may have higher intensity mental health needs are moved into the Enhanced Care Area, a smaller 2 room area within the ED. Therefore, referral to liaison psychiatry and assessments of mental capacity do not take place until further in the patient journey in ED, which might be a few hours later.

7.33 Following receipt of referral, the liaison psychiatry team make contact within an hour. It would be helpful to initiate earlier assessment processes and expedite earlier referral to liaison psychiatry. ED would benefit from resources and capacity to support assessments in the 'pitstop' and facilitate earlier contact with liaison psychiatry. In December 2022, the liaison psychiatry

[16] Admission points in ED

team and ED leads have implemented a joint mental health referral pathway to be used in the Pitstop/Triage area. This will need careful review and would benefit from the addition of trauma informed approaches.

Escalation Process

7.34 In 2019, the Care Coordinator and GP attempted to call an MDT because of increasing concerns about Penny. However, this does not seem to have happened and any meetings that took place were only within SHFT mental health services. If a HIUG referral had been agreed earlier this would have resulted in a full multi-disciplinary approach. However, this had not yet happened and therefore Penny did not benefit from having everyone involved in her life and care, sharing a fuller picture. It is important that professionals who do have concerns and make attempts as in this case to correctly bring professionals together understand that they might use the escalation process.

Understanding of Missing Person

7.35 On Penny's final attendance at ED in December 2020 she left the hospital to have a cigarette. She had already stated that she wanted to go home. However, Penny was described as in a 'mental health crisis 'on admission and that she 'reported as being suicidal'. Penny comments that she does not feel safe at home. At the same time capacity is assumed and even though she may have been physically compromised no reasonable steps are taken to consider her safety. It is possible that many factors were at play and some potential bias or normalising of self-harm or EUPD. As previously stated, the pattern seen by ED Clinicians was that Penny would be discharged from ED and referred to her CMHT and care coordinator for follow up.

7.36 A referral had not been made to liaison psychiatry. There is no immediate attempt to locate her when she does not return. Time had elapsed, and a member of the liaison team became aware that Penny was in the ED and made the decision to contact the police.

7.37 The call to Police in this case did not trigger a missing person guidance as the call was reporting a concern for safety rather than 'missing'. This essentially closed off a set of mandatory questions and action to assess current risk. There was no further follow up by the liaison psychiatry practitioner other than informing the mental health team. Hampshire and Isle of Wight Constabulary are currently taking forward learning and undertaking work to improve the identification of risk and contextual safeguarding with missing adults. A revised Missing Person's Template was implemented in 2021 by Hampshire and Isle of Wight Constabulary, to bring

greater clarity to assessment of risk when calls come through. This should ensure that expectations of the caller and the Police call handler are made clear, including what next steps should be taken. It is important for all staff reporting someone as missing to understand their own duty of care and need to own the risk. This would mean that all reasonable enquiries should be undertaken by, in this case, the health provider. This could involve contacting crisis teams, the ambulance service or known family contacts.

7.38 An understanding of the definition of 'missing' would be helpful. The College of Police defines missing as: *Anyone whose whereabouts cannot be established will be considered as missing until located, and their well-being or otherwise confirmed. All reports of missing people sit within a continuum of risk from 'no apparent risk (absent)' through to high-risk cases that require immediate, intensive action.*[17]

7.39 It is challenging in a busy ED department. However, the increasing number of presentations in December and suicide ideation might reasonably have raised concerns. There is no indication that the liaison team were routinely notified of her admission on Penny's final attendance. Therefore, there had not been the required psychosocial assessment. In addition, once Penny had spent a few hours in ED and the effects of alcohol had worn off it was felt that her risk lessened with no further probing or consideration of the cumulative picture.

Trauma Informed Approaches

7.40 It has been noted that there is a higher prevalence of exposure to trauma in childhood among people who have mental health issues and complex diagnosis such as EUPD. Molloy L, Fields L, and Trostian B (2020)[18] have highlighted that the experience of care in ED and the general environment can itself be a retraumatising experience for some people. Understanding of trauma has grown considerably over the last few years, enhanced by the work of Karen Treisman and others. It remains a difficult approach to embed in practice and yet it is important that we continue to develop our understanding of 'trauma' and how our practice can both retraumatise or help. The development of trauma informed practice in ED departments is not without challenge and yet the enormity of the need cannot be ignored.

