

VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent investigation into the care and treatment of Mr M and Mr P

A report for
NHS England

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1 Introduction

NHS South of England commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Mr M and Mr P. Mr M is a mental health service-user who killed Mr P, another mental health service-user, while both were inpatients. The killing occurred at Mr M's flat. He was found guilty of manslaughter due to diminished responsibility in July 2013.

The independent investigation follows the Department of Health guidance published in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33-36 issued in June 2005. The terms of reference for this investigation are given in full in section two of this report.

The purpose of an independent investigation is to discover what led to an adverse event and to audit the standard of care provided to the individual. An independent investigation may not identify root causes or find aspects of the provision of healthcare that directly caused an incident but it will often find things that could have been done better.

The chief executive of Sussex Partnership NHS Foundation Trust commissioned an internal investigation into the care and management of Mr M and Mr P. The director of governance and the service director for working age services led the investigation.

A review of all clinical records including paper and electronic took place. Interviews were conducted with trust staff. The trust investigation found several areas of practice that needed addressing and thirteen recommendations were made.

1.1 Background to the independent investigation

Mr P left Jade Ward at Langley Green Hospital in Crawley for a period of agreed leave at about 6.30pm on 8 August 2012.

Mr M was subject to 15-minute intermittent enhanced observations. He left the ward by climbing over the ward garden fence at about 7pm the same day.

Mr M and Mr P met by chance on the street and arranged to go to Mr M's flat, where Mr M stabbed and killed Mr P.

1.2 Overview of the trust

Sussex Partnership NHS Foundation Trust provides mental health, learning disability, substance misuse and prison healthcare services across Sussex for people of all ages. Inpatient services to East Surrey are provided at Langley Green Hospital, Crawley.

2 Terms of reference

The terms of reference for the independent investigation into Mr M and Mr P, set by NHS England, in consultation with Sussex Partnership NHS Foundation Trust are detailed below.

1. Purpose of the Investigation

To identify whether there were any aspects of the care which could have been altered or prevented the incident from happening. The investigation process should also identify areas where improvements to services might be required, which could help prevent similar incidents occurring.

The overall aim is to identify common risks and opportunities to improve patient safety and make recommendations for individual, organisational and system learning.

Main Objectives

- To evaluate the mental health care and treatment including risk assessment and risk management
- To identify key issues, lessons learnt, recommendations and actions by all directly involved in providing the care plan
- To assess progress made on the delivery of action plans following the internal investigation
- To identify lessons and recommendations that has wider implications so that they are disseminated to other services and agencies
- Identify care or service delivery issues, along with the factors that might have contributed to the incident

2. Terms of Reference

- Review the assessment, treatment and care that Mr M and Mr P received from Sussex Partnership NHS Foundation Trust.
- Review the care planning and risk assessment policy and procedures.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment
- Review the interagency working between the Trust and other agencies and how this influenced the formulation and care plan.
- Review the documentation and recording of key information
- Review communication, case management and care delivery
- To review professional judgement processes and actions and ensure they correspond with statutory obligations, relevant good practice guidance from the Department of Health, and local operational policies, (with particular reference to safeguarding)
- Review the Trust's internal investigation of the incident to include timeliness and methodology to identify:

- If the internal investigation satisfied the terms of reference
- If all key issues and lessons have been identified
- Whether recommendations are appropriate and comprehensive and flow from the lessons learnt
- Review progress made against the action plan
- Review processes in place to embed any lessons learnt
- Conducting a thematic review of the units risk assessment, risk management and care planning approaches
- Testing out the trust investigations conclusions/findings
- Seeking evidence of the implementation of their recommendations.
- Review any communication and work with families of the victim and perpetrator
- Establish appropriate contacts and communications with family/carers to ensure appropriate engagement with the internal investigation process.

3 Approach to the independent investigation

NHS England and the trust agreed that the investigation would be in two parts:

- Part 1 – a review of the case
- Part 2 - a thematic review of the unit's risk assessment, risk management and care planning approaches. As part of this process evidence would be sought of the trust's implementation of recommendations from the internal inquiry.

This report is therefore in two parts.

The investigation team consisted of Tariq Hussain and Andy Nash. Expert advice was provided by Dr Martin Lock. Biographies of the team are attached at appendix A.

We examined documentary evidence, including policies and procedures from the trust, Mr M and Mr P's clinical notes as well as the trust's investigation report. (see appendix B).

Staff we interviewed are listed at appendix C.

We have not been able to interview four members of staff who were involved in the care of Mr M or in a management position in the unit. They were dismissed after disciplinary hearings into the falsification of clinical notes relating to Mr M and Mr P. These staff were a consultant psychiatrist, a matron, a ward manager and a team leader.

Apart from the matron, the other three individuals dismissed were involved in the care of Mr M and Mr P and would have been able to help us understand why certain decisions were taken, particularly about Mr M's care. We reviewed the notes of their trust interviews but these were only partially helpful. This has limited our ability to fully understand some of the decisions about the care and treatment offered to Mr M and Mr P. We interviewed other staff and read the clinical notes. Despite these difficulties, we believe that the evidence supports our findings.

Mr M gave his written consent for us to access his medical and other records for the purposes of the investigation. We wrote to him twice at the outset to explain that we had been commissioned to carry out this investigation and offering to meet with him. We received no reply. When the report was at a final draft stage Mr M agreed to meet with us. We shared with him our draft report have taken account of his comments in the final report.

We met Mr P's sister to explain the scope of the investigation and to ask what areas of concern the family would like us to examine. She has asked us to try to answer a number of questions about the care provided to Mr P. We took these questions into account as best we could. The questions are listed in appendix D. We have also met with Mr P's sister and cousin to provide feedback on our findings.

We have complied with the request of Mr P's family that we redact in their interests any information that could identify him.

A copy of the draft report was sent to Mr P's sister and Mr M's mother. Mr P's sister contacted us with concerns about those parts of the report that describe Mr P as violent and a risk to others when he was unwell.

Mr P's sister told us that he had never been violent to his family, the public or staff in his home country and had never been convicted of a criminal offence. She told us he was a very gentle, friendly and loving man.

Whilst an inpatient in Bodiam ward, Eastbourne, and Jade ward, Langley Green, hospital, staff found him to be generally pleasant and cooperative. Whilst on the ward he did not display any signs of being a risk to himself or others.

The entries in our report which Mr P's sister disputes and asks us to remove are part of his clinical records. They were made by the psychiatric liaison nurse at Gatwick Airport and staff at wodiam Ward. The disputed entries that our report contains identifies the source the staff used to make their record.

We did not interview the psychiatric liaison nurse or the staff at Bodiam ward because our principal focus was on the care delivered to Mr M and Mr P on Jade ward. We believe that the staff who made the entries that we have included in our report had no reason to be inaccurate in their record-keeping and the staff who made those entries were from different parts of the service. These entries needed to be recorded to contribute to the formulation of Mr P's risk management plan.

We are sorry for the distress that these descriptions of Mr P have caused but we cannot remove them from the report as requested by Mr P's family because they are important in understanding the care that was given to Mr P.

We met Mr M's mother to get her perspective on his care and any areas of concern. We met her again to provide feedback on our findings.

This report includes a chronology outlining the care and treatment of Mr M and Mr P. The analysis appears in section 10, where particular issues and themes are highlighted.

Chris Brougham, senior consultant from Verita, peer-reviewed this report.

4 Executive summary and recommendations

4.1 Summary chronologies of Mr M and Mr P

4.1.1 Mr M

Mr M first had contact with child and adolescent mental health services when he was 13. His mother said he was paranoid and strange from an early age. She also told us that he had consistently used illicit drugs such as cannabis and cocaine since the age of 17. The clinical records support some of her comments.

Mr M had admissions to psychiatric units in 2005 and in April 2012. He was then admitted in July 2012. At various times he suffered from paranoid delusions, auditory hallucinations and violence and aggression.

Mr M has been imprisoned twice for burglary. He served 18 months of a three-year sentence at HMP Lewes, where he was diagnosed with schizophrenia and substance misuse problems. This diagnosis differed from an earlier one of drug-induced psychosis. Mr M had a partner and a baby but she left him shortly after his release from prison, taking their baby with her.

Mr M presented at Mill View Hospital on 3 April 2012 and was admitted to Jade Ward at Langley Green Hospital. This was his catchment area hospital. He was diagnosed with a drug-induced psychosis and paranoid personality disorder. He was discharged on 11 April 2012 and allocated to a social worker who was his care coordinator.

His care coordinator found it difficult to engage with Mr M, as Mr M had no phone and was often asleep when she called. He had disabled the front door bell in case the people who he believed to be after him called and he had locked the service entrance from the inside for the same reason.

Mr M's mental state deteriorated during July 2012 and he was referred to the trust community rehabilitation team on 20 July 2012. He was seen regularly by the team but expressed suicidal ideas including thoughts of jumping in front of a train.

Mr M was acting bizarrely on 30 July 2012. He went to a filling station where two police officers saw him crouching, apparently in fear, behind the counter. He was assessed and admitted informally to Jade Ward at Langley Green Hospital.

He told staff he had a nine-inch kitchen knife strapped to his waist. Nursing staff removed the knife and later gave it to the police.

Mr M did not mix with other patients and staff, was guarded and suspicious. He tested positive for amphetamines on admission.

Mr M continued to be monitored at 15-minute intervals on 3 August 2012 but he left the ward without staff noticing. They contacted the police who brought him back. A drug screen taken on his return was positive for amphetamines.

The notes for 6pm on 9 August say:

“Mr M was not on ward at the beginning of the night shift. Reported as AWOL [absent without leave] to the police and told that Mr M was suicidal. Police advised that they would visit his house.”

Mr M phoned the ward at 10.45 on 9 August to say he was calling from home and that patient Mr P was with him. Later the same day Sussex ambulance services called to say that Mr M had called them and appeared paranoid. Ward staff said they suspected Mr M had been taking illicit substances and that they would be discharging him in his absence.

Ward staff phoned Mr M to tell him about discharge plans but he did not answer.

The police went to the ward at 5pm and said a homicide had taken place and that Mr M was a suspect.

4.1.2 Mr P

Mr P was a 52-year-old divorced man from another European country with one adult married daughter. He lived alone in a flat close to his sister's home and worked as a tattoo artist. Mr P was well known to mental health services in his home country and was last discharged from an inpatient facility in June 2012. His GP confirmed a diagnosis of drug abuse and Attention Deficit Hyperactivity Disorder (ADHD) marked by paranoia.

Mr P travelled to the UK on 22 July 2012. He was confused and distressed when he arrived at Gatwick Airport and police arranged for him to have a psychiatric assessment.

He was assessed and admitted informally to Bodiam ward at the department of psychiatry in Eastbourne on 22 July 2012. He was pleasant and cooperative and spoke openly to staff about this desire to kill his ex-wife because she meant him harm because of the one-million-dollar inheritance that awaited him in the US. He was also expecting to see President Obama while here in England.

Mr P had a history of misuse of cocaine and cannabis and on a number of occasions on the ward he requested methadone saying he had been prescribed it at home.

He was transferred to Jade ward at Langley Green Hospital on 30 July 2012. He was risk assessed. He denied suicidal thoughts but had plans to kill his ex-wife if he returned to his home country. He displayed no signs of being a risk to himself or others while he was on the ward.

A ward round took place on 1 August. A psychiatrist assessed him as having paranoid schizophrenia.

Mr P started taking short periods of leave from 1 August and began visiting local shops. He visited the American Embassy on 7 August. A psychiatrist reviewed him on his return and discussed a discharge plan with him.

Mr P asked for his bankcard from staff and went out at 6.30pm on 8 August with JG, another patient.

JG later returned to the ward without Mr P, saying he had said he would return later. Mr P did not return. Staff reported him missing to the police at 2.00am on 9 August 2012. Mr M phoned the ward at 10.45am on 9 August to say Mr P was with him.

4.2 The incident

Mr P left Jade Ward at Langley Grange Hospital on 8 August 2012 to get money from a bank machine, as agreed with staff.

Mr M, who was subject to 15-minute intermittent enhanced observations, also left the ward at about 7pm the same day by climbing over the garden fence.

Mr M and Mr P met by chance on the street and made arrangements to go to Mr M's flat.

Mr M stabbed and killed Mr P whilst Mr P was at Mr M's flat.

4.3 Overall conclusions of the independent investigation

Our conclusions are that the care provided to both Mr M and Mr P in respect of:

- risk assessment and management;
- care planning;
- the use of the Mental Health Act; and
- the responses to both Mr M and Mr P leaving the ward on several occasions were seriously inadequate and fell well below acceptable standards.

