Bury Safeguarding Partnership

Working together to safeguard adults and children in Bury

Penelope Safeguarding Adult Review Overview Report

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1. Introduction

1.1 This review has been commissioned by the Independent Chair of Bury Integrated Safeguarding Partnership (BISP), following a decision recommended by the Case Review Group (CRG), and in accordance with the Care Act (2014), that this case met the criteria for a Safeguarding Adult Review (SAR). This SAR will be undertaken as a concise Practice Review, utilising the principles of Child Practice Reviews in accordance with Protecting Children in Wales: Guidance for Arrangements for Multi-agency Child Practice Reviews (Welsh Government 2012).

1.2 The period under review encompasses the period when the Covid-19 pandemic was affecting the lives of all UK citizens and the way in which statutory services were being delivered.

2. Summary of Learning Themes

2.1 The following are the main learning themes:

- The importance of sharing all risk factors when patients are being transitioned between services.
- Transition from one service to another leads to the loss of patients safety nets. Formalising arrangements to allow the transition process to extend after the patient has moved requires consideration.
- Risk needs to be managed on a multi-agency basis.
- Mental capacity assessment should be part of the consent process within health.
- The importance of following multi-agency Child Protection Procedures, making referrals and holding strategy meetings when young people disclose sexual abuse.
- The importance of referring patients in mental health crisis to the mental health liaison team unless they are already sectioned under the Mental Health Act.
- The need for joint protocols to provide clarity on expectations and facilitate communication between commissioners and providers.
- Next of kin need to be informed of their loved ones passing at the earliest opportunity. Press need to be restricted from reporting until after this has occurred.

3. Purpose of a Safeguarding Adult Review

3.1 The purpose of a SAR is to:

- Determine whether decisions and actions in this case comply with the policy and procedures of named services and BISP;
- Examine inter-agency working and service provision for the adult and family;
- Determine the extent to which decisions and actions were adult focused;

- Examine the effectiveness of information sharing and working relationships between agencies and within agencies;
- Establish any learning from the case about the way in which local professionals and agencies work together to safeguard adults;
- Identify any actions required by the BISP to promote learning to support and improve systems and practice.

4. Succinct summary of case

Background information

4.1 Penelope was a young person in her late teens when she died. Penelope was described as a fun character who loved to play pranks, was inquisitive and playful, and had an infectious laugh. Penelope loved life and wanted a normal life. Penelope was very caring in relation to her peers, acting as a mother hen, welcoming new residents as they arrived. Penelope was a thinker, a problem solver, she was very private and took time to talk about her issues. Penelope was much loved by her family and all the professionals who had, and were, working with her.

4.2 Penelope had spent much of her teenage years in mental health settings. Concerns were raised about Penelope's self-harm[1] behaviours in November 2017. Between 2017 and 2022, Penelope became subject to child in need planning for three periods. Initially Penelope was supported as a Child in Need by Manchester Children's Social Care, school and the Child and Adolescent Mental Health Service. Penelope was first admitted to hospital in August 2018; she was detained under Section 3 of the MHA. Three months after admission Penelope disclosed she had been sexually assaulted whilst missing without permission from the ward. Over the next five months Penelope's self-harm behaviours escalated both in frequency and seriousness; Penelope was using a variety of methods.

The review period

4.3 In August 2020 Penelope was moved to a secure unit, she was detained under Section 3 of the MHA. Initially there was varied response and engagement by Penelope with activities and the Multi-Disciplinary Team (MDT). In the first month following admission there were 18 separate self-harm incidents.

4.4 By November 2020 Penelope's engagement with therapies and education had increased with attendance at both psychology and Occupational Therapy (OT) sessions. As a result Section 17[2] leave was commenced which proved successful.

4.5 There was an increase in self-harm behaviours in January 2021. These became less frequent from February 2021.

4.6 Over the following seven months Penelope's self-harming behaviours reduced and she was being prepared for discharge. In March 2021 Penelope indicated that

[1] Self-harm is when somebody intentionally damages or injures their body. It is a way of expressing deep emotional feelings such as low self-esteem, or a way of coping with traumatic events

[2] Section 17 leave is the power of a patient's responsible clinician to grant, detained patients, leave from the hospital. A detained patient is only allowed to leave the hospital with this leave in place.

she did not feel ready to return to the family home. In April 2021 Penelope was referred to CSC; a therapeutic placement was being sought and it was deemed a Care Act assessment[3] was required in order to secure funding. By June 2021 work towards community placement began.

4.7 In July 2021 there were plans for the therapeutic placement to commence an assessment and a Care Act assessment was completed. Penelope expressed her worries regarding possible return to the family home. Penelope expressed a desire to become looked after and a decision was taken, in conjunction with her family, for her to become looked after under Section 20[4] of the Children Act in November 2021.

4.8 A move to an out of area care home which supported young people via a therapeutic team was planned for December 2021, however Penelope self-harmed and was refusing medical intervention. It was believed that flashbacks to an assault Penelope had experienced in December 2018 were the trigger for this escalation in her self-harm. The move was halted and a plan was devised to facilitate this move in a slower manner to allow Penelope the time to adjust to her new placement and new clinical staff.

4.9 Penelope's discharge to the care home took place in March 2022. Penelope was allocated a personal assistant from the Leaving Care team and as a consequence three months later, when Penelope turned 18, her case was closed to the Children's Looked After team.

4.10 After an initial, and somewhat unexpected, settled period within the care home, Penelope's self-harm behaviours increased, and on the day before her death Penelope carried out a serious self-harm event leading to a significant bleed and burns. Ambulance staff were unable to remove a bladed object from Penelope so Police were called to assist. Penelope was deemed to require hospital treatment but refused to attend. A mental capacity assessment determined Penelope lacked capacity to consent to treatment or to safeguard herself, Penelope refused to go to hospital and attempted to escape. Police had concerns regarding the high risk of Penelope going missing. In order to ensure Penelope had medical assistance in hospital, ambulance staff administered sedatives, and the police handcuffed Penelope and escorted her to A&E under the Mental Capacity Act (2005). Police officers believed Penelope required a Mental Health Act assessment[5].

4.11 When seen in A&E by medical staff Penelope was said to be much calmer, had agreed a treatment plan, negating the need for a mental capacity assessment. A decision was made to not refer Penelope to the mental health liaison team. It was believed that Penelope did not need an assessment of her mental health in A&E, and it would be better for her to receive an assessment of her mental health by

[3] An assessment under the Care Act is an assessment of needs for care and support (including transition assessments), or an assessment of a carer's needs for support.
[4] Under section 20 of the Children Act 1989, social services must provide accommodation to certain children in need in their area. Section 20 is used to accommodate children who cannot live with their families.
[5] A Mental Health Act Assessment is an assessment to decide whether a person should be detained in hospital under the Mental Health Act to make sure they receive care and medical treatment for a mental disorder

someone who knew her within the care home; Penelope was discharged. There was no communication between the hospital and the care home.

4.12 Police officers continued to have concerns regarding Penelope's mental state and still felt there was a need for mental health assessment and support. Following discussion with their supervisor, they were advised to escort Penelope back to the care home. Police officers escorted Penelope in a police van and then raised a safeguarding in relation to safety within the care home, and referred Penelope to the Access and Crisis Team.

4.13 Care home staff had expected Penelope would be admitted to hospital because of her significant bleed and because of the nature in which she had been removed from the care home, they had expected to be contacted.

4.14 On return to the care home staff, who had been unaware Penelope would be returning, consulted with the on-call clinician who advised Penelope be given prescribed PRN medication. The advice was followed and Penelope went to sleep. The following morning there were incidents of self-harm in the form of cuts/reopening of wounds.

4.15 Whilst Penelope was being discussed in a MDT meeting, Penelope went for an accompanied walk. Penelope became agitated and expressed a wish to walk on her own, staff felt Penelope's distress was being heightened by the staff members presence. After formulating and agreeing to a safety plan, Penelope was allowed to continue with her walk unaccompanied. Penelope complied with the safety plan but when spoken to Penelope 's distress had heightened. Penelope went to a nearby bridge, where she fell resulting in her death.

5. Methodology

5.1 Following notification of the circumstances of Penelope's case, and agreement by the Independent Chair of BISP to undertake a Safeguarding Adult Review, the Review Panel was established. A reviewer/chair, Nicki Walker-Hall, was commissioned by BISP. An initial set up meeting was held and the following methodology agreed.

5.2 Each agency reviewed their records and drew up chronologies of their entire involvement with Penelope between the 1st August 2020 and Penelope's death on the 17th August 2022. The single agency chronologies were analysed by the reviewer and the panel members, who developed hypotheses to further inform the key focus areas for exploration and consideration.

5.3 Each agency was required to complete a Learning Summary Report concentrating on the key focus areas. Agencies were asked to provide a brief summary of any significant incidents from January 2018 relating to the terms of reference, if it was believed that additional learning could be extracted.

5.4 Key practitioners were identified and asked to attend a practitioner's event. This event focussed on Penelope's journey through the system in order to reflect on and share learning and also to identify opportunities for improved working within and between agencies in the future.

5.5 A separate commissioners event was held to consider wider issues around commissioning and service provision.

5.6 A separate meeting was held with A&E staff to extract learning from Penelope's attendance to the department on the 16.08.2022.

5.7 A separate meeting was held with the Local Authority Designated Officer, to discuss information previously reported and considered by the LADO in relation to the care provider.

5.8 The reviewer has accessed the two latest CQC inspection reports to gain an understanding of the regulators findings both before and since Penelope's death.

5.9 The reviewer met with Penelope's family to gain an understanding of their experiences of the services provided.

5.10 The reviewer was provided with commentary on the footage from the police officers body worn cameras from the night before Penelope died, to further inform her understanding of the management of the self-harm incident on the 16.08.2022.

5.11 The reviewer completed a draft report which was analysed by the panel. Partner organisations via the Panel then had an opportunity to agree actions to address the blockages and barriers identified. The panel also considered the most appropriate method to share the learning across the workforce in Bury.

5.12 It is intended learning from the full report will be made available to the public but only after consideration by the Safeguarding Adult's Board.

6. Key Focus Areas

6.1 The following key focus areas were agreed:

- **Voice of Penelope and Penelope's lived experience –** Is there evidence of the voice of Penelope within agency records. What did practitioners understand regarding Penelope's lived experience?
- **Self-Harm Incident –** Explore the management of Penelope's self-harm incident on 16.08.2022.
- **Transition and discharge points –** Consider the effectiveness of preparation and plans at all points of transition and discharge including the move from children to adult services.
- **Section 117[6] –** Explore the management of Penelope's S117 after care.
- **Information sharing –** Consider the level and quality of information sharing both within and across agencies.
- **Management of risk –** Consider occasions when risks were present. How were these risks identified, analysed and translated into safety plans? How was risk managed across some key deliverers, acute medical care, mental health and social care? How was Penelope's family involved in safety planning? Were there gaps in inclusion of, and services to, the family?
- **Mental Capacity Act –** Is there evidence that practitioners have assessed Penelope's mental capacity at key points. Give consideration to best interest/unwise decision making, fluctuating capacity and executive functioning. Consider the use and interpretation of the Legal Framework.