[17] DefinitionofMisingCollege ofPolice2019

[18] Molloy L, Fields L, Trostian B et al (2020) Trauma-informed care for people presenting to the emergency department with mental health issues. Emergency Nurse. doi: 10.7748/en.2020.e1990

7.41 Penny's life is an example of how the impact of childhood trauma continued to pervade her life. On three occasions, she disclosed to Police during welfare checks at her home that she had been sexually abused as a child by a relative. Discussions took place between police and mental health practitioners (with Penny's permission and consent), and it was felt that it was not an appropriate time for Penny to continue to work through the disclosure as she was experiencing serious mental health crises and flashbacks. It was often at these points of heightened distress that Penny would take medication overdoses and then be admitted into ED via Ambulance.

7.42 Penny was not confident about moving forward with a police investigation following disclosures. Practitioners working with her agreed that although she was progressing with a plan to engage in deeper therapy, she was still fearful of talking and even writing about the abuse. The final decision made by Police was based on Penny's decision.

> a trauma-informed approach "**realises** the widespread impact of trauma and understands potential paths for recovery; **recognises** the signs and symptoms of trauma in clients, families, staff and others involved with the system; **responds** by fully integrating knowledge about trauma into policies, procedures and practices; and seeks to actively resist **re-traumatisation**" https://www.ljmu.ac.uk/-/media/phi-reports/pdf/2023-01-state-of-the-art-report-eng.pdf

7.43 A trauma informed /adverse childhood experience (ACE) approach is key to supporting survivors and preventing re-traumatisation. In this instance, the view of practitioners considering Penny's treatment plan was that it was too early and the risk of re-traumatisation too high. It is worth reflecting on how the view of practitioners might have unconsciously influenced Penny's decision making at the time.

7.44 There is a growing body of evidence exploring the links between EUPD and PTSD, and an understanding of the increased likelihood that people with such diagnoses will have experienced childhood abuse. Therefore, it is even more important that a trauma informed way of working is embedded in everyday work with people and is made even more explicit within the Transform pathway and its implementation. Some services nationally, now include routine enquiry or screening to measure past exposure to ACE's. [19]

Mental Capacity Assessments

[19] state-of-the-art-report-eng.pdf

7.45 It has been evident in this review that there was not a clear understanding of the process for undertaking a mental capacity assessment, neither was this documented consistently in records. It was challenging for both the liaison team and ED staff as Penny seemed to present with fluctuating capacity[20].

7.46 Assessing decision-making capacity in a person who has a diagnosis of borderline personality disorder (BPD or EUPD) following an act of self-harm is particularly challenging. It has been argued[21] that at the extremes of emotional dysregulation, people with a diagnosis of EUPD or BPD may become unable to view things objectively. Therefore, as the MARM Framework[22] points out *assessment of the person's mental capacity should include their executive function as well as their ability to understand e.g., can they manage in practice any risks and safety implications of the choice or decision being made[23].*

7.47 There was no evidence of sufficient understanding of executive functioning, or mental capacity in the context of emotional deregulation. This view was reinforced in discussions with Penny's sister who suggested that Penny's deterioration in her health and well-being in the few weeks before her death should have led to a consideration for formal admission. This was not an easy decision for Penny's sister, as many years before family members felt that Penny's rights had been unjustly taken away, and in their view for a lot less. The challenges and indeed consequences of this are clearly articulated in the quote below.

Capacity is a complex attribute, involving not only the ability to understand the consequences of a decision but also the ability to execute the decision. Where decisional capacity is not accompanied by executive capacity, and thus overall capacity for autonomous action is impaired, 'best interests' intervention by professionals to safeguard wellbeing may be legitimate. Yet executive capacity does not routinely figure in capacity assessments, and there is a risk that its absence may not be recognised. There is concern too that capacity assessments may overlook the function-specific nature of capacity, with the result that apparent capacity to make simple decisions is assumed in relation to more complex ones.' 2011 Social Care Institute for Excellence paper *Self-neglect and adult safeguarding: findings from research* (Braye, S; Orr, D; and Preston-Shoot, M).