We would have liked to discuss why these basic failures in care occurred but the dismissal of key staff made this impossible. Such failures of basic standards of care processes are usually the result of a lack of effective clinical and managerial leadership. We accept that in this investigation this can only be supposition on our part. Our view is strengthened by the actions of senior staff involved in altering clinical records to cover up the failures in care we identify in this report.

4.3.1 Predictability

The following is our criteria for assessing predictability:

We consider the homicide would have been predictable if there had been evidence from Mr M's words, actions or behaviour at the time that could have

alerted professionals that he might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred.

We do not consider that the homicide was predictable because nothing in Mr M's words, actions or behaviour suggested he was likely to become violent towards Mr P. We saw no evidence of behaviour, statements or signs that could have alerted professionals that Mr M might imminently become violent.

4.3.2 Preventability

The following is our criteria for assessing preventability:

We consider the homicide would have been preventable if professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take steps to do so. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.

We consider that the homicide was preventable because the professionals involved in the care of Mr M could have prevented the incident but did not. They:

- knew that Mr M was paranoid and had been admitted carrying a knife, had a forensic history and had told staff that he had knives in every room in his house;
- had the legal means of assessing him with a view to detaining him under the Mental Health Act;
- failed to urgently escalate his absence from the unit; and
- failed to contact the police or visit him at home when he phoned the unit on the morning of 9 August.

Our findings and recommendations are listed in the executive summary and the report in the relevant part one and part two sections. We include only recommendations we believe build on the extensive work the trust has already done to improve clinical and management systems at Langley Green.

4.4 Part one findings

F1 Staff gave insufficient attention to the assessment of Mr M by the prison forensic psychiatrist and to formulating a working diagnosis that included the possibility of a diagnosis of schizophrenia.

F2 Staff focused more on Mr M's risks to himself than risks to others, despite clear evidence to the contrary.

F3 The decision of the multi-disciplinary meeting of 9 August 2012 to discharge Mr M was a serious error. The multi-disciplinary team failed to recognise the risks he

posed to other people and possibly to himself. The team also failed to properly assess risk and put in place an appropriate care plan.

F4 The consequent failure to escalate action to check on Mr M's whereabouts when he left the unit on 8 August was a serious error.

F5 The delay in alerting the police led to a failure to safeguard Mr M and other people.

F6 An assessment under the Mental Health Act should have taken place to determine whether Mr M could be detained under Section 2.

F7 Staff we interviewed were unclear about the use of the Mental Health Act in respect of:

- the criteria for detention of those deemed to be a risk to themselves or others; and
- patients who are not detained but who are not allowed to leave the ward.

F8 Mr M should have been referred to the trust's PICU service because his needs appear to have met the trust's admission criteria. Even if not accepted by the PICU this might have provided a second opinion of his risks and strategies to deal with them.

F9 The failure to take seriously Mr M's use of weapons is addressed elsewhere in this report. The failure to communicate this information to staff and act on it was serious.

F10 Mr M's mother had vital information about his violence and paranoia that was not recorded or taken into account in any assessments on the ward.

F11 The failure to undertake a proper assessment and put in place an appropriate care plan for Mr P at Langley Green Hospital was a serious omission.

F12 The failure of staff to take into account:

- the mental state of both Mr P and Mr M;
- the risks to others that they both posed;
- the likelihood that they would purchase illicit drugs;
- the failure of staff to report either of them missing for 7-8 hours;
- the failure to understand the significance of the call from Mr M; and
- the decision to discharge Mr M in his absence are all serious errors.

4.5 Part one recommendations

R1 The trust should ensure that all staff understand the Mental Health Act, in particular in respect of the criteria for the use of Sections 2 and 3.

R2 The trust should further review the AWOL/missing persons policy in conjunction with Sussex Police and should ensure that staff in both organisations understand its operation.

R3 The trust should assure itself that informal patients are not detained illegally.

R4 The trust should issue guidance to staff on the need to ensure that all risks are clearly set out in the risk management plan and communicated to staff. The trust should also ensure that mechanisms are in place to make sure this happens.

R5 The trust should establish a process with the police, probation and prison services for rapidly obtaining information about forensic histories and index offences where patients are deemed a risk to others.

R6 The trust should ensure that staff routinely involve families in discussions and decisions about a patient's care, in line with trust policy.

4.6 Part two thematic review

The thematic review focused on risk assessment, risk management and care planning approaches. We also assessed whether the trust had implemented the recommendations from the internal investigation.

In our thematic review we:

- reviewed 10 case files from Jade and Coral ward (both acute admission wards at Langley Green Hospital);
- interviewed a range of staff who agreed to meet us, including nursing, psychology, OT, and consultant psychiatrists;
- sent a letter to patients asking if they wished to meet us. One patient from Jade ward took up this offer;
- assessed whether the trusts clinical risk arrangements in place were in keeping with national best practice; and
- meet the unit's police liaison officer.

4.6.1 Case file review

We used a Verita tool designed for assessing whether a trust's clinical risk arrangements comply with national best practice. We also assessed the clinical risk arrangements against trust policies

The 10 files were all on paper because the trust does not have a unified electronic patient record.

The importance of assessing the files was made more relevant because the trust has implemented new shift patterns and has a target of patients usually remaining as an inpatient for no more than 28 days.

Staff now work 12-hour shifts which can cause a 4-6 day gap between staff coming off duty and returning to work. The 28-day discharge target causes a rapid throughput of patients. Staff coming on duty after extended days off have limited time to review the care plans and risk assessments of all new patients and the current progress of the care of patients who remain.

4.6.2 Multidisciplinary care plans

We looked to see if the files contained a fully documented multi-disciplinary plan that is regularly updated. We found several care and risk plans on each file (medical, nursing, occupational therapy, psychology), most of which are both thoughtful and reasoned.

4.6.3 Copying community CPA plans

The case record folder has a clear instruction on its inside cover that if a care programme approach (CPA) plan has been carried out for patients known to community services before admission and who were subject to CPA, the CPA plan should be copied and attached to the file and a box ticked to indicate that this had been done. We found that this had not been carried out on any of the cases we reviewed and that staff were not aware of this requirement.

4.6.4 Legibility of entries and ease of access

We have concerns about the legibility of many entries and the inadequate format of files which leads to difficulties in accessing information quickly. There is a lack in the files of an “at a glance” summary of current risks, needs and care planning.

We think care planning documentation contained in the files does not appear to be central to managing care. It should be possible to open a file and immediately find a multi-disciplinary care plan that sets out the key components of the care plan, the specific interventions and risk assessment/management. It is not feasible for staff to trawl through 19 disorganised paper files on their return to work to find essential information.

Staff generally agreed that the use of paper files hampered their work. They did not know why an IT system had not been implemented on the wards and were not sure of the timescale for implementation.

4.6.5 Case file improvements

The manager on Jade ward told us about a handover sheet being piloted that covered history, risk, daily updates and tasks/plans for the day. On Jade ward there were examples of personal support plans being developed to focus on the needs of service-users. Interventions were agreed with the user to meet their needs.

4.6.6 Electronic patient record system

All staff told us that the lack of an IT system on the wards affected their ability to develop consolidated multi-disciplinary care and risk management plans, ensure adequate handover arrangements and provide continuity of care between ward and community services. None of the staff we spoke to knew when a system was likely to be introduced.

4.6.7 Overall conclusion of the quality of case files

Our review of clinical notes indicates that professionals have overall been assessing risk and putting in place risk management plans appropriate to the care of individuals. The files we reviewed had all relevant information that we would have expected to see and they were completed competently. This provides us with assurance that staff have a good understanding of the requirements of risk assessing and risk management.

The current IT system in place is potentially unsafe and hinders good mental health care.

4.6.8 Service user engagement

We asked whether ward-based care plans detailed specific interventions agreed with the service-user and designed to meet their needs. We met one service-user who was pleased with the quality of care he was receiving and felt fully informed and involved in decisions relating to his care. He said staff were approachable and generally available.

We found few care plans signed by patients.

4.6.9 Police liaison

We met the police officer responsible for liaison with the trust. She told us the relationship with the trust and with Langley Green Hospital was good. She identified some problems about dealing with patients who left the ward without permission. She also believed that staff did not fully understand their own powers or those of the police to return patients. She also believed there was misunderstandings over the definitions of missing, absent or absent without leave. We make a recommendation on this in part one of our report.

4.6.10 The trust's investigation and implementation of the action plan

We think the trust undertook a thorough review that met its terms of reference and the requirements in the trust's policy. The recommendations of the trust's investigation address key organisational and clinical systems and processes. They are robust and show that the trust has taken the opportunity to address the failures in the systems that led to the poor practice identified in their report and reinforced in ours.

The recommendations of the trust's investigation cover:

- clinical leadership and clinical judgment;
- governance; and
- dual diagnosis.

The evidence of staff, managers and senior clinicians in the unit leads us to believe that these recommendations have been implemented and were having a positive effect on the quality of the current service.

A number of staff told us about improvements since the incident and the subsequent implementation of the recommendations of the internal inquiry. Some staff felt it was now easier to get their 'voices heard'.

4.7 Part two thematic review findings

F13 The files we reviewed were not fit for purpose and potentially unsafe and hinder good mental health care. They do not provide a well-structured, easily accessible and effectively recorded set of clinical notes that inform the care and treatment of a patient.

F14 There is no 'at a glance' single multi-disciplinary care plan in the case files that pulls together all the individual care and risk assessment plans. Central to managing care should be a multi-disciplinary care plan that all professionals contribute to.

F15 The development of personal support plans on Jade ward is helpful.

F16 The development of a handover sheet on Jade ward is welcome.

4.8 Part two thematic review recommendations

R7 Multi-disciplinary, integrated care and risk management "at a glance" plans should be implemented immediately pending the introduction of an IT system.

R8 All current active files should be reviewed and put in good order. The format of files should be reviewed and regular audits of files should take place until an IT system is in place.

R9 Pending the introduction of a ward-based IT system, a temporary procedure should be introduced which ensures that community and ward notes are accessed as part of one process.

R10 The trust should agree how and when a new integrated community and ward IT system will be introduced and should tell staff about it.

5 The care and treatment of Mr M

Mr M first had contact with child and adolescent mental health services when he was 13. His mother says he had been paranoid and strange from an early age.

Mr M was 20 when he was admitted to Mill View Hospital psychiatric intensive care unit in 2005 under Section 2 of the Mental Health Act. This was because of paranoid delusions, auditory hallucinations, violence and aggression. His mother told admissions staff that he had consistently used illicit drugs such as cannabis and cocaine since the age of 17.

Mr M has been imprisoned twice for burglary. He served 18 months of a three-year sentence at HMP Lewes. He was diagnosed with schizophrenia and substance misuse problems during this time. This diagnosis differed from an earlier one of drug-induced psychosis.

A forensic psychiatrist referred Mr M to Linwood community mental health team (CMHT) when he was released in August 2011. He did not attend any appointments the CMHT offered him.

Mr M's partner left him shortly after his release, taking their baby with her. Mr M said he found it difficult to use some areas of the flat he lived in because of memories of his child. For example, the baby's bouncy chair was still in the living room and this upset him.

He presented at Mill View Hospital on 3 April 2012 and was admitted to Jade ward at Langley Green Hospital. This was his catchment area hospital. He was diagnosed with a drug-induced psychosis and paranoid personality disorder.

He was discharged on 11 April 2012 and allocated to a social worker who was his care coordinator. His care coordinator found it difficult to engage with Mr M, because he had no phone, was often asleep when she called and he had disabled the front door bell in case the people he believed were after him called. He had locked the service entrance from the inside for the same reason.

Clinical records describe Mr M as isolated with many problems. He had debts and difficulties with his benefits. He struggled to manage his limited income to be able to buy essentials such as food. He had a back problem for which he needed hospital treatment. He was not compliant with his medication. His care coordinator called to see him regularly - usually at least weekly.

Mr M's care coordinator found him guarded and suspicious; she thought he might have a cognitive problem. He had high anxiety levels, which seemed to be helped by pregabalin¹. Mr M told his care coordinator that he had robbed a known drug dealer and that his sister had been kidnapped at gunpoint and believed some of his paranoia could be based in reality. His care coordinator thought the diagnosis of

¹ Pregabalin is an anticonvulsant drug used for neuropathic pain and partial seizures. It has also been found effective for generalised anxiety disorders.

schizophrenia in the referral letter from Healthcare at HMP Lewes matched Mr M's presentation.

Mr M was open with his care coordinator about his use of amphetamines; he understood immediately after taking the drug that its effects soon wore off, leaving him feeling worse and more paranoid. For a period Mr M was not using amphetamines and although he remained guarded, suspicious and had difficulty retaining information, he seemed a little better. He was also worried about his inability to retain information. He wanted to go to college but was concerned he was unable to keep up with the work. Mr M's care coordinator assessed him as a risk to himself but he was not assessed as a risk to healthcare workers. His care coordinator told us she did not feel at risk when she was alone with him.