[6] You are entitled to section 117 aftercare if you have been in hospital under sections 3, 37, 45A, 47, or 48 of the Mental Health Act 1983.

- **Management of disclosure of abuse –** Examine the actions taken following Penelope's disclosure of historic sexual abuse.
- **Professional Curiosity and Escalation –** Consider whether professionals were sufficiently curious and whether escalation processes were used appropriately in this case.
- **Commissioner and Provider Arrangements –** How clearly defined were the commissioner/host arrangements and responsibilities? What assurance was required by commissioners that the host could provide the wrap around service Penelope required and what evidence did the provider submit?
- **Covid-19 –** How did Covid-19 specifically impact on service delivery in this case?

7. Engagement with family

7.1 Penelope's parents kindly agreed to meet with the lead reviewer. The reviewer is grateful to them for their invaluable contribution to this review. Their observations have been included throughout the report. The reviewer shared the findings of the review with Penelope's mother.

8. Review team

8.1 The Review Team consisted of the reviewer, Nicki Walker-Hall, and members of the BISP Review Subgroup, which included senior safeguarding representatives from the following agencies:

- Pennine Care Foundation NHS Foundation Trust (PCFT)
- Greater Manchester Police (GMP)
- Bury Adult Social Care (ASC)
- Manchester Adult Social Care (ASC)
- NHS Bury CCG (now transitioned into Greater Manchester Integrated Care Board) (ICB)
- NHS GM Integrated Care (Manchester Locality)
- Northern Care Alliance NHS Foundation Trust (NCA)
- Bury Integrated Safeguarding Partnership (BISP) Manager
- Greater Manchester Mental Health NHS Foundation Trust (GMMH)
- Cygnet Health
- Care in Mind (Care provider/care home)
- Manchester Foundation Trust (MFT)
- North West Ambulance Service NHS Trust (NWAS)
- Manchester Children's Social Care (CSC)including the Leaving Care Team (LCT)
- Care Quality Commission (CQC)

8.2 Nicki has worked in safeguarding roles for over twenty five years. Nicki has an MA in Child Welfare and Protection and an MSc in Forensic Psychology. Nicki is an experienced author of both children and adult safeguarding reviews; she has a background in health.

9. Timescales

9.1 There is an expectation that a SAR should be completed within 6 months of initiation unless there are good reasons for a longer period being required. In this instance, this timescale was not met. Initiation of the review was impacted by the volume of SAR's being conducted within Bury. Once commenced, timescales were further impacted by the late submission of a significant number of the single agency learning summary reports and, because of the complexity of the case, by the need to hold separate meetings with health colleagues, commissioners and the LADO.

10. Analysis pertaining to the Key Lines of Enquiry

10.1 Voice of Penelope and Penelope's lived experience – Is there evidence of the voice of Penelope within agency records. What did practitioners understand regarding Penelope's lived experience?

10.1.1 There appeared to be a good understanding of Penelope's lived experience across those agencies that were actively involved. Penelope's worries were clearly articulated and informed plans made on a multi-agency basis. Penelope had a number of professionals involved from all agencies which may have impacted on her ability to build trusting relationships. Mental health practitioners were clear that it would take upwards of a year to develop a truly therapeutic relation.

10.1.2 Of note Cygnet was the only placement that lasted for that length of time, and it is clear from the reduction in Penelope's self-harm behaviours over the time she was in their care, that this was having a positive impact. Penelope's parents indicated that they had a positive experience of the service, and were extremely happy with the care Penelope received. Parents indicated they were included in decision making within meetings, had frequent dialogue with the consultant, and had seen a clear improvement in Penelope's mental health.

10.1.3 There is evidence that Penelope's voice was heard when she indicated she was not ready to return to her home environment and plans were made for Penelope to become a Looked After Child at the point she was deemed to be no longer detainable under the Mental Health Act. There is further evidence that Penelope's voice was heard when Penelope indicated she was struggling to cope with the planned change of placement in December 2021. Changes to the planned date of discharge were made to allow Penelope to become familiar with the new placement, the staff and the environment at a slower pace.

10.1.4 As is somewhat understandable, and because of the nature, length and circumstances around their contact, the GP, NWAS, A&E and the police had less of an understanding of Penelope's lived experience.

10.1.5 The GP records indicate the Manchester GP practice contacted Penelope's mother on one occasion to follow up a discharge summary which mentioned safeguarding concerns, which was positive.

10.1.6 Within the A&E department there is evidence Penelope's voice was heard as all interventions and decisions made were discussed with Penelope. However, there is little evidence of Penelope's lived experiences being discussed or documented. Although carers were present on all but the last occasion, all conversations appear to have taken place with Penelope while being accompanied by care staff.

The lack of the presence of a carer reduced the opportunity for A&E staff to understand Penelope's current circumstances.

10.1.7 NWAS have recorded that on each contact that they tried to engage Penelope and hear her voice. On one occasion Penelope refused to tell NWAS staff why she had self-harmed and denied any recent problematic events had been the trigger. On the other contacts, Penelope was not able to engage with NWAS around her wishes or needs.

10.1.8 Greater Manchester Police had limited direct interaction with Penelope. Records detail that Penelope was a vulnerable young person experiencing significant traumatic mental health issues. Penelope's lived experience appeared to Police to have been distressing and highly unsettling as a result of her ongoing battle with her mental health.

10.1.9 Upon transitioning into the care home, Penelope was subject to a comprehensive care plan. The initial care plans were based on information shared from previous placements, information from previous professionals, feedback from Penelope and family members as well as information or behaviours witnessed during the transition period. These plans were completed collaboratively with Penelope to ensure they are as useful as possible in aiding Penelope's progression to life in the community, whilst also allowing staff to work with the Penelope in a consistent manner. There is evidence that Penelope engaged in the review process for her care plans each month at the care facility.

Learning point: There is much that is positive in relation to those practitioners that that were working with Penelope on a day to day basis' knowledge of Penelope's lived experience, with evidence that they were listening and taking account of Penelope's expressed wishes and feelings. It was clear within the practitioners event that those practitioners present knew and understood Penelope's lived experience well. Penelope would often express her distress through her self-harming behaviours. Practitioners from CSC, all in-patient facilities and the care provider were taking account of the impact of Penelope's prolonged period of hospitalisation on her development and lived experiences. This is less evident when services were seeing Penelope during crisis. Latterly A&E staff were overly focussed on Penelope's physical needs with less consideration to her fluctuating and escalating mental state.

10.2 **Self-Harm Incident –** Explore the management of Penelope's self-harm incident on 16.08.2022.

10.2.1 At 20.39 on 16.08.22, Penelope rang staff (from her bedroom), asking for help. Staff went up to Penelope. Penelope had made a significant cut to her right lower thigh that was bleeding heavily. It was recorded that Penelope was distressed. Staff reassured her that they would help her. Penelope became distressed at the amount of blood coming from the cut. With Penelope's consent, staff applied pressure to the leg. Staff spoke to her and used touch to calm her down while they tried to stop the bleeding. Penelope reportedly appeared shocked and distressed by the severity of the cut and the bleeding.

10.2.2 Care home staff could not stem the bleeding and after assessing the wound, contacted an ambulance. Penelope made several comments about "having to

make it worse" and saying she wanted to die. Penelope's emotional state was described by staff as "up and down during this time, going from chatting and present to distressed and upset". While staff were sat with Penelope, she repeatedly punched herself in the head and pulled at chunks of her hair. Penelope became more distressed when informed that an ambulance had been called and again when the paramedics arrived. Penelope was assessed but would not interact with the paramedics during this, telling them she was "fine" and that nothing had happened. Penelope told the paramedics she didn't want to go with them as they would put bugs in her at the hospital so the government could spy on her. Penelope became more and more distressed and attempted to reach for blades during this time to continue to hurt herself. Penelope also told the paramedics that she wished she could die and she didn't want to be here anymore. Paramedics tried to talk to Penelope about coming in the ambulance, but she refused, becoming more distressed.

10.2.3 The advanced Paramedic, felt the care provider staff appeared to be overwhelmed and possibly out of their depth with Penelope 's presentation; they were unable to share any insight into Penelope wishes and feelings and reported Penelope did not share her feelings with staff, but came to them after self-harming.

10.2.4 NWAS contacted the police for support as Penelope refused to surrender a knife and was refusing treatment. NWAS indicated that Penelope had an significant bleed which needed assessment and treatment in hospital.

10.2.5 Police officers attended in order to support NWAS to attend to Penelope's self-harm injuries. Duties involved restraint of Penelope as a preventative measure, and ultimately transport to A&E for further assessment and medical support.

10.2.6 It was deemed that Penelope lacked capacity to consent to treatment or to safeguard herself, she refused to go to hospital and attempted to escape. Police had concerns regarding the high risk of Penelope going missing.

10.2.7 In order to ensure Penelope had medical assistance in hospital NWAS administered sedatives, and the police handcuffed Penelope and escorted her to A&E under the Mental Capacity Act (2005). It is reported that Penelope's presentation fluctuated significantly and she presented with clear deterioration in mental state. NWAS requested a specialist bariatric vehicle to provide additional space to enable as dignified an extrication as possible.

10.2.8 No carer from the care provider was available to accompany Penelope as they were managing the distress of other residents who had witnessed this event. Penelope's health passport was also not sent with her to hospital due to the situation within the care home.

10.2.9 At point of triage in hospital the nurse noted a three day history of escalating self-harm, a laceration to Penelope's right leg which required suturing and burns. The nurse noted a past medical history of Post-traumatic stress disorder (PTSD) and Emotionally Unstable Personality Disorder (EUPD), that Penelope resided in a care facility and that she had "no capacity at present". There was a note on the standby sheet that Penelope was on a section 136; this information came from the call handler at NWAS and was incorrect. However it is reported that A&E staff were aware she was brought to hospital under the MCA.

10.2.10 Whilst Penelope was in the A&E department police officers continued to restrain and release Penelope in response to her fluctuating presentation.

10.2.11 When seen by the treating doctor Penelope was reportedly laughing and joking, the nurse allocated to care for Penelope was on a break. There is no record of there being a significant bleed and Penelope's wounds were cleaned and sutured. Penelope was referred to the burns clinic. The doctor made a record indicating the care provider, management, and safeguarding were to be informed. This did not happen prior to discharge.

10.2.12 Police requested Penelope be assessed by the mental health liaison team in hospital however the consultant reported that the hospital would not facilitate this citing the fact that Penelope was living at a mental health facility and is reported to have said, "the hospital do not conduct mental health assessments."

