Penny - 6 Step Briefing

The Background

Penny was 35 years old, had experienced mental health trauma for many years and had a diagnosis of Emotionally Unstable Personality Disorder (EUPD), bi-polar and anxiety. 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. Penny had previously been detained under section 2 of the Mental Health Act in 2019.

The Incident

Over many years and increasingly so during 2020, Penny 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 Emergency Department, the Liaison Psychiatry Team and a care coordinator. She was also in regular contact with the Lighthouse and called 111.
In the month prior to her death, Penny attended the Emergency Department (ED) five times. On Christmas Eve 2020, Penny left the hospital to have a cigarette and did not return. Penny tragically died from hanging.

Key Lines of Enquiry

- Was Penny's Voice captured? Was she actively involved in the care she received?
- 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.
- Evaluate the application of the Mental Capacity Act 2005 in practice.
- 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?

The Review

The Southampton Safeguarding Adult Board recommended that this case met the criteria for a discretionary Statutory Safeguarding Adult Review (SAR) and identified that there was learning relating to how agencies worked together.
All Southampton agencies involved with Penny submitted information to the review. The independent reviewer worked with a panel comprised of key agencies and a practitioner event was held to discuss at depth the key lines of enquiry and to reflect on how services responded to Penny. This was attended by those who worked with Penny directly and those representing their service.
Penny was part of a family who felt and witnessed her pain for many years and cared for her deeply. Therefore, the independent reviewer met with Penny's family to share their thoughts and experiences and to provide insight into Penny's life as part of the process of this review.

Findings

The impact of different diagnoses such as EUPD and PTSD – The EUPD pathway needs to be put into practice. There is a need for an improved interface between the Emergency Department and the Mental Health Team. The care pathway known as 'Transform' in Southern Health Foundation Trust (SHFT), needs to be shared with other services, and improve the connection and interface with other services.

High intensity user groups (HIUG) and definitions - Penny did not meet the threshold for referral to the HIUG until December 2020. The threshold is 8 attendances in 3 months. The current protocol 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 5 high intensity admissions in 1 month. It is important to think of a way to trigger an escalation even when the numbers do not meet the threshold.

Use of Multi-Agency Risk Management Framework (MARM) - There was limited understanding of the benefits and purpose of a MARM with added confusion about the interface with statutory adult safeguarding. 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.

Interface between Community Mental Health Team (CHMT) and Emergency Department (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. A pressing theme to be urgently addressed is further integration of liaison psychiatry and mental health services into ED.

Liaison Psychiatry - It would be helpful to initiate earlier assessment processes and expedite earlier referral to liaison psychiatry upon ED attendances. Referral to the liaison psychiatry does not take place until after a person has been 'triaged' in ED. This assessment does not always involve mental capacity or an assessment of mental health risk.

Escalation Process – Penny did not benefit from having everyone 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 – Penny leaving the ED did not trigger a 'missing person' which closed off a set of mandatory questions and actions to assess the current risk. Improvements are required around identification of risk and contextual safeguarding with missing adults.

Trauma Informed approaches - 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 in the Transform pathway and its implementation.

Mental Capacity Assessments - There was not a clear understanding of the process for undertaking a mental capacity assessment, neither was this documented consistently in records. There is an urgent need to increase understanding of executive functioning across services, including the ED. In addition, it would be helpful to explore how mental capacity assessments might be undertaken earlier in the ED admission process.

Interface with statutory safeguarding - The 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. 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.

Useful links for Best Practice

- Full Penny Report and Recommendations
- 4LSAB Multi-Agency Risk Management Framework - MARM
- Tackling Adverse Childhood Experiences (ACEs) State of the Art and Options for Action
- Borderline Personality Disorder has the strongest link to childhood Trauma
- Alcohol Change UK – Learning from Tragedies
- Executive Functioning – The Science of Adult Capabilities
- Working with people who self-neglect: Practice Tool (2020) | Research in Practice
- 4LSAB Escalation Protocol