Mr M's mental state deteriorated during July 2012 and he was referred to the trust community rehabilitation team on 20 July. He was seen regularly by the team but expressed suicidal ideas including thoughts of jumping in front of a train.

Mr M was acting bizarrely on 30 July 2012. He went to a petrol garage and was crouching behind the counter afraid. He was seen by two police constable support officers. They made contact with mental health services and Mr M was assessed in the A&E department of the Royal Princess Hospital. Mr M admitted taking speed and tested positive to amphetamines.

He was admitted informally to Jade Ward at Langley Green Hospital on an informal basis. The plan was:

- further assess mental state;
- establish a diagnosis;
- reinstate medication;
- assess risk and maintain safety;
- Mr M to remain on the ward;
- not to receive visitors unless agreed;
- be subject to regular drug screens;
- not use drugs during the admission; and
- engage in a prearranged discharge meeting and be referred to Addaction¹.

As soon as Mr M walked onto the ward, he told staff that he had a nine-inch kitchen knife strapped to his waist. He told staff that he did not want them to feel threatened and he had it only because people were following him. The knife was removed by staff and Mr M took his clothes off to show that he was not carrying anything else.

The police attended the ward later in the evening to see Mr M and collect the knife. The knife could not be found and initially the healthcare support worker thought the paramedics must have taken it. Police searched Mr M but found nothing.

Later in the evening the knife was found by staff and the police returned to the ward and picked it up.

¹ A specialist drug and alcohol treatment charity

Mr M was assessed using an acute inpatient mental health and risk assessment tool. Some of his historical violence and use of weapons was recorded in the assessment. The document also noted that Mr M did not express intent to harm others.

The duty doctor assessed Mr M. Mr M told the doctor that he had a weapon in every room at home and that he slept with a weapon. A health care assistant was also present and recalled Mr M telling the doctor about having knives at home. The doctor concluded that Mr M was a risk to himself and others and placed him on 15-minute observation. The staff started a 15-minute observation chart.

The following day a multi-disciplinary team meeting took place. The record says:

- known to Mid Sussex and CRHT [crisis resolution and home treatment team];
- isolating himself and expressing suicidal ideas;
- when on the ward had a knife in his possession – for self defence; and
- needs a review of diagnosis during admission.

Mr M did not mix with other patients and staff, was guarded and suspicious. He tested positive for amphetamines on admission.

Mr M continued to be monitored on 15-minute observations on 3 August 2012. Despite this, he left the ward without staff noticing. They contacted the police who brought him back. A drug screen taken on his return to the ward was positive for amphetamines.

On the ward Mr M remained suspicious and isolated himself.

Medical staff reviewed Mr M on 6 August. The management plan was:

- discuss with Mr M what help he would like;
- risk assessment;
- physical examination; and
- call GP.

The reviewing doctor's impression of Mr M was that he appeared to be depressed and that drug use had contributed to his paranoia.

A daily action planning meeting took place on 8 August. The record of that meeting says "plan for discharge."

The notes for 6pm 9 August say:

"Mr M was not on ward at the beginning of the night shift. Reported as AWOL [absent without leave] to the police and told that Mr M was suicidal. Police advised that they would visit his house."

A multi-disciplinary team meeting took place on the ward on 9 August. The records note that this was the second time that Mr M had absconded and that he engaged poorly while on the ward. The plan was:

- drugs screen on return;
- review for discharge;
- if not returned by midnight – discharge in absence; and
- crisis team input?

Mr M phoned the ward at 10.45am to say he was calling from home and that patient Mr P was also there.

Later the same day Sussex ambulance services called to say that Mr M had called them and was paranoid. Ward staff said they suspected that Mr M had been taking illicit substances and that they would discharge him in his absence.

Ward staff phoned Mr M to advise him of discharge plans but he did not answer his phone.

The police attended the ward at 5pm and said a homicide had taken place and that Mr M was a suspect.

6 Arising issues, comment and analysis

The themes addressed in this section of the report are:

- diagnosis;
- risk assessment and risk management;
- multi-disciplinary assessment and care planning;
- Mr M leaving the ward;
- use of the Mental Health Act; and
- communication.

6.1 Diagnosis

When Mr M was about to be released from HMP Lewes in August 2011, the prison forensic psychiatrist wrote a referral letter to Sussex Partnership Trust saying Mr M had a:

“previous history of two clear psychotic episodes, the most recent with first-rank symptoms are not clearly linked to substance misuse, is suggestive of a primary psychotic illness, possibly schizophrenia”.

Mr M’s care co-ordinator, who had worked diligently to engage him before his admission, told us:

“I felt he had schizophrenia but, at the beginning when I was seeing him, he was telling me that he wasn’t taking any other substances except from diazepam....”

The nurse in the Crisis Team told us:

“Yes, my understanding was that, yes, he had schizophrenia”.

Yet the clinical notes and multi disciplinary assessments often say:

- “Drug induced psychosis with personality disorder”;
- “Main problem is drug addiction”;
- “Acute onset psychosis probably drug induced” and
- “Difficult to formulate diagnosis in light of substance misuse”.

Mr M’s care co-ordinator told us:

“it was quite unclear because we had one thing that said he had schizophrenia and we had somebody else saying that he had a paranoid personality disorder; we had other people saying that yes, he has a psychosis but it is drug induced”.

And:

“There was some debate about the diagnosis. It bubbled along....”

Our expert forensic psychiatrist says:

“...staffs’ concerns about Mr M and the need to refer him to a dual diagnosis team was due to their pre-conceived ideas that he suffered from either a paranoid personality disorder or a series of drug induced psychoses and they presumably regarded this as beyond their expertise”.

“I am of the opinion that given how common multiple diagnoses are it would ...seem strange that patients have to be referred to Dual Diagnosis teams.....If dual Diagnosis Teams accepted all patients with multiple diagnoses they might well have to deal with virtually all inpatients in some inner city areas”.

...”a failure to appreciate the opinion expressed by (the prison) consultant forensic psychiatrist, after the assessment carried out at HMP Lewes in 2011. It is difficult to know if the multidisciplinary team were even aware of this assessment. The consultant forensic psychiatrist had appreciated that Mr M had a long history of abusing illicit substances, which might well have affected his mental state, but it was still thought he had continued to experience psychotic symptoms when illicit substances had not been abused for significant periods of time. The psychotic symptoms elicited second and third person hallucinations and persecutory delusions.....and it led that doctor to conclude that Mr M suffered from a process psychotic illness which might well be schizophrenia”.

6.1.1 Comment

Three of the staff dismissed were directly involved in Mr M’s care. Without interviewing these staff it is difficult to understand how a diagnosis of schizophrenia was overlooked, without any debate, with the focus shifting to Mr M having a drug-induced psychosis. Some staff accepted the diagnosis of schizophrenia but could not shift thinking away from an unstated formulation which was effectively drug-induced psychosis with drug misuse being the primary issue and Mr M being more of a risk to himself than others. Some staff told us that it was difficult to get their voices heard before the homicide and the changes arising from the internal inquiry. This may have contributed to this situation.

Whatever the reason for the formulation of a drug induced psychosis, the failure to include schizophrenia as a possible element of it had implications for Mr M’s risk assessment/management and care planning.

6.1.2 Finding

F1 Staff gave insufficient attention to the assessment of Mr M by the prison forensic psychiatrist and to formulating a working diagnosis that included the possibility of a diagnosis of schizophrenia.

6.2 Risk assessment and risk management

National policy says risk assessment and risk management should be at the heart of effective mental health practice. Trust policy says that all service-users should have a risk assessment completed as part of the assessment. Any risks or issues around safety identified should be incorporated into the service-user's care plan and reviewed as appropriate for up to a maximum of 12 months.

The trust's clinical risk assessment and management policy and procedure reflects the principles of positive risk management and includes collaboration with the service-user and carer. It notes several levels of risk assessment:

- brief screening -and if a more comprehensive screening is indicated;
- level 1 risk assessment- and if inpatient admission is required;
- adult acute inpatient risk assessment and 72 hour plan (equivalent to Level 1);
- multi-disciplinary risk review;
- weekly risk care plan;
- a level 2 MDT risk assessment is for those being deemed to be "high risk"; and
- there is also a comprehensive forensic risk assessment for inpatient forensic patients.

The risk screening tool covers the following areas:

- suicide;
- self-harm;
- self-neglect;
- harm to others; and
- the care of children.

Several risk assessments for Mr M appear on file. We summarise their contents below.

6.2.1 Level 1 risk assessment – 30 July 2012

This, according to the trust's policy, is the assessment undertaken before admission. It shows for Mr M:

- suicide risk indicators in last 12 months – 9 out of 15 which is a relatively high score;

- aggression/violence risk indicators in last 12 months 4 out of 17 which is a relatively low score; and
- the indicator for “use of weapons” is marked “no”, despite his carrying a nine-inch knife on admission and having weapons in every room at home.

6.2.2 Acute inpatient and mental health risk assessment- 30 July 2012

This is a different risk management tool to the level 1 risk assessment and is a more detailed assessment. It shows for Mr M:

- nine of 23 indicators for risk to self (such as suicide) are marked ‘yes’; and
- seven of 27 indicators for risk to others (such as violence/aggression) are marked as ‘yes’.

Key comments in these assessments are:

- “Extremely suicidal ideas”;
- “Sleeps with weapons....due to self defence against people against him” and
- “Wants to end his life, has (illegible) lots of ways but best to throw himself under a train”.

6.2.3 Acute inpatient care. Risk and mental health care plan – 1 August 2012

The risks identified in this care plan are:

- expressing intent to harm himself;
- drug use;
- isolated and withdrawn;
- admitted with large knife;
- served a prison sentence for burglary and has been under probation;
- previous history of aggression and violence secondary to drug use; and
- not expressing intent to harm others.

The risk and care plan had the following components:

- establish a therapeutic relationship;
- engage with OT;
- nurse on intermittent observation to assess level of suicide risk;
- engage in adaptive strategies;
- provide psycho-education about harmful effects of drug use;
- establish whether presentation is indicative of mental illness and substance misuse;
- random urine drug screening, enforce ward policy regarding substance misuse;
- liaise with community team regarding discharge planning; and
- liaise with neurology regarding back pain.

6.2.4 Acute inpatient care. Risk and mental health care plan – 6 August 2012

The care plan included the following statements:

“K. has expressed suicidal thoughts. He feels paranoid that people are after him”.

“...has not exhibited any signs of aggression or violence while on admission. K however, prior to admission was in possession of a 9 inch knife for his protection as he felt people were following/after him. K. also has some significant forensic history”.

6.2.5 Level 2 risk assessment multi-disciplinary – 9 August 2012

This is fully completed but illegible. We comment on issues of illegibility in our Part 2 thematic review.

6.2.6 Mr M and knives

One of the nurses who admitted Mr M to Jade Ward told us about the risks Mr M posed to himself and others:

“I asked him (on admission) if he had any other weapons or anything else about his person he could hurt anyone with and he said no and, in fact he started to pat himself down and take his clothes off. It was trainers, I think and I remember thinking you have hidden blades in your shoes because that is not normal. I didn't feel in danger.”

We also asked the nurse what they were going to do about his disclosure of having knives in each room of his flat. She told us:

“I know we had communicated between the team and there was to be an alert made on eCPA, so the community team were aware of that. To be honest we didn't discuss that at the review I attended”.

Our expert forensic psychiatrist says:

“...it would appear all the professionals involved in the assessment and treatment of Mr M failed to appreciate the significance of Mr M's paranoia and what it had led him to do in recent times”.

“It would appear Mr M was generally regarded, by all the psychiatric staff, as posing a low risk to others”.

“I amof the opinion that they (staff) underestimated the significance of a 9 inch knife strapped to his abdomen”.

6.2.7 Comment

It is difficult to understand why staff did not take into account the real risks Mr M posed to others when formulating their risk assessments and risk management plans. Our inability to interview three members of staff adds to our difficulty. The documentation on file is confusing and sometimes illegible. The notes show some understanding that he had a forensic history but no attempt was made to seek further information.

6.2.8 Finding

F2 Staff focused more on Mr M's risks to himself than risks to others, despite clear evidence to the contrary.

6.3 Multi-disciplinary assessment and care planning

The acute inpatient care – risk and mental health care plan dated 6 August 2012 notes the following interventions:

- 1:1 time for Mr M;
- monitor mood and mental state;
- encourage Mr M to engage in OT activities;
- nurse Mr M on appropriate level of observation;
- Mr M to remain on ward to minimise access to drugs; and
- serve Mr M prescribed medication.