10.2.13 Whilst A&E staff do not conduct mental health assessments the Mental Health Liaison Team (part of PCFT) are contactable 24/7 and do. Penelope was not referred or seen by the Mental Health Liaison Team. Subsequent the PCFT Access and Crisis Team were contacted; the team followed up with the care provider on the 17th August 2022 and were assured that Penelope was being assessed by their mental health duty nurse. The referral was therefore closed. The care provider was provided with contact details the team should they require support.

10.2.14 Penelope was in a care home which had a wraparound service, however there may have been a lack of understanding of what that service provides. There was time when Penelope would have been in her own room unsupported, and times when additional professional services were not available e.g. out of hours.

10.2.15 There was no consideration of returning Penelope to her care home via ambulance. Police were requested to escort Penelope back to the placement. The attending Police officers sought advice from a supervisor who advised officers to escort Penelope home where a mental health assessment could be undertaken subsequently. Police officers continued to have concerns regarding Penelope's fluctuating presentation, as she continued to attempt to self-harm via banging her head, pulling her hair and also attempting to remove the dressings to her wounds. Penelope voiced possible paranoid delusional ideation that the paramedics had injected her with bugs.

10.2.16 Penelope was escorted home and a safeguarding was raised by police, indicating concerns regarding Penelope's mental state and the need for a mental health assessment and support.

10.2.17 Care home staff were surprised when Penelope she was returned by the police to the care home at 02:35am as no one from the hospital had communicated with them that this was the plan. Care home staff questioned the decision with the police officers and felt that they had no choice other than to accept Penelope back. They liaised with the Clinical On-Call nurse, who agreed a plan should Penelope's risk increase again. Care home staff were advised to offer Penelope PRN medication and support and try to settle her to bed. Penelope accepted PRN medications, going to sleep shortly afterwards. A review was to be organised in the morning by the care provider duty practitioner.

10.2.18 The Access and Crisis team manager contacted the care provider later that day and was advised that Penelope was being assessed by the duty mental health

nurse. The Access and Crisis team manager advised the care provider that the referral would be closed however if their mental health nurse required further advice, they could contact Bury Access Team and the number was provided. The, the referral was then closed by the Access and Crisis team.

10.2.19 Leaving Care services and Penelope's personal assistant were not notified of the self-harm incident on 16.8.22. There does not appear to be evidence of any prior discussion or planning to make sure that the placement would inform Leaving Care services of serious incidents. This may have been because the placement were providing all aspects and oversight of Penelope's care, or because of the lack of a care co-ordinator, but as leaving care were the only external service open to Penelope at this time, this should have been in place and documented. The care home were sending updates but as there was no care co-ordinator this was to a manager in ASC. Parents report they were not informed of this, or any of the incidents in the days prior to Penelope's death. This is likely to be because Penelope had explicitly requested that although she wanted them to get weekly updates of progress from the staff team, she did not want incidents to be shared with her family. Penelope indicated that she did not tend to talk to her parents about incidents.

Learning point: Managing cases when individuals are in mental health crisis is always complex. Policies, procedures and processes are there to support all staff to work safely. In this case usual processes were not followed. Penelope should have been referred to the 24 hour mental health liaison team for an assessment of her mental health whilst in the A&E department. Issues of poor communication regarding Penelope's legal status and confusion regarding the status of her placement, and the lack of a health passport or accompanying carer, appear to have influenced the way Penelope's care was managed. A&E staff had an expectation that Penelope was residing in a mental health facility with 24 hour mental health support which was not correct. The reviewer learned that if a patient is transferred from an in-patient mental health facility, to the A&E department for treatment of wounds, the would not be called prior to the patient being transferred back to mental health facility. However this was not the case for Penelope as the placement was a care home and specialist residential mental health service, providing treatment and rehabilitation, and as such she should have been seen by the mental health liaison team prior to a decision to discharge. Following discharge a wider MDT including a care co-ordinator, the Leaving Care Service and, if Penelope had consented, her parents, following the incident on 16.8.22 would have allowed for a multi-agency review of the potential heightened risk and vulnerabilities Penelope may have been experiencing and of the risk management plan.

Learning point: Police officers and care home staff believed that if Penelope required a Mental Health Act assessment this would have required her to be seen in A&E. There are alternate avenues to obtaining such an assessment. They could have requested the assistance of her GP or referred to ASC.

10.3 Transition and discharge points – Consider the effectiveness of preparation and plans at all points of transition and discharge including the move from children to adult services.

10.3.1 In this case there were two types of transition. There was the transition between placements, and the transition from children to adult services. The way this transition should be managed is covered within NICE guidelines.[7] It is recognised that all transitions need to be carefully managed and are often complex when working with children or adults experiencing mental ill health.

Transition between services

10.3.2 CSC note that earlier transitions between settings pre-dating the review period appeared to change quickly and the notice provided to children's social care at times was limited. On one occasion the plan to move Penelope was only shared on the day of the move. Penelope struggled with this move and spoke directly to the social worker about wanting to leave the new placement.

10.3.3 Historically a number of attempts had been made to transition Penelope between hospital and home. Penelope was successfully supported to return to the care of her parents on one occasion however, following re-admission, further attempts made were unsuccessful.

10.3.4 During the review period Penelope struggled when future plans were discussed around a return home and also struggled with those plans as they were being developed. v reported diminished confidence in her own ability to cope in the community, particularly having had a previous experience of a failed attempt to discharge her to the family home. Both Penelope and her family agreed that they could not support her safely at home.

10.3.5 It was at this stage that a placement option was considered. From March 2021 a specific care facility was identified as the most likely placement for step down. Possible discharge dates were discussed and set for '4-5 months' time'. 'Talking Maps' were assigned to complete a person specification. All known appropriate information was shared by Cygnet Hospital at point of referral to the care facility.

10.3.6 Transition from Cygnet Hospital to the care facility was initially commenced in November 2021. However, following the ward being on Covid-19 Red alert and three self-harm incidents in quick succession, during one of which Penelope had expressed an intent to end their life when cutting their arms. Penelope indicated she was feeling overwhelmed. Penelope had at this time been refusing oral antibiotics as she reported wanting her wounds, already infected, to get worse.

10.3.7 During this meeting a Best Interests discussion was held and all agreed that it was in Penelope's Best Interests to enforce the administration of intramuscular antibiotics, so as to avoid the wound infection spreading systemically. The transition plan was collaboratively paused within an MDT in December 2021 in response to Penelope expressing feelings of being overwhelmed, contracting Covid-19, and an increase in Penelope's self-harm behaviours; Penelope and her family were involved with all multi-agency partners in this decision. This was good practice.

[7] NICE Guidance – Transition from children's to adult' services for young people using health or social care services. It aims to help young people and their carers have a better experience of transition by improving the way it's planned and carried out. It covers both health and social care.

10.3.8 An eight week transition plan was put in place in January 2022, which included slowly building Penelope's time at the care home, getting to know the staff, planning her room as well what services Penelope would require going forward; funding was discussed in relation to CAMHS in the community. Discussion regarding future placement if recall to hospital under the Mental Health Act was required post discharge. It was agreed that this would need to be to a Psychiatric Intensive Care Unit (PICU). Confirmation of agreement for Section 117 aftercare was documented.

10.3.9 In preparation for discharge Penelope was offered relapse prevention work in the interim with the psychology department at Cygnet. Day visits to the new placement commenced late in February 2022 without incident. Periods of overnight leave commenced on the 3rd March 2022.

10.3.10 There was a clear understanding of the worries in respect of Penelope and the difficulties in respect of transition. Penelope was reluctant at times and worried about the transition. This was given lots of consideration and plans were delayed to support a more gradual transition for Penelope, which was agreed by all agencies. The care facility were also fully sighted in respect of all Penelope's identified needs, detailed information was shared in order to ensure that they were able to meet identified need and provide the appropriate levels of support.

10.3.11 Prior to discharge as planned in March 2022, various meetings were held to discuss if discharge was safe following a recent incident of cutting. There was evidence of Penelope's mother being involved in the discussion. These meetings were attended by the Cygnet MDT and external parties including commissioners, home area team and the team at the care facility. The possibility of sending Penelope on extended S17 leave was discussed but it was agreed that this would be counterproductive and discharge should go ahead.

10.3.12 Neither the Manchester or latterly the Bury GP Practice were involved directly in any transition planning discussions. Information was sent to the GP practice via letters, which were not always clear in terms of the expectation of the GP going forward. However, there wasn't any evidence that either GP practice attempted to seek additional information following receipt of the letters by the various partners. Neither GP practice was aware of what the transition plans for Penelope were and, at one point, wasn't sure where Penelope was residing, whether she was still an inpatient or whether she had moved to her new placement. Although this information wasn't shared clearly with the GP, it also wasn't questioned at the time.

10.3.13 Penelope was discharged with discharge medication in place. Discharge paperwork was completed as appropriate highlighting known and current risks, contingency plans and relevant contact details. A follow up meeting was planned for early April.

Learning point: In this case there is evidence that the transition from the in-patient secure unit to the care facility was well considered within the confines of the way services are configured. A planned discharge was delayed due to an increase in Penelope's self-harm behaviours indicating practitioners were taking account of Penelope's mental state. Whilst the transition between the two services followed a lengthy period of introduction and information sharing

between the two services, there was not the same level of communication with primary care colleagues. What practitioners at the practitioner's event recognised was that at the point of transition between placements, Penelope lost the safety net of knowing, the ward, the routines and the expectations, but also her own safety net of knowing the staff and other patients, and she was in greater command of her actions and responsible for the consequences of those actions. All the attachments that had been built up over a year were gone. The way services are designed does not allow the in-patient setting staff to have any involvement with the patient once they are discharged into another services care.

Learning point: Discharge should always be considered from the point a patient is admitted. The transition period is considered to be from point of initiation until transfer. Just as there is a need for a period of time prior to discharge so there is need for receiving services to be able to contact, and seek advice and support with the discharging services, if it would be beneficial to the patient, for a period of time post discharge. Consideration of a post discharge multi-agency meeting to consider any unforeseen issues should be given. Whilst there is some evidence that discussions did take place between the two placements, currently there is no formalised process for this, it is not a recognised practice and is not incorporated into an established or agreed framework.

Transition from Children's to Adult Services

10.3.14 The transition between children's services and adult services was one which had been considered as part of planning for Penelope. Manchester use the Northwest Framework based on provision and standards to go to the market to find a placement. There was evidence in records of discussions held and directions made for referrals to the appropriate services, this included GMMH.

10.3.15 In August GMMH received a referral from Manchester North CMHT (CMHT) in relation to Penelope transitioning between child and adult services. The referral was discussed, and a professionals meeting was held in September 2021. Legal status was considered, as well as future planning for Penelope in adult services. It was agreed in a meeting the following day, where Penelope was present, that a Care Act assessment was needed and she consented to this taking place.