[20] Fluctuating capacity is when a person's ability to make a specific decision change frequently or occasionally.
[21] Fuchs, T. (2007). Fragmented Selves: temporality and identity in borderline personality disorder. Psychopathology.40: 379-387
[22] 4LSAB-MARM-Multi-Agency-Risk-Management-Framework-June-2020.pdf

7.48 On Penny's admission in ED on December 22nd the liaison team recommended that Penny was detained using UHS's own refusal of treatment policy. Penny remained in ED until she was reassessed and discharged by liaison psychiatry the next day. Penny did not make any attempt to leave ED during this attendance. The liaison team also pointed out that capacity may be impacted by emotional dysregulation and would have to be assessed at the time she is being asked to decide. However, this was not pursued by the clinician in ED. Paragraph 4.4 of the Code of Practice says that an assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made and not their ability to make decisions in general*. (COP team 39 Essex Chambers, p:7).*

7.49 Since Penny's tragic death there have been many improvements in UHS; workshops and masterclasses have taken place in 2022 to prepare staff to complete mental capacity assessments. This has included some tailored development work in ED. The multiagency capacity assessment tool has been promoted amongst staff in UHS. However, there is an urgent need to increase understanding of executive functioning across services, including ED. In addition, it would be helpful to explore how mental capacity assessments might be undertaken earlier in the ED admission process, when people are at the 'front door', that is the 'pitstop'[24].

Interface with statutory safeguarding

7.50 One area that might usefully have been explored was Penny's neglect of her appearance and hygiene. In April 2020, it was noted that her appearance was 'good' in CMHT records. Between October and December, the CMHT records documented increasing concerns about 'self-neglect'. Her hair was described as 'dishevelled' and her nails as 'awful'. This was seen as out of character for Penny who took considerable pride in her appearance. This rather rapid and sudden onset change was not recorded in ED records or liaison psychiatry.

7.51The potential for self-neglect was not raised as a safeguarding concern but seen as part of the deterioration in her mental health and subsequent increase in her alcohol intake. As observed earlier, a MARM might have prompted wider discussions.

7.52 The Southampton Mental Health Standard Operating Procedure for Safeguarding Adults sets out the delegated responsibility for SHFT when dealing with safeguarding concerns and enquiries. The review has not found a clear understanding of when and how enquiries are undertaken. The

[24] This is the initial triage point in ED.

Section 75 subgroup is asked to audit the number of enquiries and outcomes. In addition, the links with the corporate SHFT safeguarding team are unclear.

8. Summary

8.1 This review has focussed on the services working with Penny and therefore has inevitably explored the role of health services. A theme to be urgently addressed is integration and embedding of liaison psychiatry and adult mental health services into ED departments. The mental health services and ED are employed by different organisations, with separate policies and certainly with distinct systems. Greater alignment of all processes and staff would be not only helpful, but urgent, such as basing liaison psychiatry team members in the ED, and an earlier intervention liaison psychiatry referral process.

8.2 The review has identified other areas for improvement and reflection such as the use of 'paper records' in ED. Whist this was not noted by practitioners as a major obstacle it nevertheless might have contributed in some way to lack of ease of retrieving information at each contact.

8.3 The review has found that adult mental health services working with Penny were acutely aware of her increasing distress. This was evident in the way in which mental health services stepped up support to her in December 2020, via the Crisis Resolution team. However, this at times appeared like 'gatekeeping 'to family and to Penny who was feeling increasingly unsafe.

8.4. Likewise, the GP was a pivotal point of contact for Penny, constantly advocating for her and sharing care with mental health services. Yet, some of these escalating concerns and conversations were not shared with ED who still operate two years later with different information systems and differing priorities. Therefore, even though services external to ED intensified their support this was not conveyed clearly enough to ED staff. This meant that the risk was not completely shared.

8.5 Practitioners voiced their concern and frustrations that Penny's experiences are replicated and the interface between acute health services and mental health services remains both an opportunity and a risk; a chasm in the system for people who are frequently in ED through self-harm, alcohol, and variable diagnoses. Crucial learning from this review is to explore the interface between the acute NHS services such as ED and adult mental health services. There

is a great need to connect the systems and build a collective intelligence which overcomes boundaries. After all, who is the centre and why are we here?