The following MDT assessment and plan was formulated at a multi-disciplinary team meeting held on 9 August 2012 attended by a doctor, staff nurse, ward manager, community team leader and one other (designation not known):

“MDT. Pt. absconded from ward again (2nd occasion). Still not returned. Concerns re drug use again. Admitted w. paranoia, isolation, carrying weapons. Poor engagement during admission. Not benefiting (illegible)...admission informally, not detainable.

Plan

1. Police notified re abscontion (sic)
3. Drugs screen when returned to ward
3. For PMS alert (weapons use)
4. Liaise with consultant re Crisis Team input > review for discharge > if not returned by midnight for discharge in absence
5. Discuss discharge options with Dr P.

Impression

- Known substance abuse
- Long forensic with previous prison
- Poor service engagement.....

- Poor relationship with family
- Current admission as a result of self/neglect/paranoia/suicidal ideas
- difficult to formulate diagnosis in light of substance misuse and poor engagement
- pt currently (writing unclear)....police notified”.

The notes confirm that Mr M was on intermittent observation all the time he was in hospital. His charge nurse told us:

“This observation is appropriate when patients are assessed to be potentially, but not immediately at risk of suicide or potential risk to others. This means that the patient’s location must be checked at specified intervals...”

“Patient’s subject to intermittent observation should not leave the ward environment without an appropriate escort, unless this is part of an agreed and documented care plan”.

“We use the zoning system as well, as a form of identifying the risk”.

“Those who are on 15 minute observations they automatically showing that there is something going on, that is why they are on the observations, so they remain on red zone”.

6.3.1 Comment

A number of risk assessments and care planning meetings were held and recorded.

6.3.2 Multi-disciplinary meeting

A planned multi-disciplinary team meeting took place on the ward on 9 August. The notes say this was the second time that Mr M had absconded and that he engaged poorly while on the ward.

Mr M’s care coordinator was not available for the multi-disciplinary team meeting and her community team manager represented her. He told us the meeting lasted about 30 minutes. He told us that Mr M’s forensic assessment was on eCPA (CPA record stored electronically and used by community teams) but information about his index offences was not.

The community team manager was not aware of Mr M’s index offences. In retrospect, he felt he had only bits of information. He was not told Mr M was on 15-minute observations. The meeting discussed whether he was able to be sectioned and decided that he was not.

The community team manager told us he had to insist that the issues about knives be put on to eCPA system. He also told us that if he knew all the risk information he would not have agreed to discharge Mr M in his absence.

6.3.3 Comment

It is difficult to see why the decision to discharge Mr M if he did not return to the unit was made at the MDT meeting on 9 August 2012. This decision does not take account of the various assessments carried out and in particular the acute inpatient care – risk and mental health care plan dated 6 August 2012.

Nothing in the notes explains why Mr M was discharged in his absence, nor has anybody given an adequate explanation.

A working assumption might be that staff saw his drug use as his primary problem which they could not help with and that any risk was to himself rather than to others.

Our expert forensic psychiatrist says:

“There seems to be a failure to appreciate that even if, after comprehensive assessment of Mr M’s mental state in appropriate conditions, that the psychotic symptoms were drug induced did not mean nothing could be done about them or that their existence did not pose a significant danger to Mr M’s safety or the safety of others”.

6.3.4 Comment

The failure to take account of the possibility that Mr M was suffering from schizophrenia and the focus on Mr M’s drug use seem to have driven the risk assessment and care planning process in a particular direction.

6.3.5 Finding

F3 The decision of the multi-disciplinary meeting of 9 August 2012 to discharge Mr M was a serious error. The multi-disciplinary team failed to recognise the risks he posed to other people and possibly to himself. The team also failed to properly assess risk and put in place an appropriate care plan.

6.4 Mr M leaving the ward

Mr M was being monitored at 15-minute intervals all the time he was on Jade ward. He first left the ward without permission on 3 August and the staff phoned the police, who brought him back.

Despite his level of observations, Mr M left the ward again at about 7pm on 8 August without staff noticing.

A nurse on the night shift recorded in the notes at 6 am that:

“Mr M was not on ward at the beginning of the night shift. Reported as AWOL [absent without leave] to the police and told that Mr M was suicidal. Police advised that they would visit his house.”

The nurse on that night shift told us he had been told on handover that Mr M was not on ward and that he had jumped over the fence. He was also told that it was believed that Mr M/Mr P were together.

The nurse on the night shift called Mr M on his mobile at 10pm and left him a message. He told us that he also phoned the police about the same time to report Mr M but received no reply.

He told us he was busy with two admissions at the time so he did not phone the police again until midnight.

He told us that when he reported Mr M missing to police they took details about risk assessment, paranoia, medication and said they would be in touch.

The police called back at about 2am and also took Mr P's particulars. The night nurse told the police about the knives issue related to Mr M. The police asked him if Mr M was on section. He felt that even though Mr M was not on section the police might be able to persuade him to come back.

Mr M called the ward at 10.45am on 9 August he said that Mr P was with him and he was at home. Staff did not notify the police at this stage.

Sussex ambulance services called later the same day to say that Mr M had called them and was paranoid.

6.4.1 Comment

In light of the risk assessments carried out and the knowledge of Mr M's history available to staff, the failure to call the police until later that evening is difficult to understand. In particular, as on a previous occasion when Mr M had left the ward, the police were notified and they returned him because of the phone call from the ambulance service describing him as paranoid.

6.4.2 Findings

F4 The consequent failure to escalate action to check on Mr M's whereabouts when he left the unit on 8 August was a serious error.

F5 The delay in alerting the police led to a failure to safeguard Mr M and other people.

6.5 Use of the Mental Health Act 1983

This part of the report addresses two issues:

- Should consideration have been given to detaining Mr M under the Mental Health Act?
- Informal status and absence without leave protocols.

We considered whether Mr M should have been assessed under the Mental Health Act given the high level of risk he posed. If detained he might then have been kept off illegal drugs and a proper diagnosis made.

Our expert forensic psychiatric says:

“Staff might well have argued that they did not have the right to use powers under the Mental Health Act 1983 to detain Mr M in hospital for medical treatment. In my opinion that was incorrect as it failed to take into account the risk Mr M posed to others”.

“.....further consideration should have been givento his detention under the MH Act to ensure the treatment plan could be effectively imposed on him”.

The possibility of putting Mr M under section was never discussed. All the staff we spoke to believed it was not possible to section Mr M because he was willing to stay on the ward; this was further reinforced by a collective view that he was low risk to others. He would have met the criteria for detention under Section 2 or 3 of the Mental Health Act¹ if he had been assessed as posing a high risk to others

The relevant part of the criteria for Section 2 is:

“(b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.”

Our expert forensic psychiatrist says:

“Mr M had a significant history of illicit substance, which was thought to have adversely affected his mental state. Indeed at the bottom of page 3 of the Sussex Partnership RCA final report it was said, "Jade ward multidisciplinary team were clear that the task was to assess his level of psychosis during a drug free period to enable a diagnosis to be made...". If at the time of his original admission it was thought this could not effectively be done because JS would leave the ward and abuse further illicit substances then, in my opinion, it would have been perfectly legitimate for the psychiatric professionals to have made a case for JS's detention under the MHA, 1983, so he could be kept on the acute ward and hopefully away from illicit

¹ Section 2 (s2) allows a person to be admitted to hospital for an assessment of their mental health and receive any necessary treatment. Section 3 (s3) allows a person to be detained in hospital for treatment.

substances. If that was thought to be difficult, or even impossible, then consideration could have been given to his transfer to a psychiatric intensive care unit, which could only happen if he was detained, for continuing assessment and treatment. One of the many factors that would be considered in making this decision should have been the perceived risk JS presented to others.”

All the staff we spoke to believed it was not possible to section somebody who was willing to stay in hospital, even if they posed a high risk. This is a common misconception, as our expert forensic psychiatrist points out:

“To be fair to the staff in Langley Green Hospital it would be reasonable to note that many psychiatric units would have made the same decision as they did at the time of Mr M original admission but I would suggest many units might have acted differently following the absconsions (sic).”

6.5.1 Comment

Following a review of the draft of this report by NHS England’s solicitors, discussion has been held between them and the authors of this report. The solicitors agree that our summary set out below is an accurate description of the law related to admission under the MHA of a person who states that they are willing to be admitted but whose mental state may make an informal admission inappropriate.

Our expert forensic psychiatrist says:

“There are a number of reasons why it would be necessary to consider detention under the Mental Health Act 1983 if patients with the capacity to make the decision say they are willing to accept admission. The patient might have a history of suggesting compliance with treatment recommendations only to renege on that, sometimes within a very short period of making promises to the professionals. There might be a history of significant violence, either in the recent past or currently, which would possibly necessitate admission to a secure psychiatric unit. There might be a history of significant illicit substance misuse, which is thought to be having an adverse effect on the patient's mental state. The professionals might conclude that without restricting the patient's movements they will be unable to prevent further misuse of illicit substances and further problems for his mental health.

Mental Health professionals must be aware that a patient with the capacity to make the decision simply saying they are willing to accept informal admission does not end all consideration of the mode of admission. In the majority of cases such patients will be admitted informally but an important minority will be detained under the Mental Health Act 1983 as it is concluded their safety and/or the safety of others remains at significant risk.”

6.5.2 Comment

Our view is that Mr M met the criteria for admission for assessment. He was suffering from a mental disorder that warranted his detention and he needed to be detained because he was deemed to be a risk to himself but he was also a risk to others. These factors were clear on admission and this should have led to a request for a MHA assessment with a view to admission under Section 2 or 3.

Some staff thought that despite being an informal patient Mr M could not leave the ward. The following is from the clinical notes:

“K. Informal patient, 15 minute intermittent observations. K. requested to go to the shops, but as he is on 15 minute intermittent observations this was not possible. K. understands that he cannot go out on his own until his observations have been revised.”

A charge nurse told us that even if a patient were informal, they would not let them out without an escort if they were on intermittent observations.

A care co-ordinator told us that there was also an issue of informal patients on locked wards who cannot get out when they wish to, because the ward door is locked.

6.5.3 Comment

Staff we interviewed seemed to misunderstand the use of the Mental Health Act when someone is willing to stay in hospital informally but is assessed as a risk to themselves or others. This may be a more widespread misunderstanding and a point of learning in mental health services.

The staff did not understand that patients in these circumstances can be detained if the risk to themselves or others is strong, though other criteria would also need to be satisfied. We also saw evidence that some informal patients were told that they could not leave a ward if they were on 15-minute observations.

Staff also appear to believe that the decision not to section someone, even when they are high risk, is protecting their human rights, while telling a patient that they cannot leave a ward even when they are informal, is not a breach of their human rights.

6.5.4 Findings

F6 An assessment under the Mental Health Act should have taken place to determine whether Mr M could be detained under Section 2.

F7 Staff we interviewed were unclear about the use of the Mental Health Act in respect of:

- the criteria for detention of those deemed to be a risk to themselves or others; and
- patients who are not detained but who are not allowed to leave the ward.

6.6 Referral to a psychiatric intensive care unit

We also considered whether Mr M should have been placed in a psychiatric intensive care unit (PICU) to enable him to be kept off illegal drugs and to assist in formulating a firmer diagnosis.

Our expert forensic psychiatric says:

“I am of the opinion that Mr M was treated on an inappropriate ward. In my opinion consideration should have been given to his transfer to a psychiatric intensive care ward, certainly after his first absconion (sic) and the abuse of illicit substances.”

The trust’s PICU Eligibility Criteria include the following:

“Patients with behavioural difficulties which seriously compromise their physical or psychological well-being or that of others which cannot be safely assessed or treated in an open/acute ward or crisis resolution team.”

6.6.1 Comment

Mr M should have been referred to a PICU. This was justified on the basis of his forensic history and because he had left the unit without permission and on return tested positive to amphetamines. The referral process would have allowed for a second opinion of his risk and even if he had not been accepted, this might have helped determine how he should have been cared for on the ward and whether other strategies to mitigate his risks could have been implemented.

6.6.2 Finding

F8 Mr M should have been referred to the trust’s PICU service because his needs appear to have met the trust’s admission criteria. Even if not accepted by the PICU this might have provided a second opinion of his risks and strategies to deal with them.

6.7 Informal status and absent without leave protocols

Chapter 22 of the Mental Health Act code of practice says:

“This chapter gives guidance about action to be taken when patients are absent without leave (AWOL) or have otherwise absconded from legal custody under the Act.”

The trust’s AWOL policy says:

“An AWOL person is a patient detained, or for Supervised Community Treatment Patients (SCT) is recalled to hospital or the SCT is revoked, or subject to Guardianship under the Mental Health Act, whereas a missing patient has informal status.”

The Sussex police officer responsible for liaison with the trust told how they differentiate between people who are missing and those who are absent:

Missing – anyone whose whereabouts cannot be established and where the circumstances are out of character, or the context suggests the person may be subject of crime or at risk to themselves or another.