10.3.16 The worker from CMHT attended the ward and Penelope engaged well with the Care Act assessment. Penelope was insightful about future challenges, and she was aware of the acceptance of a placement. The Care Act assessment looked at who was to provide funding when Penelope turned 18 years old. The Care Act assessment was completed in mid-September 2021; a community support package recommended. Liaison took place with the senior social care lead for Manchester GMMH and as Penelope was under section 117 aftercare the onus was on GMMH to provide the care co-ordination.

10.3.17 There were concerns about the funding as it appeared it had not been taken to panel. A GMMH transitions service is in place that, because of Penelopes age, should have taken Penelope's case to both the children's and adults funding panels. Because of changes in personnel, it has not been possible to establish if this happened. It is clear that while there is a system in place this was not followed. CSC are and were part of discharge planning meetings.

10.3.18 In April 2022 GMMH received a referral through the Gateway from CAMHs, Penelope was by now in the care home, funding had been agreed and the panel required a further Care act assessment to continue funding Penelope when she turned 18 years old. CMHT allocated for someone to complete the Care act assessment in June 2022. CMHT made contact with the placement in July 2022. Penelope was reported to be doing well; there was no direct contact with Penelope. The Care act assessment was not completed prior to Penelope's death.

Learning point: Because of the complex and differing arrangements that are in place for children and adults, it is essential that transitions of young people nearing adulthood are actively manged by the service commissioned to deliver transition, to ensure young people continue to receive the care they need post 18. Identifying specific individuals who will remain involved post discharge and bringing them together for a review post discharge would assist.

10.4 Section 117 – Explore the management of Penelope's S117 after care.

10.4.1 Section 117 of the Mental Health Act 1983 (MHA) places a statutory duty upon local social services and the ICB (formerly CCG) to plan and provide mental health after care for those detained in hospital under a treatment section of the MHA (section 3, 37, 45A, 47 and 48); this includes children and young adults. This is triggered on discharge.

10.4.2 As Penelope had resided within Manchester before becoming detained, her aftercare fell to Manchester Local Authority and Manchester Clinical Commissioning Group. For children, CSC and the CCG jointly managed the process for commissioning and placing children in conjunction with education. In Manchester there is a complex system with separate adult and child funding panels, whilst in Bury there is one joint Children and Adult's funding panel which simplifies the process. In this case funding was split 50/50 between CSC and the CCG.

10.4.3 There was a clear focus on identifying and accessing a placement which would prevent further transition for Penelope when she turned 18, which would not have been in her best interests. The proposed care facility was identified as a provider of Section 117 after care services that prevented this and provided a greater level of stability, supporting Penelope's transition from hospital. It was identified as an appropriate placement to meet and support Penelope's enduring mental health needs, whilst supporting transition to adult services and care in a community setting.

10.4.4 The placement worked with the LA and the CCG to secure the placement. Section 117 aftercare needed to be in place in order for funding to be obtained for the placement. The placement then continued to liaise and promote positive multi-agency working practices with all professionals involved in Penelope's care.

10.4.5 Aftercare for all patients admitted to hospital for treatment for mental disorder is planned within the framework of the Care Programme Approach CPA. The CPA is an overarching system for coordinating the care of people with mental disorders.

10.4.6 There is evidence that liaison with relevant statutory agencies was made in regards to this during Penelope's admission at Cygnet. Relevant parties were in attendance at CPA and professionals meetings, which also considered Penelope's

ongoing educational needs and her transition from being a young person to an adult.

10.4.7 Whilst Penelope's placement was agreed by the MDT, it is clear that subsequently Penelope's Section 117 aftercare was not subject to the usual management. Penelope's case was referred to Manchester's Mental Health joint LA/health funding panel and decision's made regarding the funding of the out of area placement, and the coordination of Penelope's care should have remained within CSC until a successful handover to the Community Mental Health Team within GMMH had occurred. GMMH should then have allocated a care coordinator and managed the case alongside the allocated care homes responsible clinician. This did not happen. Whilst the care home were following the CPA policy and communicating with all involved agencies, there was no care coordinator to manage the case within GMMH.

10.4.8 The reviewer learned that at that time there were gaps in services. The CCG children's commissioner post was vacant, in addition there were no children's or Mental Health nurses in the CCG complex care team, and no operational clinical case manager in Manchester CCG. Currently there is no clear policy that the Local Authority and ICB follow for out of area placements

Learning point: The need for section117 aftercare was appropriately identified in CPA meetings and appropriate referrals were made. Difficulties arose because of the lack of allocation of a care coordinator within GMMH. This omission meant there was no one overseeing the management of Penelope's section 117 aftercare.

10.5 Information sharing – Consider the level and quality of information sharing both within and across agencies.

10.5.1 In September 2019, Penelope was reported to Police as being suicidal after being discharged from Prestwich Hospital and had been followed by staff as she appeared to make an attempt to jump from a bridge, this information was omitted from the list of modes of self-harm shared with Cygnet.

10.5.2 During Penelope's admission to Cygnet, there were frequent meetings held in respect of Penelope. In the main these were well attended by involved professionals, this allowed for detailed discussion in respect of assessments of Penelope's mental health, and assessment of her continued admission into hospital subject of Section 3. Meetings also allowed for the sharing of social care assessments in respect of the support available to Penelope and her family.

10.5.3 There is evidence of external parties being invited to and being involved in CPA and professional meetings.

10.5.4 There is evidence of good information sharing from the Northern Care Alliance to the GP in discharge letters, especially regarding safeguarding concerns. However it is not clear from the A&E nursing notes what information was shared with Penelope's placements when she was discharged back to their care. Although a discharge letter was completed for each admission this may have been given direct to Penelope. However, on all but the last attendance Penelope was accompanied by carers, therefore they should have received the same information verbally as Penelope.

10.5.5 Consideration was given to the appropriate level of involvement by external agencies. For example in a CPA on January 2021 a professionals meeting was planned ten days later. A target was set for the social worker at Cygnet Bury to chase the 'child in need' plan as site had been aware that such existed but this had not yet been received. It was unclear at the time if Penelope would remain open to children's services or if they would close the live case due to admission to hospital.

10.5.6 Relevant agencies were involved in care planning and professionals meetings. This included colleagues from the commissioning team, home area care team, education providers, advocacy and parents.

10.5.7 Once a possible discharge date and appropriate provider were identified in March 2021 other agencies were requested to consider a service specification based on the known history and risk management requirements for Penelope.

10.5.8 There is evidence of appropriate information sharing with the care provider in regards to known risk to self and others and historical information pertaining to safeguarding concerns. Involvement of key agencies is evident throughout the admission. Of particular note are the pre discharge discussions in March 2022 which involved all relevant parties in decisions around the appropriateness of discharge from section and placement at Cygnet against potential for extended S17 leave. This is well documented.

10.5.9 During the transition period – frequency of contact and notifiable events were agreed between the service and the home team's assigned point of contact (usually social worker and/or care co-ordinator). Professionals involved in the wider MDT will usually be notified of any incidents that occur within service – this will either be an overview email or the incident report itself sent over. They will also receive either weekly or monthly external communication reports. These are comprehensive update reports

10.5.10 The care provider submitted reports every month, alongside the most recent MDT meeting minutes. MDT meetings were held monthly. In June 2022 a CLA Review and a CPA Review were held.

10.5.11 There is evidence of the multi-agency network coming together to review plans for Penelope both during hospital admissions and during Looked After reviews following Penelope's transfer to the care home. There is oversight from Penelope's IRO and evidence of her visiting Penelope to gain her wishes and feelings and Penelope being part of review meetings in relation to plans being made when she was in placement.

10.5.12 A Hospital Passport was developed for Penelope but there was nothing in Penelope's care plan to say this must accompany her at each hospital visit. This was largely because it would be unachievable if Penelope went to hospital from the community and not her care home. The hospital passport contained information in relation to the care and treatment of Penelope as well as relevant contact details for care provider clinicians to aid contact if a discussion was required. It was believed it would be best if the hospital passport could be shared electronically and work had been completed previously with Fairfield Hospital in an attempt to get these passports added to their electronic system. Fairfield had raised concerns that these passports could become out of date and that they are

potentially too comprehensive for A&E staff to distinguish the most salient information during an acute presentation. However, the information contained in them relates primarily to an agreement that if a young person presents with a changed mental state, or if there are any concerns, the clinician on-call is available to discuss the service and what can and cannot be provided in service to young people, particularly out of hours.

10.5.13 The serious self-harm incident on 16.8.22, was not immediately referred to children social care, thus the leaving care service was not made aware at the time of the incident. This meant that a strategy meeting and multi-agency review of this incident was not held. A multi-agency approach at that time would have led to risk management plans in respect of the increased risk being considered on a multi-agency basis. (For further information please see section 10.2)

10.5.14 NWAS shared information with appropriate agencies on each contact.

10.5.15 Information appears to have been shared appropriately between Police and Partners, with effective communication regarding risk management planning through multi-agency strategy meetings requested by CSC as risk, and episodes of missing person reports, escalated. There is good evidence of coordinated information sharing through these periods.

10.5.16 When Penelope attended the A&E department as a child, safeguarding referrals were raised and sent to the Local Authority.

10.5.17 Following attendances to A&E or the Minor Injuries Unit during Penelope's time at the care home, there is little evidence of escalation in regard to the Mental Health placement, although carers were present it isn't clear if NCA escalated the concerns through GMMH. There appears to have been no consideration as to whether it was safe for Penelope to return to care setting where she had come to harm. It would have been helpful to have had an MDT and risk management meeting with all involved agencies.

10.5.18 A cause for concern was received by Adult Social Care around mid-day the 17th August 2022 from the Police. This referral includes the following information:

'Police assistance requested by Ambulance due to Penelope having significantly self-harmed and knives in her possession. Initial suggestions that MHA to be used as Penelope refused to go to hospital. Penelope was then handcuffed and restrained due to her trying to access blade. Penelope reportedly taken to hospital. Notes suggest Penelope not placed on a section and Police attended to restrain her due to fluctuating behaviours. Described as 'calm and co-operative' at times and displaying some self-harming behaviour/statements relating to self-harm at other times, trying to abscond etc. Erratic behaviour referenced. Discussions with Sgt took place and Police reportedly advised to return Penelope back to placement'. The referral did not include the officers and NWAS's concerns that although staff at the care home were following process they were, 'struggling to cope and appeared out of their depth'.

10.5.19 The request was for increased support for Penelope due to concerns regarding her mental health and no allegations relating to abuse/neglect had been raised. For that reason the cause for concern was sent back, within half an hour of receipt, for review/response.