8.6 Improvements have been made with a more robust protocol for early nurse led referral to liaison psychiatry by ED nurses. This would be enhanced by a mental health nurse post in ED to support assessment, referral and risk management. More work will need to be done to challenge cultures and develop a trauma informed practice approach.

8.7 Practitioners have articulated the emotional cost of working with people who have such intense and fluctuating needs. The work is both overwhelming and challenging and yet paradoxically they remain committed and passionate to service improvement for the most vulnerable of adults such as Penny.

8 Next Steps and Recommendations

Recommendation 1 MARM

- SSAB and ICB should ensure that the review of the MARM Framework has specific guidance to remind NHS staff of the need to use the MARM Framework when it is noted that mental health risks are increased and escalated in intensity
- The Southampton Division of mental health services in SHFT should prepare a briefing from the above review of the MARM and ensure that the potential for a MARM is a prompt in all MDT and risk meetings, as per the SOP.

Recommendation 2 Understanding of EUPD

SHFT will review and further develop the complex personality disorder pathway (Transform) and ensure that it is known and shared across all agencies

Recommendation 3 Understanding of mental capacity for people with a diagnosis of EUPD and dual diagnosis

- SSAB should consider additional training on understanding Executive Functioning and assessing capacity with reference to people with EUPD and dual diagnosis
- UHS and SHFT should review their current safeguarding and mental capacity training to ensure that Executive functioning is highlighted with its relevance to assessment.
- UHS should explore opportunities to improve assessment of both mental health risk and mental capacity of people in crisis earlier in the admission process in ED

Recommendation 4 Exploring a way to share updates between CMHT and ED (SHFT, UHS, PHU)

- The lead nurses of NHS Trusts such as UHS and Portsmouth Hospitals University NHS Trust (PHU) and SHFT should agree a protocol to ensure that ED receives timely updates about people with escalating mental health needs who use ED frequently.
- Liaison Psychiatry should continue with their plans to have members of the team placed directly in ED and not in neighbouring sites.

Recommendation 5 A coordinated model for people with complex mental health needs who use health services frequently

- UHS/the ICB/SHFT/PHU should consider working together to identify funding streams for an improved core HIUG service to bring professionals together and develop shared care plans, including greater links with psychology, ED, clinical leads, and improved access threshold.
- UHS and ICB should explore funding and resources to increase mental health nursing capacity within ED.
- UHS should further develop the new protocol for nurse led liaison and referral to liaison psychiatry to ensure earlier referrals in the patient journey.
- UHS should update the action cards developed to update ED staff on care of people with high-risk mental health presentations

Recommendation 6 Missing Persons Policy and Duty of Care

- UHS and SHFT should develop a joint policy and guidance for any person who is found to be 'missing' from ED and issue a briefing to ensure that all reasonable initial enquiries are made by health staff in ED to locate the person and that they should continue to inform and update the Police
- Hampshire and the Isle of Wight Constabulary should audit the use of the amended Missing Person's template to be assured that the level of risk assessment is accurate, and roles and expectations of each agency are clear.

Recommendation 7 Trauma informed Approaches

- SSAB should consider training and development sessions to remind staff of the impact of childhood trauma and how in adulthood this is further compounded by traumatic events leading to retraumatisation.

Recommendation 8. High Intensity User Service

- UHS should re-examine the threshold for referral for people who do not meet the threshold of 8 attendances over 3 months but may have escalating high risk presentations over a shorter period.

Recommendation 9 Section 75 The Section 75 subgroup should audit the number and quality of safeguarding enquiries undertaken by the Southampton division in line with the SOP, including whether pursued through a S42 or not, and that enquiries carried out under S75 fulfil legal duties.

- Conduct an audit to review the way Section 75 has benefitted outcomes for adults at risk of abuse and neglect, and assures itself that the referral pathways into safeguarding are clear and are being followed; this should consider referrals both from within the Southampton division and from outside the Trust in respect of individuals receiving services from the Trust, and that it is clear where responsibility for safeguarding triage is located – that is,who determines whether the circumstances referred meet the S42 criteria for a safeguarding enquiry – and that those responsibilities are being fulfilled in practice.