Absent – a person not at a place where they are expected or required to be.”

Mr M left the ward twice without telling staff. The police were informed both times. The police returned him on the first occasion, 3 August. The records for the second occasion say “K. was not on the ward at the beginning of the night shift and has been reported AWOL”.

‘AWOL’ is clearly a term applied to someone who is legally detained yet staff use it to apply to an informal patient. A staff nurse told us:

“I think (Mr M was described as being AWOL even though he was not on section) because he was on 15 minute intermittent obs. Obviously to be on 15 minute obs. There were some concerns, even though he is an informal patient.”

A care coordinator told us:

“If somebody went AWOL they would usually try and find out where he is and bring him back, or find out what’s going on. Not discharge him.”

Staff are confused about the use of the term ‘AWOL’. A charge nurse told us:

“People tend to use the term wrongly. It was just ‘Absent without leave’, we do apply the term we use, if it is an informal patient who is still absent, but we tend to use the latter, ‘Leave, without’ – we tend to use- that is leave without permission or something like that.”

The police officer responsible for liaison with the trust told us that working relationships were generally good but that there were some tensions around the interpretation of 'AWOL'. She told us:

- that the police expected the trust to take responsibility for returning people unless a risk assessment indicated suicide or violence risk; the most reported AWOLs were not in this category;
- that the police had no power to return patients not under section and missing;
- that nurses had the same legal right as the police to compel someone on a section to return;
- that the police made a distinction between missing (do not know where they are) and absent (know where they are); and
- that formal police/trust written agreement was under review.

The trust's internal review found that 'AWOL' was not recorded on the correct form and therefore details were difficult to access. The trust action plan recommended that the 'AWOL' Policy be reviewed and the revised policy be relaunched.

6.7.1 Comment

The term 'AWOL' is specifically used in the Mental Health Act code of practice to apply to detained patients. Staff use this term in respect of informal patients. This is important because it has legal implications and can lead to misunderstandings with the police. The trust policy uses the term "AWOL" for detained patients and "missing" for informal patients. The police use the terms "missing" and "absent" rather than "AWOL", leaving scope for confusion.

The trust internal inquiry recommendation focuses on AWOL forms not being completed correctly.

A brief (16 pages of large font, double spaced) trust Mental Health Act Policy does not cover the complexity of Mental Health Act functions.

6.8 Recommendations

R1 The trust should ensure that all staff understand the Mental Health Act, in particular in respect of the criteria for the use of Sections 2 and 3.

R2 The trust should further review the AWOL/missing persons policy in conjunction with Sussex Police and should ensure that staff in both organisations understand its operation.

R3 The trust should assure itself that informal patients are not detained illegally.

7 Communication issues

Mr M was admitted to Jade Ward on 30 July 2012. He told staff he had a nine-inch kitchen knife strapped to his waist. The knife was removed by staff. The duty doctor then carried out medical admission procedures. Mr M told the doctor he slept with a weapon and kept one in every room. The healthcare assistant who was present confirmed what Mr M had said and the information was recorded on the comprehensive assessment (Inpatient) form, completed on admission.

Nine members of staff attended the multi-disciplinary team meeting on 31 July. The record of the meeting noted that Mr M “when on the ward, had a knife in his possession - for self defence”. No mention is made of his having weapons in every room or sleeping with a weapon. Weapons are not mentioned on the Acute Care MDT Clinical Review forms completed on 3 August 2012 and 6 August 2012. The issue surfaced again at the Acute Care MDT Clinical Review meeting on 9 August, which agreed to discharge Mr M. The community team manager who attended the meeting said he had to ask for an alert to be put on eCPA for possible possession of weapons.

7.1 Comment

Staff continually underestimated the use of weapons by Mr M and the risk that this posed to other people. This is consistent with the prevailing view that he was more of a risk to others than to himself. However, it is of concern that the significant information about his use of weapons was not consistently communicated between staff. Where it is mentioned, the focus is on Mr M having been admitted with a knife; his sleeping with a weapon and having weapons in every room seems to have been forgotten. Mr M’s mother (see section eight) also confirms that she told staff at Langley Green about his use of weapons. It is doubtful whether this information would have been put on eCPA but for the intervention of the community team manager.

7.2 Finding

F9 The failure to take seriously Mr M’s use of weapons is addressed elsewhere in this report. The failure to communicate this information to staff and act on it was serious.

7.3 Recommendation

R4 The trust should issue guidance to staff on the need to ensure that all risks are clearly set out in the risk management plan and communicated to staff. The trust should also ensure that mechanisms are in place to make sure this happens.

The clinical notes and MDT reviews contain numerous mentions of Mr M having had a forensic history. We saw no evidence that the detail of his forensic history was gathered by staff on Jade ward. The community team manager told us that Mr M's forensic history was on eCPA, but further information could have been obtained from the police or probation.

Mr M's care co-ordinator and the community team leader told us that there was no policy or process for getting information about index offences or for seeking information about forensic histories, outside of the MAPPA¹ process. As far as we know Mr M was not subject to MAPPA.

Mr M's care coordinator told us:

“We didn't even know he had been discharged from Probation and there's an awful lot of a lack of communication between everybody I think. There's an awful lot we didn't know.”

“I wouldn't have been going to see him in his flat on my own”.

7.4 Recommendation

R5 The trust should establish a process with the police, probation and prison services for rapidly obtaining information about forensic histories and index offences where patients are deemed a risk to others.

¹ Multi Agency Public Protection Arrangements

8 Interview with Mr M's mother

Mr M's mother told us:

- the police files recorded a number of incidents in which Mr M was involved;
- on one occasion she found Mr M covered in blood;
- Mr M had self-harmed;
- Mr M should have been "sectioned" – he was clearly a danger to himself and others;
- Mr M suffered from long-term paranoia – knives, tools, weapons in every room; hidden under floorboards, five locks on door, smashed entry phone;
- Mr M had been in prison for violence – he had beaten up a drug dealer;
- Mr M once set fire to himself when tagged;
- Mr M tried to blow up his flat;
- Mr M was never violent to her; and
- she had found glass wrapped in his towel on the ward and that staff had said 'What did she expect them to do?'

The trust's clinical risk policy (January 2012) says:

"Risk assessments and risk management plans should involve collaboration with the service and carer."

Mr M's mother said she had told staff at Langley Green Hospital all this and that she was never involved in discussions about his care. She was involved in supporting him, even though he did not live at home. She also visited him while he was at Langley Green Hospital.

8.1 Finding

F10 Mr M's mother had vital information about his violence and paranoia that was not recorded or taken into account in any assessments on the ward.

8.1.1 Comment

Where a patient has not specifically stated that s/he does not want their family involved in decisions about their care (which was not the case here) families should be involved so as to gain a better understanding of their psycho-social history.

8.2 Recommendation

R6 The trust should ensure that staff routinely involve families in discussions and decisions about a patient's care, in line with trust policy.

9 The care and treatment of Mr P

Much of the background information about Mr P came from our interview with his sister. The dismissal of staff we mention earlier in this report caused us the same difficulty in reviewing Mr P's care as it did with Mr M.

Mr P was a 52-year-old divorced man from another European country with one adult married daughter. He lived alone in a flat near his sister's home and worked as a tattoo artist. He was well known to mental health services in his home country and was last discharged from an inpatient facility in June 2012. His GP confirmed a diagnosis of drug abuse and Attention Deficit Hyperactivity Disorder (ADHD) marked by paranoia.

Mr P travelled to the UK on 22 July 2012. The police at Gatwick Airport noticed that he was confused and distressed and arranged for him to be assessed by the psychiatric liaison team at East Surrey General Hospital A&E department. They noted that he spoke little English.

The A&E mental health liaison nurse spoke to Mr P's daughter and his sister. They said Mr P had had many admissions to mental health services in his home country and that when he became acutely ill he could become violent, particularly against people who he thought were part of some conspiracy. Mr P's family also said he kept his beliefs to himself when in hospital because he knew he would be detained longer if he did not. They told the liaison nurse that he had been violent towards them in the past.

The psychiatric liaison nurse at Sussex Partnership NHS Foundation Trust wrote a referral letter to mental health services explaining that Mr P came to the UK because he believed his ex-wife had hired someone to kill him. He was also expecting to see President Obama while he here.

Mr P was admitted on an informal basis to Bodiam ward at the department of psychiatry in Eastbourne on 22 July 2012. He was pleasant and cooperative and spoke openly to staff about this desire to kill his ex-wife because she meant him harm because of the one-million-dollar inheritance that awaited him in the US.

Mr P had a history of misuse of cocaine and cannabis and on a number of occasions on the ward he requested methadone saying he had been prescribed it at home.

Mr P was transferred to Jade ward at Langley Green Hospital on 30 July 2012. He was risk assessed and denied any suicidal thoughts but had plans to kill his ex-wife if he returned to his home country. The clinical records note that these plans were very fixed and that he had no insight. Mr P was placed on general observations. Staff found him to be generally pleasant and cooperative. Whilst on the ward he did not display any signs of being a risk to himself or others.

A ward round took place on 1 August. A psychiatrist assessed him. His history was noted and he was diagnosed with paranoid schizophrenia. He also had a physical diagnosis of:

- Type 2 diabetes Mellitus;
- Hypertension;
- peptic ulcer; and
- hepatitis C.

The management plan was:

- arrange for an interpreter;
- allowed to go to shops with staff;
- medication reviewed; and
- chart BM (blood glucose monitoring) before each meal and then review.

Mr P started taking short periods of leave from the ward, visiting the local shops, from 1 August 2012.

A psychiatrist reviewed Mr P on 7 August and a discharge plan was discussed. Mr P said he might go into bed and breakfast and work as a tattoo artist in London and that he did not want to return to his home country because it was corrupt.

His clinical notes contain several entries about Mr P's intention to go to the American Embassy to see "Obama's people". The clinical records on 7 August note that "Mr P was up early.....and left the ward". Another patient said he had gone to the US Embassy in London. He returned by 3pm and said he was angry "because he was turned down".

Mr P was given his medication at 9.30am on 8 August. Staff noticed he tried to hide it but they encouraged him to take it.

Mr P asked staff for his bankcard and went out at 6.30pm with another patient, JG.

JG later returned to the ward without him, saying he said he would return later. Mr P failed to return. Staff reported him missing to the police at 2am on 9 August 2012.

Mr M phoned the ward at 10.45am on 9 August to say that Mr P was with him.

10 Arising issues, comment and analysis

The themes are:

- risk management and care planning before admission to Langley Green;
- risk management and care planning on Jade Ward at Langley Green;
- access to an interpreter;
- family liaison and liaison with his embassy and medical service and
- questions raised by Mr P's family.

10.1 Risk assessment and care management prior to admission to Langley Green

Mr P was an informal patient on Bodiam Ward at the Department of Psychiatry, Eastbourne, until his transfer to Jade Ward on 30 July 2012.

During this period ward staff made contact with Mr P's family and his medical practitioner in his home country. They established the need for an interpreter. They learned that Mr P:

- had a psychiatric history and had been sectioned in his home country;
- had a history of random violence towards family, staff members and members of the public when unwell;
- had a history of drug use;
- had delusional beliefs about President Obama ;
- expressed a desire to kill his ex-wife who he believed to be a princess and
- had no insight into his behaviour.

The acute inpatient mental health and risk assessment plan drawn up on 22 July 2012 was:

- contact trust interpreter services;
- liaise with family;
- consider transfer to home country;
- medication...monitor for efficacy and side effects;
- consider assessing under the MHA 1983 if patient attempts to leave hospital and
- nurse on intermittent observations (15 mins).

This care plan was put together on the day of Mr P's arrival in the UK and apart from his physical health needs it addressed all his needs and developed a care plan which clearly identified risks.

He regularly expressed threats to kill his ex-wife and exhibited delusional behaviour about President Obama.

The subsequent acute inpatient plan and clinical notes continued to identify a high risk of violence and delusional behaviour with poor insight. Mr P was given a full physical health examination on 25 July.

He left the ward on one occasion accompanied by a member of staff to go to a cash machine.

Mr P was transferred to Jade Ward at Langley Green Hospital on 30 July 2012, this was the closest hospital to Gatwick Airport, where he had been assessed. Managers told us that this is the usual process for patients likely to be returned to their home country.

10.2 Risk assessment and care management on Jade Ward at Langley Green

Mr P's records contain a poorly completed acute inpatient risk and an undated mental health plan that does not address any of the risks staff at Eastbourne identified. A number of sections are not completed and the plan does not address his history of violence and detention under his home country's mental health legislation. It includes:

- "Interventions to manage the identified risks and mental health difficulties;
- Interpreter needed...;
- Escorted leave until review;
- Advised to take prescription medication;
- Liaise with family for (illegible) history + facilitate repatriation;
- link with Embassy and
- 1:1 to explore options/concerns".