10.5.20 A second referral to adult care was received at midday on the 17.8.22 from A&E, this linked to the same cause for concern as the above. The A&E Nurse raised concerns regarding Penelope seriously self-harming and needing a review of her care needs. Contact was made with the care home the following day to discuss but there was no answer. Penelope had sadly passed away prior to this call.

Learning point: Whilst there is evidence of good information sharing between agencies at planned meetings, the issue appears to be one of requiring two way communication through conversations, so all the relevant information could be shared in a clear and timely manner. Clear risk assessment information which should have informed care plan and risk management was not shared at the point Penelope's care transferred to Cygnet. This information related to her visiting a bridge whilst distressed, omitting this information meant it was unknown to staff at either Cygnet or the care home and had not been part of any risk assessment. Information that the care home staff were possibly struggling to manage Penelope in her distress might have prompted a different response from the ASC safeguarding team. The lack of availability of Penelope's hospital passport would have made it more difficult for A&E staff to know who to contact during Penelope's admission when a carer was not present. Issues relating to hospital passports have been a feature in two other local SARs, SAR Robert and SAR Walter.

10.6 **Management of risk –** Consider occasions when risks were present. How were these risks identified, analysed and translated into safety plans? How was risk managed across some key deliverers, acute medical care, mental health and social care? How was Penelope's family involved in safety planning? Were there gaps in inclusion of, and services to, the family?

10.6.1 Regular meetings were held in respect of Penelope throughout children's social care involvement, involving education health and importantly parents. There is also evidence that Penelope was included in meetings where appropriate. There appeared to be a shared understanding of the worries in respect of Penelope and her identified needs, risk and strengths. Meetings appeared to be held on a regular planned basis although they did not always consider the risk relating to specific and significant incidents, the meetings provided summaries of progress and assessments however did not always consider the incidents which had occurred between meetings in any detail; this is likely because of the volume of information needing to be shared.

10.6.2 There was evidence of information being shared between Cygnet and CSC when incidents occurred and the detail of attendances at hospitals following incidents were well understood, however it was not always clear what had happened as a result in respect of whether this had resulted in further assessment of Penelope in relation to her mental health, in order to inform plans.

10.6.3 Penelope was admitted to Cygnet Bury in August 2020. On admission her risk was assessed and documented clearly within the electronic record. This was highlighted as episodes of self-harm (cutting, ligatures, head banging, overdose, swallowing, setting fire to clothes) and AWOL. The initial risk management plan restricted S17 leave to emergency reasons only and placed Penelope on 12 checks within the hour which meant that Penelope would be physically observed by a

member of staff at intervals of no more than 5 minutes. 5 minute observations are not prescribed within the relevant policy however, by working outside of policy, this allowed for more frequent observations without the more restrictive intervention of 1:1.

10.6.4 There is good evidence of review of observations at significant points throughout the admission. For example, following hospital admission for endoscopy following a swallowing incident discussions were held prior to discharge regarding level of observation required to manage risk on return. However, there were occasions where Penelope was assessed as being 'green' on the daily risk assessment (meaning 7 days with no incidents) where there may have been opportunities to review observations levels more frequently based on periods of time without incident, documentary evidence was not always available to indicate if reviews were undertaken at certain points. Further there was some evidence during the admission that documentation of observation levels was not cross referenced against the various electronic documents. It is of note that this may have led to more frequent observations rather than missed observations.

10.6.5 Access to risk items was carefully considered and well documented throughout ward round minutes. Penelope was able to request items and discuss this with the team before decisions were made. Rationale for not returning items was clear in the ward round minutes and there was evidence of a staged approach to access to risk items which was reviewed against incidents. Where there had been an increase in risk behaviours, responses to this in terms of access to items appeared to be defensible and rational.

10.6.6 Following incidents of self-harm there is evidence of triangulation via the various electronic mechanisms. Appropriate responses were made in terms of reassessing risk and assessing physical health risks following incidents of head banging.

10.6.7 Where episodes of seclusion were required, management of risk to self was documented and considered. For example following violence and aggression towards staff in late October 2020 Penelope was taken from seclusion to 'open door seclusion' directly in response to her ongoing risk of head banging – seeking to maintain her safety but also the safety of others. Seclusion reviews were conducted in line with policy and was terminated as soon as was practicable.

10.6.8 Access to S17 leave was gradually increased and decisions around increases were appropriate. S17 leave with family members was a feature of this and was appropriate to level of risk.

10.6.9 The incident in 2019 when Penelope appeared to make an attempt to jump from a bridge was not shared when Penelope's care transferred to Cygnet and therefore was not known to the therapeutic placement. This is significant as this could have been taken into account when considering whether the care home was a safe placement for Penelope; it was known to the LA Local Authority Designated Officer that there had been previous concerns regarding residents going to the bridge near the residence.

10.6.10 There is evidence of risk assessments on the GMMH EPR system in November 2021. However there is no clear risk assessments on transition from CAMHS to CMHT.

10.6.11 There is evidence of clear risk management within the transition plans discussed with the therapeutic placement. In January 2022 during a CPA a discussion was held regarding Penelope's access to risk items whilst on leave as it was thought Penelope had secreted a razor blade during a visit to the care home. The therapeutic placement stated that they were unable to restrict access to risk items due to their policies and procedures. Colleagues at Cygnet were clear that this could be covered under the Mental Health Act and Section 17 paperwork given that, at that stage Penelope was legally still under their care. Whilst it was positive to see the smaller details being discussed within the transition plan, if the care home were clear they couldn't restrict access to bladed items and the hospital felt that was necessary to ensure Penelope's safety, the suitability of the placement for Penelope should have been given further consideration.

10.6.12 During overnight leave in March 2022 the care home contacted Cygnet to notify them that Penelope had caused significant cuts with a razor blade and had been taken to A&E where she had received 14 stitches. Cygnet reminded the care home that S17 paperwork stated no access to razors, batteries or magnets however the care home restated that this was not possible as their service is 'least restrictive'. It is a concern that this had remained in the plan even though the care home had been clear they could not prevent access to potentially harmful objects; again this did not prompt a review of the suitability of the placement to meet Penelope's needs at that time.

10.6.13 At the point of discharge in March 2022 there is good evidence of discussion and consideration of ongoing risks and the recent self-harm incident as detailed above. All relevant parties were involved in this discussion and it was deemed that continuing detention in hospital or transfer on extended S17 leave would be counterproductive. Therefore Penelope was discharged from section and transferred to the care home as planned.

10.6.14 Records detail that Penelope was making good progress in her placement following discharge from hospital.

10.6.15 In April 2022 Penelope self-harm in the form of cuts on three separate days; during one event Penelope tied a ligature, refused hospital treatment and tried without success to leave the care home.

10.6.16 At the initial MDT review meeting in April 2022 with Penelope's clinical and residential team, noted that whilst there had been an incident of cutting, a debrief completed with the duty nurse had been helpful and Penelope had allowed staff to look at her wound. There had also been no interference with the wound. Compassionate touch had been used effectively.

10.6.17 Over the next three months there were three days when Penelope self-harmed via cutting and one occasion via burning, all were managed in the home but on one occasion medical attention was required.

10.6.18 Whilst Penelope had told staff about self-harm cuts, she was very reluctant to go to hospital to have her wounds treated. A plan was made for her to attend the walk-in centre for treatment of her wounds where necessary, rather than A&E. Penelope reported that she found this a less threatening environment and the plan would improve her compliance with treatment.

10.6.19 As Penelope's self-harm behaviours reduced her medication was reviewed and decreased. Penelope had a number of outings visiting both home and London with her family and whilst Penelope expressed some concerns, these went well and without incident.

10.6.20 During this period Penelope learned a friend had completed suicide. Penelope was able to talk about this in therapies and there was no increase in her self-harm behaviours.

10.6.21 Penelope supported a new young person's transition into the service, her motivation improved. Penelope had been bought a rabbit and was taking good care of it.

10.6.22 Penelope completed an application for a Health and Social Care course at Bury College, starting in September.

10.6.23 In July Penelope reported that she was proud to have been incident free since May. Penelope reported that the reduction in Clonazepam had really helped and that she felt ready for another slow decrease.

10.6.24 From mid-July Penelope started to self-harm seeking help from staff via telephone; Penelope reported feelings of being overwhelmed.

10.6.25 In early August there was one incident of self-harm in the form of burn to right leg which was managed in the care home, Penelope again reported feelings of being overwhelmed. Care home staff managed these incidents by following the agreed management plan using a combination of soothing music, grounding techniques, community time.

10.6.26 Following this increased risk of burning there were discussions between the residential team, Penelope's clinical nurse specialist and the consultant psychiatrist. The incidents were reviewed as were the risk assessments and historical incidents of burning. Penelope worked with her CNS in their sessions to identify thoughts to set herself on fire, and the anticipated result of helping her to manage difficult emotions. There was no evidence that Penelope had intent to set herself on fire nor suicidal ideation during these sessions and reviews. Penelope had strong protective factors in her family relationships and there was evidence of future planning. Parents indicated there had never been any intent to end life and that all Penelope's self-harm had been a cry for help.

10.6.27 The clinical nurse specialist working with Penelope was due to change his role. This upcoming ending had been discussed over a long period with Penelope, but it was noted to be difficult, as they had a good relationship and, historically, relationships ending and significant changes had been a trigger for increased self-harm. Penelope was also enrolled in college from September and the MDT review noted that all of these changes and transitions were potentially overwhelming for Penelope. The MDT discussed the change in risk presentation, with increased burns. Owing to the number of changes occurring in Penelope's care and experiences, it was agreed not to make any further reduction to Penelope's medication.

10.6.28 In the 5 days prior to Penelope's death Penelope self-harmed in the form of cutting every day except one. On all occasions Penelope required follow up medical attention

10.6.29 The incident on the day before Penelope died is dealt with in full in section 10.8.

10.6.30 From a Primary Care perspective the Bury GP was aware of Penelope's risk to self and were aware of all episodes of self-harm that required medical treatment and care, the GP practice wasn't aware of what the risk management plan was for Penelope. Neither GP practice's records show read codes/flags for safeguarding and LAC which was a missed opportunity. The Manchester GP practice didn't have any contact with Penelope during the timeframe for the review.

10.6.31 NWAS was not involved in any aspect of Penelope's ongoing care planning. Following NWAS attendance to Penelope on the 16th August 2022 Penelope was assessed to be lacking in capacity and NWAS ePR was clear and comprehensive that the Advanced Paramedic consulted with the on–call NWAS Medical Director to ensure Penelope was transported with the least possible distress to her. The paramedic was balancing trying to stop Penelope further self-harming as much as possible, whilst trying to ensure the safety of Penelope and NWAS/Police/Care Staff. This was a very challenging incident and Penelope's distress and lack of capacity were clearly communicated on handover to Hospital. The ePR records indicate that care staff told NWAS that Penelope's family were only to be contacted should Penelope be sectioned under the MH Act; this was in line with Penelope's wishes.