No further risk management plans appear on file.

Mr P's clinical notes show that there were no problems with his care while he was on the ward. The notes regularly describe him as "*pleasant*", with only one mention of Mr P's propensity to be violent "*no risk of suicide, but could become aggressive if frustrated*" dated 1 August 2012.

The fact that Mr P was "paranoid about his family" is mentioned once.

However, he was on general observations all the time he was on Jade ward. The trust's *Observation and Therapeutic Engagement Policy* says:

"General observation is the minimal acceptable observation for all patients, which means having sight and contact with the patient at least hourly to ensure their physical and mental wellbeing is known. General observations must be recorded."

Several notes refer to Mr P's intention to go to the American Embassy to see "Obama's people". Another patient said Mr P had gone to the embassy on 7 August. Despite the fact he was on intermittent observations no action appears to have been taken to dissuade him from going to the embassy. The notes for 8 August say "he

did not have a good response at the Embassy". He clearly remained paranoid saying he had been followed to and from the embassy by two people followed him everywhere. Nothing more is said about this, nor about his leaving the ward again despite being on intermittent observations.

10.3 Access to an interpreter

Mr P spoke some English. The file notes:

"language barrier, but could express himself well enough in English but he feels inadequate....Speech – simple English language"

The notes and the daily handover sheets contain numerous references about the need to arrange an interpreter but this was not done. We asked staff about ease of access to interpreters:

"It depends what language you are looking for. It can be tricky".
"Generally....people are aware of the need to have interpreters...?"

10.4 Family liaison and liaison with the embassy and medical services

Several notes mention the need to liaise with Mr P's embassy but again nothing seems to have happened. The note for the 6 August is the only one to refer to contact with his doctors in his home country. It says, "Liaise with sister and doctor in re repatriation home".

There is no record in the notes of any contact by staff with Mr P's family. The notes say that on one occasion that Mr P had been in contact with his sister. Mr P's sister told us that she had asked him to talk to a member of staff about paying for a flight home. She heard a member of staff say "No!" loudly. She asked on another occasion without success to speak to a member of staff. Staff told us that that they would not usually refuse to speak to a patient's relative. Staff acknowledged that the ward can get busy and sometimes relatives will be asked to phone back.

10.4.1 Comment

The contrast between the quality of risk management and care planning at Eastbourne and Langley Green could not be starker.

Staff at Eastbourne liaised with Mr P's family, his doctors and embassy immediately. They obtained a full history and developed a care and risk management plan that took into account Mr P's diagnosis of schizophrenia, delusional beliefs, history of violent behaviour, drug use and physical health. They were working to a clear plan to enable Mr P to be repatriated to a hospital in his own country, which included the use of the Mental Health Act 1983 if necessary.

In contrast, staff at Langley Green did not undertake a risk assessment or develop a care plan. Mr P's propensity to violence and threats to kill his wife seem to have been forgotten with almost daily references to him as "pleasant". Using the trust's risk assessment framework would have helped staff manage these static and dynamic risks as opposed to just focusing on how he presented at the moment.

Contrary to what the notes say in places, an interpreter was not arranged, his family were not contacted and neither were his doctors nor embassy. Despite being on 15- minute observations, he left the ward to pursue his delusion of seeing "Obama's people" at the US Embassy. The notes contain no analysis of this or any updated risk assessment to take account of it.

Our forensic expert psychiatrist says:

"I have ...concerns about the assessment of Mr P. It would appear that most of the staff were under the general impression that Mr P's mental state was responding to treatment. That appears to have resulted in Mr P being allowed periods of unescorted leave...In my opinion it would appear that there was a failure to appreciate the significance of Mr P wanting to visit the American Embassy in order to make contact with President Obamaand the distress he experienced when he was not able to achieve this....In my opinion it is likely that Mr P's mental state was far less stable than the staff assumed".

10.4.2 Finding

F11 The failure to undertake a proper assessment and put in place an appropriate care plan for Mr P at Langley Green Hospital was a serious omission.

11 The events of 8 and 9 August 2012

Mr P left Jade Ward at 6.30pm on 8 August 2012 with another patient, on agreed leave to visit local shops.

Mr M, who was subject to 15-minute intermittent enhanced observations, also left the ward by climbing over the garden fence at about 7pm the same day.

Mr M and Mr P met by chance on the street and arranged to go to Mr M's flat. The patient with Mr P was invited but she declined and returned to the ward after lending Mr P and Mr M £20.

Staff decided not to tell police immediately that both Mr M and Mr P were missing and waited for them to return of their own accord. Staff reported them both missing at 2.00am on 9 August. The staff nurse who contacted police told them he suspected that Mr P might be with Mr M.

Mr M phoned the ward at 10.45am on 9 August to say he was calling from home and that Mr P was with him. He said that people were trying to get him everywhere and that he wanted to prove to somebody that "stuff was happening" in his flat. The member of staff who took the call was aware of discussions about the possibility of discharging Mr M and did not treat this call as a matter of concern.

Multi-disciplinary team review discussed Mr M and decided to discharge him in his absence.

Mr M stabbed and killed Mr P at his flat.

Our expert forensic psychiatrist says:

"As noted there had been some concerns about his (Mr P) compliance with treatment recommendations. Despite the continuing symptoms and variable compliance he continued to be allowed unescorted community leave".

"Given the respective illicit substance misuse histories of Mr M and Mr P it would appear to be a reasonable assumption that they might well have bought illicit substances. Given their respective psychiatric histories, and what would appear to be continuing paranoia and possible other psychiatric symptoms, these might well have adversely affected their mental states".

11.1 Finding

F12 The failure of staff to take into account:

- the mental state of both Mr P and Mr M;
- the risks to others that they both posed;
- the likelihood that they would purchase illicit drugs;

- the failure of staff to report either of them missing for 7-8 hours;
- the failure to understand the significance of the call from Mr M; and
- the decision to discharge Mr M in his absence are all serious errors.

12 Overall analysis

We conclude that the care provided to both Mr M and Mr P in respect of risk assessment and management, care planning, the use of the Mental Health Act and the responses to their leaving the ward on several occasions were seriously inadequate.

12.1 Predictability

The following is our criteria for assessing predictability:

We consider the homicide would have been predictable if there had been evidence from Mr M's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred.

We do not consider that the homicide was predictable because nothing in Mr M's words, actions or behaviour suggested he was likely to become violent towards Mr P. We saw no evidence of behaviour, statements or signs that could have alerted professionals that Mr M might imminently become violent.

12.2 Preventability

The following is our criteria for assessing preventability:

We consider the homicide would have been preventable if professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take steps to do so. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.

We consider that the homicide was preventable because the professionals involved in the care of Mr M could have prevented the incident but did not. They:

- knew that Mr M was paranoid and had been admitted carrying a knife, had a forensic history and had told staff that he had knives in every room in his house;
- had the legal means of assessing him with a view to detaining him under the Mental Health Act;
- failed to urgently escalate his absence from the unit and
- failed to contact the police or visit him at home when he phoned the unit on the morning of 9 August.

13 Methodology

This part of the report sets out our findings in respect of our thematic review into the unit's risk assessment, risk management and care planning approaches. We also comment on the trust's implementation of recommendations from the internal inquiry.

Verita developed a tool for assessing whether trusts have clinical risk arrangements in place in keeping with best practice (see appendix E). This covers:

- clinical risk policy and procedure;
- alignment with other policies;
- training;
- individual risk management plans;
- use of the Mental Health Act; and
- duty of care to those who present a risk to themselves and others.

To carry out this thematic review we:

- reviewed 10 files from Jade and Coral ward (both acute admission wards at Langley Green Hospital)
- interviewed a range of staff including, nursing, psychology, OT, and consultant psychiatrists
- sent a letter to patients asking if they wished to meet us. One patient from Jade ward took up this offer
- met the unit's police liaison officer.

The 10 files were all on paper because the trust does not have a unified electronic patient record. We reviewed these files against the criteria set out below.

- Was there a fully documented multi-disciplinary plan in the clinical file that was regularly updated?
- Did the ward-based care plans detail specific interventions agreed with the service user that were designed to meet their needs?
- Was the risk management plans part of routine mental health assessments?
- Did risk management plans define and consider acute factors, static factors, dynamic factors and stable or chronic factors?¹
- Had Mental Health Act documentation been completed effectively?

We reviewed five files from Jade Ward and five from Coral Ward. The files related to a mixture of short- and longer-term patients, including a number subject to detention under the Mental Health Act.

We discussed with staff the processes and systems of assessment, care planning, ward team care discussions and other related matters.

We offered to meet any service-users. One took up the offer.

14 Policy

The trust has a *Clinical risk assessment and management policy and procedure* dated January 2012. It cites a bibliography showing where the expected standards of practice are derived from. The policy is robust and based on best practice. The trust also has a policy for *Assessing risk for violence*.

The policy reflects the principles of positive risk-management and includes collaboration with the service-user and carer.

The risk-screening tool covers:

- suicide;
- self-harm;
- self-neglect;
- harm to others; and
- the care of children.

The policy says “Risk management is not just the responsibility of individuals and this policy is part of the Trust’s wider risk management strategy” It is clearly cross referenced with other policies, including Care Programme Approach (CPA) which, it says, “this policy should be read in conjunction with”.

The CPA policy clearly states that risk assessment and risk management are two of the essential elements of the CPA. It also says “risk management, crisis and contingency planning are integral” to CPA. It refers to the need to cross-reference the CPA policy with the trust’s clinical assessment and management of risk policy.

The Langley Green Hospital operational policy also has explicit references to risk assessment and management.

Clear expectations are set out in the Clinical assessment and management of risk policy.

The duties of all staff are clearly defined. For example:

“A level 1 comprehensive risk assessment appropriate to acute inpatient care is contained within the acute care admission documentation”. [p12]

“The Risk and Mental Health Care Plan will be reviewed at least weekly and at each MDT review and whether there is a change in clinical presentation...” [p12]

“The person undertaking or leading on a risk assessment is responsible for ensuring that the finding and recommended actions are clearly documented, signed and dated and communicated to all parties” [p15]

“Allclinical staff will be trained in the principles, standards and use of risk tools” and “this formal training will be updated every three years”. [p15]

14.1 Clinical and professional supervision audit report in respect of risk management

The trust undertook a thorough audit of supervision of 84 staff over a range of teams in March 2013.

A key outcome of this audit was that “Risk management and Safeguarding was not routinely discussed in 23% of supervisions”. An action plan was put in place with a completion date of September 2013.

The trust told us that the:

“Supervision Audit was not signed off by the Audit Team and therefore this has not been shared and actioned. The audit is in the process of being repeated by the Audit and Effectiveness Team using a new template and should be completed by the end of quarter 4”.

15 Files

15.1 Context

We reviewed files on both Jade and Coral Wards. We concluded that our review of clinical notes indicated that professionals had in general assessed risk and put in place risk management plans appropriate to the care of individuals. The files we reviewed had all the information we would have expected and were completed competently. This provides us with assurance that staff have a good understanding of the requirements of risk assessing and risk management.

Alongside our review of the content of the files we found issues that seriously reduces the value of the work of individuals in carrying out assessments and writing risk management plans.

Before dealing with the detail of our review of files, we set out here the context of changes to shift patterns and targets for discharge. We do so because the current clinical file system is paper-based and is the only means by which staff record assessments, and care and risk plans. Therefore the clinical files must be organised and completed in a way that provides for easy access to the information needed to provide safe and effective care.

15.2 Shift patterns and discharge targets

New staffing shifts were implemented on both wards and day staff now work 12-hour shifts, which can mean a gap of 4-6 days between staff coming off duty and returning to work.

The discharge target for patients is 28 days, though they can stay longer if it is clinically necessary. A number of interviewees told us that this target meant the throughput of patients was quite rapid.

A consequence of the shift pattern and the 28-day discharge target was that a member of staff returning after a number of days off might find a significant number of patients had been discharged and new ones had arrived.

It is not within our remit to comment on the shift patterns or the 28 day discharge target; however it is within our remit to comment on how shift patterns and rapid discharge arrangements may impact on risk and care planning. Neither was it in our remit to comment on whether clinical decisions were correct. We did, however, review the structure, readability and effectiveness of notes underpinning clinical care.

15.2.1 Comment

Staff coming on duty after a few days' break need to update themselves on the changes to the patient population and their current risk management and care planning in the short time allocated to morning handover. Therefore, the

clinical records need to be completed in an easily readable way to understand a patient's needs and risks.

Staff chose the 10 files we reviewed but we had no reason to suppose these were not representative of usual practice. The files we read were:

- hard to navigate;
- badly organised;
- occasionally illegible; and
- in some cases the author had not signed an entry or had not recorded their designation.