10.6.32 During Penelope's attendances in A&E, whilst she was under constant supervision, there was no consideration as to whether there was a risk management plan in place post discharge or whether this needed reviewing in the context of Penelope having come to harm within her placement.

10.6.33 The police assessment of risk in this case was limited to dynamic risk assessment on the two occasions when Penelope was missing from her secure mental health placement. On both occasions appropriate methods were used to return Penelope to her placement. On 16th August 2022 Officers appear to have utilised a number of different tactics to address risk in a dynamic fashion, from use of physical restraint to personal interaction to build trust and rapport with Penelope.

10.6.34 CQC's inspection following Penelope's death found much that was positive within the placement in relation to risk management:

- Risks to people were assessed and regularly reviewed. This included a range of bespoke and person-centred individual risk assessments, a comprehensive assessment of the home environment and a locality risk assessment. The provider mitigated any identified risks through a range of methods.
- The provider used an evidence-based risk assessment tool to identify each person's risks and developed risk management plans for the risks identified.
- Staff received training in identifying and managing individual risks.
- Staff regularly discussed the risks presented by people and associated risk management strategies at multi-agency meetings, team meetings, in supervision and reflective practice sessions

10.6.35 On the day Penelope died she started to re-open her wounds. Penelope was at this time supported by a member of staff at placement and, in accordance with

her management plan directed to go for a walk with a member of staff. During the walk Penelope was described to be becoming agitated. Penelope was allowed ten minutes to 'cool down' and staff advised they would call her and she would be expected to answer. Ten minutes later Penelope did answer the call from a member of staff and advised she was at a bridge.

Learning point: This review highlights the importance of knowing and considering all risk factors on a multi-agency basis. Information regarding Penelope's visit to a bridge whilst absent without leave from placement, was omitted when Penelope transferred to Cygnet. As a consequence this risk factor was not known to either Cygnet or the care provider. This omission meant that risk management plans were unable to include all knowable risk factors. Had this been known it is highly likely that the choice of calming method may have been different on the day of Penelope's death.

Learning point: It is not clear whether Penelope's presentation on the 16th & 17th August 2022 required a formal mental health act assessment. The ethos of the therapeutic placement was one of least restrictive practice however there needs to be recognition that, in the interests of a person's safety, there may be times when this is necessary. Plans discussed prior to transfer to the care home included admission to PICU if there was an acute presentation. The therapeutic team were trying to get a genuine review of risk based on Penelope's presentation over the previous 24 hours. They were weighing up the best approach, knowing that going to hospital was a trigger for v's distress to increase and knowing that she had a history of minimising or not fully engaging in mental health reviews with doctors/people she did not know well. The discussion regarding whether, after her review, a MHA assessment was required was ongoing at the time that Penelope left the house. It is clear care home staff were struggling to safely manage Penelope when her self-harm behaviours escalated on the evening prior to her death and again when she was distressed whilst out for a walk, however the staff member accompanying Penelope had been part of the duty review and had the best relationship with Penelope. If a strategy meeting/multi-agency meeting had been convened on the morning of the 17th August 2022 this would have provided an opportunity for collective decision making and potentially a different approach.

10.7 **Mental Capacity Act –** Is there evidence that practitioners have assessed Penelope's mental capacity at key points. Give consideration to best interest/unwise decision making, fluctuating capacity and executive functioning. Consider the use and interpretation of the Legal Framework.

10.7.1 Following admission to Cygnet in August 2020 an admission assessment was completed by the Responsible Clinician. This included elements of capacity considerations. Penelope was assessed as having fluctuating capacity at this stage in relation to her care and treatment and therefore S62 (allowing for urgent treatment to be given) and a Second Opinion Appointed Doctor assessment requests were made to confirm treatment plans due to suspected lack of capacity in these issues.

10.7.2 There is evidence of appropriate family involvement in decision making in regards to best interests. Shortly after admission and following a period of non-

compliance with medication the team at Cygnet Bury involved the family of Penelope in decision making relating to her medication regime and the possible introduction of depot medication.

10.7.3 In late September 2020 following a disclosure from Penelope that she had been spitting out her medication both Penelope and her family were again involved in decision making regarding depot medication which was agreed.

10.7.4 On occasions where hospital admission was required due to incidents of self-harm Penelope's family were involved in decision making regarding treatment where capacity was assessed as lacking. For example on one occasion Penelope's family were consulted with regards to a planned endoscopy to remove a swallowed pen. Consideration of capacity and involvement of the family are well documented.

10.7.5 During attendances to the A&E department Penelope's mental capacity was not formally assessed by the treating medic except on one occasion when Penelope wanted to take self-discharge. On that occasion she was deemed to have capacity.

10.7.6 Capacity was reviewed as part of the ongoing CPA process and this was well documented. A mental capacity assessment completed in September 2021, concluded Penelope did not having capacity to understand the support needs or weigh up advantages and disadvantages of receiving or not receiving care/treatment. The assessment was clear that Penelope would require ongoing support with her mental health needs and hadn't developed the skills to live independently. Without this support it was deemed Penelope's mental health was likely to suffer and she would be at high risk of relapse; it was felt maladaptive coping strategies could lead to increased risk to self, others and future hospital admissions.

10.7.7 On 16th December 2021 following a significant incident of self-harm a best interests meeting was held due to lack of compliance with antibiotic medication. This followed a previous conversation with medical professionals about the possibility of IV medication being administered, although this was later declined due to its invasive nature. Penelope had been assessed as lacking capacity in this area. The meeting was attended by Penelope's mother and discussed possibility of covert medication due to noncompliance. Documentation of this meeting was good.

10.7.8 GMMH identified a lack of consideration of Mental Capacity assessments.

10.7.9 Within CSC records, whilst planning was evident it was not made clear whether the response to specific incidents was always subject of review within multi-agency meetings. Summary and overviews were provided but it was not always clear whether assessments had been undertaken following specific incidents and what the outcome of these was.

10.7.10 Across the two days of the 16th and 17th August 2022, there were a total of 4 mental capacity assessments, completed or instructed by the care provider to review the requirement for increased restriction and or external agency support.

10.7.11 On 16th August following the significant self-harm in the form of cutting, staff at the care home recognised that the wound would require treatment and that Penelope did not have the capacity to not inflict further harm; staff used protective touch, holding her hands, to prevent further harm. Staff then assessed

that Penelope lacked capacity to refuse treatment for their wounds and called for paramedics.

10.7.12 It is clear that both police officers and ambulance staff attending to Penelope were considering her mental capacity when they responded to this incident. They were concerned regarding Penelope's fluctuating presentation and "erratic" behaviour. A detailed capacity assessment was recorded and the rationale as to why Penelope did not have capacity was also documented, along with considerations of the decision made by the Advanced Paramedic in Penelope's best interests. It was recorded on the best interests' decision making tile of the ePR, that NWAS staff had also considered alternatives such as referral to primary care. However, NWAS staff recorded they felt the most proportionate action in the best interests of Penelope was to transport Penelope to Hospital for care as there was a very high risk of further self-harm and Penelope had suffered a significant injury which was not able to be successfully assessed or treated in the pre-hospital environment.

10.7.13 Police had concerns regarding the high risk of Penelope going missing. In order to ensure Penelope had medical assistance in hospital sedatives were administered, Penelope was handcuffed and escorted to A&E under the Mental Capacity Act (2005).

10.7.14 The triage nurse noted Penelope lacked capacity; the records don't reference any specific decision that this related to so it is not clear whether this was based on a new mental capacity assessment or restating the assessment of the paramedics. Whilst in A&E Penelope's presentation fluctuated significantly. Penelope agreed to and had her wounds treated; she was referred to the burns clinic. As Penelope was not refusing treatment it becomes somewhat understandable that no mental capacity assessment was conducted by the treating medic however, as there was doubt around Penelope's capacity to agree to treatment, and in light of the fact she had received sedation, safeguarding processes and mental capacity assessments should still have taken place.

10.7.15 The GMP learning summary report indicates that officers are not suitably qualified to assess mental capacity as defined by the Mental Capacity Act, and only make decisions on this basis in cases where an individual presents a danger to themselves or other members of the public whilst in a public place as defined by section 136 of the MHA.

10.7.16 Police officers continued to have concerns regarding Penelope's fluctuating presentation. When officers were transporting Penelope home she continued to attempt to self-harm via banging her head and attempting to remove the dressings to her wounds. Penelope voiced possible paranoid delusional ideation that the paramedics had injected her with bugs. At this point Police could have exercised their powers under section 136[8] of the Mental Health Act and transported Penelope to be assessed. However this would have meant returning Penelope to the A&E she had just been discharged from. Officers escorted Penelope home as instructed and a cause for concern (safeguarding) was raised

[8] Under section 136 of the Mental Health Act 1983 (the Act), a police constable has the power to remove, or detain in a place of safety in the interests of that person or for the protection of others, any person who appears to be suffering from mental disorder and to be in immediate need of care or control.

with concerns regarding her mental state and the need for mental health assessment and support. There is however evidence that they did use some of the techniques within Penelope's management plan to calm Penelope which was good practice.

10.7.17 On 17th August, Penelope was seen for a mental health review with a duty nurse as a follow up review from the incident the previous day. During this review Penelope had reported feeling extremely low and stating that "I don't know what I'll do if I am here tomorrow". Penelope engaged in the full review and accepted support and care from the staff team. Following this review, Penelope reopened the cut to their leg. Penelope engaged with staff, asking for support to dress the wound and to change out of clothes that were bloodied. Penelope accepted care and agreed to make a plan to spend time with a favoured staff member.

10.7.18 When Penelope went for a walk on the 17th August 2022, the staff member reported that although they were walking slowly and Penelope was calm in manner, her walking with Penelope was increasing agitation and Penelope repeatedly stated that she wanted to go for a walk on their own. The staff member, who was an experienced member of the care home team and had been part of the duty review, assessed Penelope's capacity to make a decision to go for a walk unsupervised, and identified no other risk behaviours or factors with Penelope seemingly engaging in her safety plan (as per her risk management plans which predated the 17th August 2022), showing the staff member her phone and that it had charge and agreeing to a plan of contact.

10.7.19 The same staff member considered that there had been no previous risk incidents in the community whilst in placement; this provided a sense of reassurance. This risk assessment was considered alongside Penelope's wishes and a belief that they had the capacity to make the decision to go for a walk. The staff member checked her assessment with the duty nurse who had assessed Penelope on return to the house and this plan was agreed and followed as per risk management plans for Penelope.

10.7.20 Penelope did answer the agreed welfare phone check, however it was clear to the member of staff making the call that Penelope was distressed and stated "I can't do this anymore". Due to this increased distress a decision was made under best interests to contact the police to support efforts to locate Penelope.