15.2.2 Finding

F13 The files we reviewed were not fit for purpose and potentially unsafe and hinder good mental health care. They do not provide a well-structured, easily accessible and effectively recorded set of clinical notes that inform the care and treatment of a patient.

We reviewed whether there is in the files a fully documented multi-disciplinary plan which is regularly updated.

Several care and risk plans are in each file, most of which are generally both thoughtful and reasoned, there were:

- acute in-patient care, risk and mental health care plans (described by all staff as the 'nursing plan'); and
- multi-disciplinary care plans, which are effectively the medical plan. This is often buried in handwritten clinical notes and is hard to find.

Additionally, the files included:

- occupational therapy care plans; and
- psychology care plans.

The case record folder has a clear instruction on its inside cover that if a care programme approach (CPA) plan has been carried out for patients known to community services before admission and who were subject to CPA, the CPA plan should be copied and attached to the file and a box ticked to indicate that this had been done. We found that this had not been carried out on any of the cases we reviewed and that staff were not aware of this requirement.

Some of the patients we reviewed were subject to CPA before admission and we found no copy of the CPA plan on any file. Staff told us they can access the CPA on the community electronic network.

15.2.3 Comment

We presume that the instruction to print a copy of the community CPA and place it in the file is to ensure that it is easily available to inpatient staff. We also found that no staff member realised that this process was to be followed.

Placing a copy of the CPA plan on file would be evidence of staff recognising the need to ensure that CPA information and objectives are used in ensuring continuity of care between the ward and the community.

There is a need for a multi-disciplinary care plan to be formulated. The plan should be easily accessible. Such a plan is important in ensuring that all professionals understand their contribution to the overall care of the patient. Such a plan did not exist in the files we reviewed.

We think care planning documentation does not appear to have been central to managing care. It should be possible to open a file and immediately locate a multi-disciplinary care plan which sets out the key components of the care plan, the specific interventions and risk assessment/management.

This is particularly important given:

- 19 patients on each ward at any one time;
- a target of 28-day discharge; and
- changes in rosters which involve staff working twelve hour shifts meant a potential gap of four to six days between leaving the ward and returning to work.

It is not feasible for staff to trawl through 19 disorganised paper files on their return to work to find the essential information they need to know. It is also likely that, given the 28-day discharge target, a number of new patients will have been admitted. There is a daily handover sheet which gives brief details about each patient and a handover meeting which, given the limited time allocated when shifts cross over (this only occurs between days and nights). This morning handover meeting is unlikely to be sufficient to enable all but the most cursory discussion to take place.

We were told that “Reflective Practice” meetings discussed cases in detail, though we found no evidence in the 10 files we reviewed of any minutes and outcomes from these meetings.

15.2.4 Finding

F14 There is no ‘at a glance’ single multi-disciplinary care plan in the case files that pulls together all the individual care and risk assessment plans. Central to managing care should be a multi-disciplinary care plan that all professionals contribute to.

We asked whether ward-based care plans detailed specific interventions agreed with the service-user and designed to meet their needs

All patients' needs were generally described needs as "difficulties" and we found little evidence of patient involvement, for example, a signature. Some files detailed specific interventions, mainly of a medical nature.

We saw examples on Jade Ward of personal support plans being developed that focused on service-users' needs and had interventions agreed with the user to meet them.

15.2.5 Finding

F15 The development of personal support plans on Jade ward is helpful.

We asked whether risk management plans were part of routine mental health assessment

Risks were generally identified and managed and risk was seen as a part of routine mental health assessment. However, finding risk assessments in the files was sometimes difficult.

We asked whether risk management plans defined and considered acute factors, static factors, dynamic factors and stable or chronic factors.

The trust uses a system of risk assessment and management based on the "5xPs" approach:

- presenting;
- predisposing;
- precipitating;
- perpetuating; and
- protective.

Our reading of the files shows that clinical staff used this methodology consistently.

We asked whether Mental Health Act documentation was completed effectively.

Mental Health Act documentation was complete in all the files we saw.

16 Meeting with a service-user and staff

We met one service-user who was pleased with the quality of care he was receiving on Coral Ward and felt fully informed and involved in decisions relating to his care. He said staff were approachable and generally available.

We met a number of staff of various grades and disciplines including consultants, OTs, ward managers, staff nurses and healthcare assistants.

The key points from the meetings are as listed below.

16.1 Multi-disciplinary care planning

Staff confirmed that there was not an easily accessible multi-disciplinary care and risk management plan in the files. Most thought there should be one but said that not everybody agreed with this idea.

They did not know why CPA documentation was not routinely attached to files. One member of staff told us that the MDT care plan was uploaded to eCPA so that the care coordinator was aware of the ward-based plan.

16.2 Quality of files

Staff generally agreed that the use of paper files hampered their work and they did not know why an IT system had not been implemented on the wards or when one might be.

Staff said that there was no guidance available to them on the use of handwritten notes and that sometimes notes were illegible. One member of staff said access to computers was not a problem.

Notes audits are supposed to take place monthly. The trust told us:

“Clinical notes audits are completed by the ward manager on a monthly basis with the outcome shared with the primary nurse. Our next step is to routinely share with the ward medical team”.

16.3 Handover arrangements

Staff told us that handover arrangements between shifts were tight and that it was not feasible to read through 19 files at the start of each shift. Handover arrangements focused on the major events of the previous 12 hours. The changes in shift arrangements and the 28-day discharge target had compounded this problem.

The ward manager on Jade ward told us about a handover sheet being piloted that covered history, risk, daily updates and tasks/plans for the day.

16.3.1 Finding

F16 The development of a handover sheet on Jade ward is welcome.

16.4 Risk management

Staff confirmed they knew about the trust's risk management policy.

Staff knew about the trust's policy that risk management and assessment and training should take place every three years.

16.5 Occupational Therapists (OTs)

OTs are not integrated in the ward team. They rarely contribute to overall care planning. We were told of plans to address this by making OTs more ward-based.

16.6 General

Several members of staff spoke of improvements since the incident and the subsequent implementation of the recommendations of the internal inquiry. Some staff felt it was now more possible to get their 'voices heard'.

16.7 IT Systems

The lack of an IT system on the wards affected the ability of staff to develop consolidated multi-disciplinary care and risk management plans, ensure adequate handover arrangements and provide continuity of care between ward and community services. None of the staff we spoke to knew when a system was likely to be introduced.

17 Police liaison

We met the police officer responsible for liaison with the trust.

17.1 Absent Without Leave ('AWOL') Policy

A formal police/trust written agreement was under review.

The police expected the trust to take responsibility for returning people to the wards unless a risk assessment indicated a risk of suicide or violence. Most AWOLs were not in this category.

The police had no power to return patients not under section and nurses had the same right as police to compel the return of a patient who was under section.

The police distinguished between "missing" (don't know where they are) and "absent" (know where they are).

Tensions existed between police officers and ward staff about their respective responsibilities.

Joint training would help but time was restricted.

We commented on the use of "AWOL" policies earlier in our report and made the following recommendation:

"The trust should further review the AWOL/missing persons policy in conjunction with Sussex Police and should ensure that staff in both organisations have a shared understanding of its operation".

17.2 Liaison meetings

Specific groups meet regularly.

Monthly meetings take place between police custody officers, the neighbourhood inspector, ward manager and matron. An approved mental health professional chairs.

Meetings about individuals take place as necessary.

17.3 Section 136 Mental Health Act 1983

The police believed too many people are detained under Section 136¹ of the Mental Health Act. In the last year in Sussex, 900 people were placed on Section 136,

¹ This section provides powers for a policeman to remove a person suffering from mental disorder and to be in immediate need of care or control to a place of safety.

putting a strain on police time and resources. However, a multi-agency review showed that while most orders were appropriate, the key issue was the support those detained under 136 received before coming to police attention.

136 assessment suites are generally good but are often not fully staffed. Staff have to be taken from wards, so the 136 assessment suites are often closed as a result of a lack of staff available to cover them. The trust says it is not commissioned to provide 136 suites. As a result, police have nowhere to take people out of hours except A&E.

17.4 Working relationships

The police said these were generally good at a management level but frustrations often occurred at practitioner level.

There is sometimes a difficulty at night when problems with a service user needed to be escalated. Police managers were on duty at night to deal with problems, whereas NHS managers were on call, and this could lead to tension.

18 Conclusions

Input by professionals into clinical notes was consistent with good mental health practice. However, we were concerned about the legibility of many entries and the inadequate format of files that led to difficulties in accessing information quickly. There is no “at a glance” summary of current risks, needs and care planning in the files.

The current practice of patients’ clinical notes being contained in paper files is potentially unsafe and hinders good mental health care.

18.1 Recommendations

R7 Multi-disciplinary, integrated care and risk management “at a glance” plans should be implemented immediately pending the introduction of an IT system.

R8 All current active files should be reviewed and put in good order. The format of files should be reviewed and regular audits of files should take place until an IT system is in place.

R9 Pending the introduction of a ward-based IT system, a temporary procedure should be introduced which ensures that community and ward notes are accessed as part of one process.

R10 The trust should agree how and when a new integrated community and ward IT system will be introduced and should tell staff about it.

19 The trust internal review and progress with its recommendations

19.1 Introductory comment

We think the trust's serious incident policy and procedure is a thorough and robust approach to managing and investigating serious incidents within explicit timescales. The duties and responsibilities of individual managers are clear.

The policy is explicit about mandatory reporting to external bodies such as police or the Health and Safety Executive.

The policy sets out what needs to be done immediately after a serious incident, including ensuring that the environment is safe and that immediate risk is assessed, and the steps to be taken afterwards. These include ensuring the safety of staff and patients and securing clinical records.

The policy sets out the process for working with families and staff after an unexpected death.

The policy sets out how an internal inquiry should be undertaken, including the use of root cause analysis as detailed by the Department of Health and the National Patient Safety Agency.

The policy says internal inquiry reports must be made available to:

- NHS Sussex;
- HM Coroner;
- HSE;
- Quality Improvement Group;
- Clinical Risk Group; and
- Adults at Risk or Safeguarding Children.

The terms of reference for the internal review were:

- to establish the facts;
- to establish any root causes to the incident;
- to provide a report recording the investigation process;
- to establish and record notable practice and any identifiable service/care delivery problems;
- to establish how risk of a recurrence may be reduced;
- to formulate recommendations; and
- to provide a means of sharing learning from the incident.

19.1.1 Comment

We think the serious incident procedure was followed. We think the trust undertook a thorough review that met its terms of reference and the requirements in the trust's policy.

Our expert forensic psychiatrist agreed with most of the conclusions of the internal review, though he notes that "there are a number of important omissions and there was a lack of depth to the understanding of what some of the problems were".

In our view the report does not cover sufficiently the use of the Mental Health Act and staff's understanding about when patients can be detained or not and the use of absent without leave procedures. We have made recommendations about these matters earlier in the report.

19.2 Recommendations and action plans arising from the trust's internal investigation

The trust's report identifies several areas that needed improvement and makes 13 recommendations. We interviewed senior managers and staff and reviewed the extensive documentation the trust gave us. The following recommendations appear in the trust investigation report.

The recommendations address key organisational and clinical systems and processes. They are robust and show that the trust has taken the opportunity to address the failures in the systems that led to the poor practice identified in their report and reinforced in ours.

Staff, managers and senior clinicians made clear to us that the implementation of these recommendations was improving the service.

We set out these recommendations as written in the trust report because they provide the reader with an understanding of the scope of the recommendations.

19.2.1 Clinical leadership and clinical judgment

1. An immediate clinical review of the standards of care across the hospital was undertaken as soon as initial concerns were raised by the reviewer. This review led to changes in leadership and strengthened governance.
2. The review identified a worrying lack of clinical leadership and clinical decision-making relating to the inpatient care of Mr M and Mr P. The degree of negligence is such that a separate investigation has been taken forward in accordance with the trust disciplinary policy. The specific issues to be considered should be the stewardship of care, formulation of risk, planning of treatment and consideration of dual diagnosis.

3. The clinical director to review the effectiveness of clinical leadership across LGH and in conjunction with the service director, to agree and implement planned improvement actions.
4. The findings of this review to be fed back to multi-disciplinary teams across LGH and to clinical leaders across the trust. This to be facilitated with time and space for staff to reflect on their own clinical practice and/or clinical leadership. The format to be a Report and Learn Live event. This recommendation is aimed at emphasising the importance of multi-disciplinary team working as a basic requirement to good care.
5. Reflective practice, which supports the opportunities for the multi-disciplinary team to constructively challenge the formulation and plan of care to be available within all inpatient settings with an expectation that all staff engage, including senior staff.
6. Clinical leaders within trust wide CRHTs to ensure a crisis contingency plan are in place for every service user. The plan must clearly state to service users, which services to contact and who they can contact when they are in crisis and in need of unscheduled care.