10.7.21 There is clear evidence that across the two days Penelope's capacity fluctuated. Care home staff utilised their knowledge of Penelope, their risk management plans, known risk history, presentation and engagement to inform their decisions about when restrictive interventions were required to safeguard. Unfortunately care home staff were unware of the previous incident where Penelope was restrained by a member of the public to prevent her from causing herself harm at a bridge.

Learning point: During the review period there is evidence that those practitioners working within mental health establishments were assessing Penelope's mental capacity during key incidents. What is not evidenced is a clear record of those assessment and decisions in partner agencies records following MDT's. There is little evidence to suggest acute hospital staff were completing mental capacity assessments, although these should be part of the consent

process, during Penelope's time in the A&E department. This is despite Penelope displaying behaviours which were deemed by police officers to require periods of restraint. It does not appear any consideration was given to the fact that Penelope had received sedation prior to attendance and that this might have resulted in a reduction of Penelope's ability to make a choice regarding accepting or refusing treatment.

10.8 **Management of disclosures of abuse –** Examine the actions taken following Penelope's disclosure of historic sexual abuse.

10.8.1 In 2018 Penelope made disclosures to health professionals within GMMH suggesting she had been the victim of abuse on two occasions. On the first Penelope reported being the victim of an assault by a male adolescent; Penelope did not disclose any details about the perpetrator or the nature of the assault. Then in October 2018 Penelope made a disclosure that she they been sexually assaulted by an unknown male 30/40 years old. Staff ensured Penelope's parents were aware so they could support Penelope, staff also offered support to Penelope to report this incident to the police. Penelope declined. Staff revisited the possibility of reporting the incident to the police with Penelope however this did not happen as Penelope continued to decline. No referral was made to CSC which is not in line with child protection procedures.

10.8.2 In October 2020 Penelope handed staff a hand written disclosure of historical abuse during a 1:1 session. This was in relation to a sexual assault by a young male Penelope had met online. No specific details were shared regarding his identity. On this occasion a safeguarding referral was made to the Local Authority Safeguarding Team although there appears to have been a significant delay.

10.8.3 The Children's Services files indicate the first record they had of the disclosure was in December 2020. A record of the conversation suggests that *'the social worker cannot make a referral to the police because there is insufficient information to make a concrete referral. In addition (Penelope) doesn't wish to take any action at the moment. Penelope can of course revisit this if she wants to but there is no real prospect of progressing this anytime soon'.*

10.8.4 Record of the conversation makes reference to 'information shared by GMMH staff' who had been the first to receive the disclosure from Penelope. The information passed to the allocated social worker in December 2020 outlined that Penelope was having flashbacks of a sexual assault that happened in the past with somebody outside of the family home. Penelope at this time does not want to report the incident to the police. The hospital indicated they felt like this incident could have been the trauma that has triggered Penelope 's self-harm and current admission.

10.8.5 Whilst records repeatedly refer to Penelope as a victim of sexual harm, there was no consideration to holding a strategy meeting. It appears this was accepted as a sensitive subject and a potential trigger for Penelope's mental health deterioration, and so Penelope's wishes to take no further action were deemed to be being respected.

10.8.6 After the disclosures made in November 2020, Penelope was fully assessed and clinical review considered her a victim of sexual harm as part of her ongoing assessment alongside her other emotional difficulties. As such it is clear the

medical review considered this aspect of her needs and also recommendations for follow up care in the community being trauma informed.

10.8.7 The decision to offer Penelope care and accommodation at the therapeutic placement, was on the basis that they would be able meet Penelope's complex emotional needs and adapt a trauma informed approach to support and planning around risk management.

10.8.8 In July 2021 Penelope made a written disclosure of a sexual assault that took place at age 13 and gave this to a nurse. This was considered to be the same disclosure as made earlier. Penelope did not want to pursue this further but discussed that thoughts of this had increased and that she had struggled with this. Appropriate support was given. Incident reports were completed. This disclosure did not include new information.

10.8.9 This information was considered and shared with the care provider upon Penelope's discharge from Cygnet and was considered in the matching process with the care provider.

Learning point: Penelope's disclosures of sexual abuse should have been referred to CSC at the time of the disclosure as per child protection procedures. The decision not to consider Penelope's disclosures across the partnership, as part of a strategy meeting prevented the police from contributing to a collaborative plan and missed an opportunity for the police to share any potentially relevant intelligence.

10.9 Professional Curiosity and Escalation – Consider whether professionals were sufficiently curious and whether escalation processes were used appropriately in this case.

10.9.1 Whilst Penelope was an in-patient there is evidence of professional curiosity in terms of reviewing of plans for Penelope and undertaking of assessments to review Penelope's presenting needs by a multi-agency network. There is also evidence of plans in terms of transitions being reviewed in line with Penelope's needs and this being adapted in line with her needs.

10.9.2 Risk management and plans for recovery were at the focus of her care. An MDT approach was evident including external agencies and Penelope alongside her family. There is clear evidence that management strategies were escalated when required but also considered within least restrictive practice.

10.9.3 Professionals were 'curious' with regards to concerns raised by Penelope in relation to allegations of abuse but these were not reported as expected; frontline staff did consult with senior staff who agreed the decision.

10.9.4 When there was a lack of clarity around the involvement of community services, and in response to Penelope's transition from children's to adult services, appropriate escalation and referral took place.

10.9.5 CMHT Manchester did not contact Penelope for a two month period following her move to the care home, the reason cited was that Penelope had had intense involvement from other agencies as well as CAMHS and significant risk assessments; the transfer of care between CAHMS and CMHT was inadequate. It appears throughout CAMHS services that once a child reaches 18 years old they

are closed as soon as possible with no overlap on care, in such a complex case it would have been useful for CAMHS to remain involved for a 3-6 month period to give a thorough handover and to allow Penelope to engage with adult services.

10.9.6 It could be argued that A&E staff were not sufficiently curious before discharging Penelope on the 16th August 2022, and that staff needed to ascertain what that service provided prior to discharging Penelope, and determine whether Penelope would be in a safe environment. However the department was under pressure that night. At the time of Penelope arrival there were 59 patients in the ED . ED has a capacity of 2 rapid assessment cubicles for ambulance arrivals, 13 cubicles, 8 resus cubicles and 5 paediatric cubicles. The corridor can have 7 patients. 4 ambulances were outside unable to transfer their patients in. There was a 4 hour wait to see a clinician. Due to Penelope presentation and police presence she was prioritised and seen after 1 hour 10 minutes of arrival. At the time of her discharge there were still 45 patients in ED and 5 ambulances waiting to transfer in. Performance that day against the 4 hour national target was 59% showing issues with flow and long waits for patients. Although the ED was pressured Penelope was prioritised and seen by a senior doctor.

10.9.7 Both police officers and care home staff questioned the decision to return Penelope to placement given the support available to them in the night. The police are recorded as having called their senior officers for confirmation to leave Penelope, which was given. Care home staff liaised with the Clinical On-Call nurse, reporting significant anxiety about Penelope returning; a plan was agreed should there be an increase in Penelope's risk again.

10.9.8 It is unclear from the records as to whether MALM processes were considered at this time, however service developments since this time have built in process of MALM meetings as part of escalation processes for young people who are in hospital, which supports escalation and professional curiosity from the multi-agency network.

10.9.9 On the morning of the 17th the duty nurse picked up the handover from on-call and reviewed the incident with Penelope. The duty nurse did not know Penelope and as such organised a meeting with the Consultant Psychiatrist and the staff member who knew Penelope best, to discuss the risk presentation and what would be required to best assess Penelope's current need. They met at 10:30am and discussed the events of the night before, including a brief history of Penelope's risk presentation and recent discussions with her Clinical Nurse Specialist (CNS).

10.9.10 It was deemed important that a face to face assessment of Penelope's mental state should take place and that this might help her to feel validated in her risk and needs, as she was reporting feeling invalidated at hospital the night before. It was deemed more appropriate to continue to support Penelope to work on managing her risks in the community. The Speciality Doctor would also see Penelope on the following day, if the duty review didn't develop any more immediate plans. The Consultant Psychiatrist prescribed an increase back to the previous prescription for Penelope's medication.

Learning point: Whilst there is evidence of professional curiosity and escalation by front line practitioners, the response to escalation did not consider sufficiently

the safety of Penelope either in her environment or in the plans that were made. The police officers advice to return Penelope to the care home in a police van whilst somewhat understandable did not take sufficient account of the behaviours Penelope was currently displaying and there does not appear to have been any consideration of using alternative powers available to the police e.g. section 136. Whilst decisions made within the MDT at the care home on the 17th August 2022 had the potential to increase safety in the longer term e.g. increased medication, there was insufficient consideration of alternate options outside of the scope of the care provider service. Whilst the reviewer agrees that a face to face assessment should have taken place, this should have been a Mental Health Act assessment and was required as a matter of urgency. Care home staffs escalation of their concerns in relation to the support that was available to them overnight, were also not given sufficient consideration in making plans going forward.

10.10 Commissioner and Provider Arrangements – How clearly defined were the commissioner/host arrangements and responsibilities? What assurance was required by commissioners that the host could provide the wrap around service Penelope required and what evidence did the provider submit?

10.10.1 Penelope's placement at Cygnet was commissioned and overseen by NHSE Specialist Commissioning team and not Manchester CCG as was standard practice, and were clearly defined.

10.10.2 Although Penelope was placed in a Bury care home her usual place of residence is in Manchester. Commissioning arrangements in Manchester differ to those in Bury causing a lack of clarity for senior managers.

10.10.3 Penelope's placement at the care home was commissioned by the Multi-Agency Resource Panel which is a tri-partite agreement between Manchester Social Services (lead), GMMH and NHS GM Manchester Commissioning Team.

10.10.4 Placement searches for Penelope were undertaken by the commissioning service within Manchester Children services from July 2021. At the time of the referral for placement searches Penelope was an in-patient receiving treatment under section 3 of the mental health act. Penelope was diagnosed with complex trauma, PTSD and EUPD.

10.10.5 The placement search was undertaken based on the needs of Penelope. Information which had been shared during the on-going MDT meetings supported and informed the assessment.

10.10.6 The care provider was identified as a potential placement. Extensive searches were undertaken to ensure the care provider had experience to manage Penelope's presenting mental health needs and presentations.

10.10.7 Following a number of placement planning meetings, and the care provider conducting their own assessment, a formal offer was made. The placement was deemed suitable for Penelope by all actively involved agencies. The Bury GP practice were not involved in the commissioning of Penelope's placement, as was usual practice.

10.10.8 Following the completion of due diligence, permission to accommodate, and the placement with the provider being agreed, a comprehensive transition plan was

developed. This was undertaken over several months and was reviewed and extended in line with Penelope's presenting needs. It was presented at Manchester MARP panel for senior governance and joint funding agreement.

10.10.9 The placement is registered to support the needs of young people suffering from mental ill health, providing accommodation and treatment. As the placement was registered for care in the accommodation, this therefore did not fall under the processes of unregulated placement and therefore did not go through the review in relation to High Risk placements.

10.10.10 Given Penelope's age at the time, transition planning was undertaken with GMMH for when Penelope turned 18 years and GMMH took responsibility for the ongoing treatment/care of Penelope and ongoing funding of the placement.

10.10.11 There were no concerns raised to commissioning about the quality of the placement, care or treatment being provided to Penelope following discharge, therefore as per policies and procedures further checks were not undertaken as these would be based on analysis of risk.

10.10.12 As part of the review process the reviewer learned that concerns had been raised with the LADO in relation to the care home. Those concerns related to the number of callouts to GMP for residents leaving the home in an unplanned way; it was reported that there had been no attempt by staff to follow them. There were also concerns regarding the location of the establishment as there was a bridge over a road nearby. There had been two incidents of a young person going to the bridge in 2021.

10.10.13 The reviewer learned that whilst the new member of staff had followed policy they had interpreted the policy/model in an unhelpful way and was overly rigid in their interpretation. The staff member was sent for retraining and additional input from their manager. The policy was reviewed and flowcharts introduced to make this as clear as clear as possible to all staff members.

10.10.14 It is clear that the young people resident at the care home are there in order to progress from the very restrictive environment within hospital, and learn the skills required to live in the community, and there is a need to place some trust in the young person. However this raised a concern regarding the threshold for intervention and how incidents lead to changes in risk management.

10.10.15 The reviewer learned that a young person's overall care, progress and risk presentations are routinely reviewed monthly within core groups and MDT reviews. Core groups are specifically focused on reviewing risk, updating risk management plans, amending care plans and reviewing the recovery star. MDT reviews can make changes to treatment plans and medication regimes to ensure that risk is managed safely and therapeutically. Therefore, risk assessments, formulations and management plans are routinely updated and revised at a minimum frequency of monthly. Risk management plans and managing mental health care plans are always reviewed following any incident for a young person.

10.10.16 Outside of normal working hours there is an out of hours on call service. The clinical on-call staff offer guidance to the staff following risk incidents and ensure that practice is carried out therapeutically and safely alongside the placements model of care. On call clinicians are also available to liaise with external professionals such as hospital staff or police if necessary. Plans will be reviewed and amended

where appropriate by the duty or on-call nurse to reflect the current risk profile and the MDT or the young person will then review these changes and consider them alongside the risk formulation, to see if any further amendments are required.

10.10.17 One of the options that could have been explored In the historic cases was the use of Deprivation of Liberty Safeguards (DOLs) legislation. The LADO was informed it was felt that it wouldn't be possible to have one resident on a DOLs and not another; this raised concerns as to whether there is conflict between the ethos of the service and use of legislation designed to safeguard people. Again this appears to have been the erroneous view of a member of staff and it is reported that the care home do use DOLs but there remains a concern about locking doors as this impacts on other residents, and can induce further dangerous action being taken, e.g. jumping out of windows.

10.10.18 Following the incidents raised by the LADO, and other events, the CQC were informed. Regular meetings and discussions take place following notifications of incidents where specific incidents are considered separately and evidence is provided to demonstrate how risks have been assessed, formulated and managed safely to reduce any potential harms to young people and staff. These plans are also regularly shared with multi-agency partners for review as well as being subject to the providers internal incident governance framework, audit and lessons learned processes.The CQC carried out inspections in 2021 and 2022. On both inspections CQC brought specialist advisors on site to review risk from a mental health perspective (2021 had a Psychologist; 2022 had a mental health specialist). Following these inspections the care home received a grading of good for risk management.

10.10.19 Currently CQC do not have powers to investigate individual complaints and/or safeguarding concerns. The CQC can only observe staff interactions during site inspections and have no powers to attend outside of agreed inspection processes. It is the local authority's role to investigate safeguarding concerns.

Learning point: The commissioning of placement for Penelope went smoothly and no concerns were ever raised regarding the placement during the time Penelope was a resident, therefore no review of those arrangements were deemed necessary. However the lack of a care co-ordinator and lack of a multi-agency approach made it unlikely any concerns would be identified. Currently there is no clarity regarding when the placement should communicate with commissioners. The introduction of joint protocols would facilitate communication between the commissioner and the host, give clarity on expectations, and support oversight of residents in placements.

10.11 **Covid-19 –** How did Covid-19 specifically impact on service delivery in this case?

10.11.1 Penelope was an in-patient during the height of the pandemic. Penelope contracted Covid-19 in December 2021 which contributed to the delay in transitioning to the care provider.

10.11.2 Despite the concerns regarding the pandemic, there is no evidence that Covid-19 impacted on the level of care afforded by Cygnet, the GP, the Police, the care provider or NWAS.

10.11.3 NCA report that Covid-19 meant several changes to the way care was delivered particularly in the emergency department. All staff donned full PPE, which made it difficult to build relationships with patients and communication became more challenging as patients could not see staffs faces. Patients were also required to wear masks which could be distressing and uncomfortable. Departments also had segregated areas for patients who were suspected of having Covid-19, meaning patients could have been moved more than normal.

10.11.4 At times there may have been less staff available in departments due to high levels of staff sickness along with staff being moved to other departments and supporting with Covid-19 vaccines/swabbing. This may have led to higher levels of delays in accident & emergency departments.

10.11.5 Whilst this was the general picture, there is nothing to suggest the care afforded to Penelope during her attendances was directly affected by the pandemic.

10.11.6 Whilst Covid-19 restrictions were in place this restricted the CSC services ability to meet with professionals and also Penelope on a face to face basis. This could potentially have affected the relationship the social worker was able to build. Parents and practitioners report Penelope struggled at times to build trust with professionals, and it would have been difficult to build and sustain a trusted relationship over telephone calls. Whilst there was good evidence of face-to-face visits and direct work with Penelope when this was possible during Covid-19 restrictions these interactions were reduced and were not conducive to supporting Penelope.

Learning point: Agencies did well to keep the impact of Covid-19 on patients to a minimum. Restrictions resulting from the pandemic made changes to the way practitioners and services were operating. This likely had a negative impact on practitioners ability to develop a trusting relationship with Penelope. Penelope was impacted by contracting Covid-19 and this contributed in part to Penelope's delayed discharge.

Learning outside of the Key Lines of Enquiry

10.11.7 Learning relates to communication between the care home and Penelope's parents and how Penelope's parents were informed of her death. Mother had up to 20 conversations a day with Penelope and was fully involved in Penelope's life as was her father. Parents noticed a change in the level of communication between care home staff and themselves after Penelope had been there a month. They were not informed there would be a change. The reviewer has reviewed the agreement Penelope made and parents should have continued to receive regular updates.

10.11.8 Penelope had not shared with her parents that she was self-harming more frequently. Parents indicated they were not contacted following the incident of self-harm on the 16th August 2022. The reviewer is clear that this was in-line with Penelope's wishes.

10.11.9 Mother was informed that Penelope had gone to A&E the following morning and had Facetime communication with Penelope. Penelope was tired so was left to sleep. From teatime parents were constantly trying to communicate with

Penelope and with the care home when Penelope did not pick up. Staff at the care home had been instructed not to pick up the phone. Parents saw that there had been an incident at a bridge on the teatime news. Mother feared it was Penelope but had received no call. Parents report that the Police came to inform them that Penelope had passed away, approximately 2 and ½ hours after the event.

Learning point: Consideration needs to be given to informing parents at the earliest opportunity. When such an incident occurs restrictions on press reporting need to be considered immediately. Whilst it is absolutely appropriate to plan the most sensitive way to inform families, if an incident has already been reported in the news this must happen with speed.

11. Examples of Good Practice:

- The Manchester GP followed up on safeguarding concerns in discharge summary.
- Good information sharing from the Northern Care Alliance to the Manchester GP in discharge letters, especially regarding safeguarding concerns. Good subsequent information sharing between the Manchester GP and Penelope's mother in relation to discharge summary
- Police officers made good use of escalation processes and there is evidence of good documentation of Police actions in the context of Penelope's Mental Capacity assessment
- good use of escalation by Social Care to request strategy meetings as risk escalated and ensure an informed approach to risk management.
- GMP - Good assessment of dynamic risk and inter-personal communication documented
- NCA - Follow up management plan, antibiotic therapy and follow up to Burns/Treatment room and safeguarding referral completed
- NCA - Safeguarding referrals completed on each admission informing LA of their concerns
- When Penelope was Under 18 and living in the care home NWAS staff raised safeguarding concern notifications on each contact which is good practice when attending to a child who is self-harming with suicidal ideation
- NWAS - Comprehensive and detailed ePR completed to a very high standard, this was shared electronically on handover at hospital
- The Care Provider has an extremely comprehensive referrals and assessment process
- There is clear evidence of a gradual and appropriate approach to discharge. Responses to risk behaviours during the transition period were considered and appropriate with involvement of Penelope and her family

- Involvement of potential placements commenced as early as practicable and there was good involvement of other external parties throughout Penelope's hospital admission
- The implications of transition from child to adult services were fully considered. There is strong evidence of multi-agency working throughout the transition process across Cygnet, CSC and the Care Provider
- The transition plan for Penelope was very person centred

Appendix i – key to acronyms/ abbreviations

A&E	Accident & Emergency
ASC	Adult Social Care
AWOL	Absent Without Leave
BISP	Bury Integrated Safeguarding Partnership
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CLA	Children Looked After
CMHT	Community Mental Health Team
CNS	Clinical Nurse Specialist
CPA	Care Programme Approach
CRG	Case Review Group
CSC	Children's Social Care
CQC	Care Quality Commission
DOLs	Deprivation of Liberty Safeguards
ECG	Electrocardiogram
ED	Emergency Department
EUPD	Emotionally Unstable Personality Disorder
GM	Greater Manchester
GMMH	Greater Manchester Mental Health NHS Foundation Trust
GMP	Greater Manchester Police
GP	General Practitioner
ICB	Integrated Care Board
KLOE	Key Lines of Enquiry
LA	Local Authority
LAC	Looked After Child
LCT	Leaving Care Team
LADO	Local Authority Designated Officer
MALM	Multi-Agency Leads Meeting
MCA	Mental Capacity Assessment
MDT	Multi-Disciplinary Team
MHA	Mental Health Act
NCA	Northern Care Alliance NHS Foundation Trust
NWAS	North West Ambulance Service NHS Trust
OT	Occupational Therapy

PCFT	Pennine Care NHS Foundation Trust
PICU	Psychiatric Intensive Care Unit
PPE	Personal Protective Equipment
PRN	Pro Re Nata (when required)
PTSD	Post-Traumatic Stress Disorder
SAR	Safeguarding Adult Review
SEDU	Specialist Eating Disorder Unit
ToR	Terms of Reference