19.2.2 Governance

7. The application of established audits used in inpatient services by matrons to be reviewed and a trust wide approach that involves a degree of objective scrutiny to be implemented.
8. Clinical records must be used within supervision, of all professions and at all grades, to ensure compliance with quality standards. Supervisors to focus on effective risk assessment, care planning and the overall understanding of the formulation and risk.
9. Trust wide risk assessment and management training to strengthen its emphasis on risk of homicide.
10. All general managers to be reminded of the procedure of sealing notes following an SI, this to be done in a personal discussions to ensure full understanding.
11. The allegation that records were altered post incident and presented as contemporaneous to be investigated in accordance with the disciplinary policy.
12. The AWOL policy to be reviewed and the revised policy to be re launched in each clinical team making clear the expected practice.

19.2.3 Dual diagnosis

13. A dual diagnosis Report and Learn Live event to take part using this report and one other to set the context for learning.

Much of the work being undertaken is part of a comprehensive redesign of systems and processes relating to care pathways and the management of risk and other related matters.

The trust sent us a copy of the service development plan for Langley Green Hospital January – December 2014. It is attached as appendix F.

20 Conclusion

We think the trust followed its policy and procedures for managing a serious untoward incident.

We think the investigation met the requirements of the trust's policy. The inquiry report was overall of good quality with clear terms of reference that were adhered to.

The report did not cover sufficiently the use of the Mental Health Act and we have made recommendations about this in Part 1 of our report.

The internal report made clear recommendations and an action plan was developed to manage and monitor implementation. The extensive documentation the trust gave us demonstrates substantial progress.

Team biographies

Tariq Hussain

Tariq is a former nurse director who brings to Verita his considerable experience in the fields of learning disability and mental health services. Tariq has undertaken a wide range of reviews for Verita, including numerous mental health homicide investigations. Before joining Verita he served for eight years as a non-executive director of a mental health trust with board-level responsibility for complaints and serious untoward incident investigations. Tariq also gained extensive experience of investigations and tribunals as director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting (UKCC). He has also served as a member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain. Tariq also served as a council member of the UKCC and deputy chair of two national nursing boards.

Andy Nash

Andy has a background in management in local government and the NHS and started his career as a social worker. He has also worked in national inspection and regulation, service improvement and policy development and implementation at the Department of Health. His specialist fields are social care and mental health. Andy now works as an independent consultant.

Dr Martin Lock

Dr Lock is a consultant forensic psychiatrist in private practice with extensive experience in adult general and forensic psychiatry. He has worked in all levels of secure psychiatric care, in HMP Wormwood Scrubs, ran a court diversion scheme, worked in a drug dependency clinic, an alcohol clinic and a mother and baby unit.

Since joining the Mental Health Review Tribunal as a medical member in 2003 Dr Lock has sat on almost a thousand tribunals. In addition to this he sat on hundreds of cases during his time on the Parole Board of England and Wales.

Throughout his career Dr Lock has assessed thousands of adults in mental health, criminal, childcare, family, immigration, personal injury and other civil cases, and sat on numerous inquiries into suicides and untoward incidents in secure psychiatric units.

Documents reviewed

Medical records

- Mr M's medical and nursing records
- Mr P's medical and nursing records

Policies and procedures

- Langley Green Hospital – operational policy, January 2010
- Searching patients and their property policy and procedure, May 2010
- Absent without leave (AWOL) policy, September 2010
- Mental Health Act 1983 policy, October 2010
- Safety, privacy and dignity policy, October 2010
- Physical examination and ongoing healthcare policy, October 2010
- Care programme approach policy, October 2010
- Dual diagnosis of mental health and substance misuse policy, December 2010
- Drug and alcohol use by service users policy, July 2011
- Seclusion policy and procedure, September 2011
- Clinical risk assessment and management policy, January 2012
- Assessment of persons under Sections 135 and 136 of the Mental Health Act 1983, January 2012
- Observation and therapeutic engagement policy, October 2012
- The prevention and management of violence and aggression (PMVA) policy, October 2012
- Serious incident (SI) policy and procedure, October 2012
- Psychiatric intensive care unit (PICU) operational policy, March 2013
- Information for detained patients policy, July 2013
- Acute inpatient mental health service operational policy, September 2013

Internal report

- SI review report, September 2012
- SI action plan, updated January 2014

Other

- Staff interview transcripts from internal investigation
- Staff rotas
- Clinical and professional supervision audit report, March 2013
- NPSA suicide prevention toolkit, June 2012
- Audit of acute care inpatient notes, 2013
- Acute care pathway document

- Langley Green Hospital clinical notes audit report, June 2013
- Langley Green Hospital service development plan, January – December 2014

List of interviewees

Staff from Sussex Partnership NHS Foundation Trust including:

- Director of nursing standards and safety
- Interim general manager of Langley Green Hospital
- Police liaison officer
- Mr M's care coordinator
- Nurse consultant
- Two health care assistants
- Two staff nurses
- Charge nurse

Meetings with:

- Mr M
- Mr P's sister, (twice) second accompanied by her cousin
- Mr M's mother (twice)
- A range of staff who agreed to meet with us including, nursing, psychology, OT, and consultant psychiatrists as part of the Part 2 thematic review
- One patient on Jade Ward as part of the Part 2 thematic review

Questions from Mr P's sister

1. Why did the ward not call the police until 2.00am when Mr P went missing at 6.00pm?
2. Why did the ward not ask the police to go the address they knew Mr P was at?
3. Why was Mr P not provided with an interpreter? [You said that you had spoken to Mr P on the phone the day before he was killed and that he was frustrated that he did not know what the doctors were saying and what medication he was being put on. He was very disturbed].
4. Why were his medical records changed? [The trust had told you that only Mr M's notes had been altered whereas the day after the incident the police confirmed that Mr P's had also been changed].
5. Why were four members of staff dismissed?
6. Why and how was Mr M allowed to be in a position to kill Mr P?
7. Why did staff on Jade ward refuse to talk to you when you were talking to Mr P? [This happened twice and on one occasion you said that you heard a member of staff say very loudly "No!" when Mr P asked staff to speak to you. You said that you wanted to talk to staff about paying for a flight for your brother to return to Denmark where you would meet him.] You agreed that you would try and identify on what dates you made the calls so that the inquiry can seek clarification on these matters.
8. Why would staff not allow Mr P to call his bank when he was having problems accessing money from an ATM because he had not told his bank he was in the UK?
9. Why did staff allow Mr P to go to the Danish/American (which?) Embassy when they knew he was delusional about President Obama?
10. Why did staff allow Mr P access to a computer (buy a computer?) when using a computer contributed to his delusional state e.g. accessing White House newsletters?
11. Where is Mr P's jewellery - a gold necklace with cross and two gold rings? (The police have told you that they are not with his possessions which they are holding).

Appendix E

Tool for assessing whether trusts have clinical risk arrangements in place in keeping with best practice (Mental health)

	Benchmark	Evidence	In place yes/no
Clinical risk policy and procedures	<p>There is a trust wide policy and procedure in place for clinical risk assessment based on up to date best practice.</p> <p>The policy reflects the principles of positive risk management. This includes:</p> <ul style="list-style-type: none"> • collaboration with the service user and others involved in care; • the importance of recognising and building on the service user's strengths; and • the organisation's role in risk management alongside the individual practitioner's <p>The policy includes the following areas:</p> <ol style="list-style-type: none"> 1. violence (including antisocial and offending behaviour), 2. self-harm/suicide, 3. self-neglect 	<p>Policy and procedure</p> <p>Interview staff</p>	
Alignment with other policies and arrangements	<ol style="list-style-type: none"> 1. Risk management is part of the Care Programme Approach (CPA) and aligned closely with it. 2. The CPA plan includes identifying specific interventions based on an individual's support needs, taking into account safety and risk issues. 3. Care plans are drawn up and meet all of the service user's needs, including needs relating to risk. 	<p>CPA policy and procedure</p> <p>Interview care coordinators</p> <p>Talk to service users</p>	

Training	All staff involved in risk management receive relevant training. This is updated at least every three years. This includes Knowledge and understanding of mental health legislation as an important component of risk management.	Training plans Interview staff	
Individual risk management plans	<ol style="list-style-type: none"> 1. Screening for risk and needs is part of a routine mental health assessment 2. Each individual risk management plans defines and considers the following risk factors: <ul style="list-style-type: none"> • Acute factors or triggers that change rapidly • Static factors are unchangeable, e.g. a history of child abuse or suicide attempts. • Dynamic factors are those that change over time, e.g. misuse of alcohol. • Stable or chronic risk factors. These do not tend to change 3. Risk management plans are developed by multidisciplinary and multiagency teams operating in an open, democratic and transparent culture that embraces reflective practice. 4. There is a plan of action in place for the service user specific areas to manage the risks identified. 5. The plan is developed with the service user and their carer. 6. The risk management plan includes a summary of all risks identified, formulations of the situations in which identified risks may occur, and the actions to be taken 	Read individual risk management plans Interview staff Talk to service users and carer	

	<p>by practitioners and the service user in response to a crisis</p> <p>1. The risk management plan is regularly reviewed.</p>		
Use of Mental Health Act and second opinion	<p>1. The Mental Health Act is used as a last opportunity but is used appropriately to manage a risk of harm to self and others.</p> <p>2. A second opinion be sought from a psychiatrist or a specialist services when appropriate, for instance if a service user has a history of serious violence.</p>	<p>Read care plans and records</p> <p>Interview staff</p>	
Duty of care to those who present a risk and others	<p>1. Mental health professionals recognise that reducing the risk of self-harm, suicide and self-neglect is part of the practitioner's fundamental duty to try to improve a service user's quality of life and recovery</p>	<p>Interview staff and managers</p> <p>Read community mental health team minutes</p>	

Definitions

Risk (in mental health)

The likelihood of an event happening with potentially harmful or beneficial outcomes for self and others. (Possible behaviours include suicide, self-harm, aggression and violence, and neglect; with an additional range of other positive or negative service user experiences.)

Risk assessment

A gathering of information and analysis of the potential outcomes of identified behaviours. Identifying specific risk factors of relevance to an individual, and the context in which they may occur. This process requires linking historical information to current circumstances, to anticipate possible future change.

Positive risk management

Positive risk management means being aware that risk can never be completely eliminated, and aware that management plans inevitably have to include decisions that carry some risk. This should be explicit in the decision-making process and should be discussed openly with the service user.

Positive risk management includes:

- working with the service user to identify what is likely to work
- paying attention to the views of carers and others around the service user when deciding a plan of action
- weighing up the potential benefits and harms of choosing one action over another
- being willing to take a decision that involves an element of risk because the potential positive benefits outweigh the risk
- being clear to all involved about the potential benefits and the potential risks
- developing plans and actions that support the positive potentials and priorities stated by the service user, and minimise the risks to the service user or others
- ensuring that the service user, carer and others who might be affected are fully informed of the decision, the reasons for it and the associated plans
- using available resources and support to achieve a balance between a focus on achieving the desired outcomes and minimising the potential harmful outcome.

References

- Best Practice in Managing Risks: principles and guidance for best practice in the assessment and management of risk to self and others in mental health services (2007)
- Mental Health Policy Implementation Guide: A Learning and Development Toolkit for the whole of the mental health workforce across both health and social care (2007)
- New Ways of Working for Everyone: A best practice implementation guide (2007)
- Refocusing the Care Programme Approach: Policy and Positive Practice Guidance (2008)

- No Health Without Mental Health (2011)
- National Institute for Clinical Excellence (NICE) (2005) CG25 Violence: The Short-Term Management Of Disturbed/Violent Behaviour In In-Patient Psychiatric Settings And Emergency Department London: NICE
- National Institute for Health and Clinical Excellence (NICE) CG16 Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care London: NICE

Langley Green Hospital service development plan

Service Development Plan. Langley Green Hospital. January – December 2014

This paper outlines the service development plan for the Acute services in North West Sussex for 2014. The intention of this paper is to provide the hospital with a strategy to assist the unit to move forward.

Over the past 6 months vacant senior posts have been recruited to and as a consequence Langley Green has a stable leadership team in place - clinical and managerial. This provides the hospital with the opportunity to take the care and treatment forward.

It is important to acknowledge that throughout the past 18 months staff working at Langley Green Hospital have continued to demonstrate a commitment to providing care and treatment to the people being admitted and it is important this paper builds on this.

This paper acknowledges the need for the service to take some baseline measurements so we do not build the developments on assumptions but have a clear understanding of the areas of good practice as well as areas for improvement. This will also enable the ward teams to develop and implement individual ward/team plans with support, assistance and direction from the leadership team.

Phase 1 - Baseline Measurement of current care and treatment.

- 1. Baseline measurement of all wards, CRHT and Weald** by utilising the 'Clinical Review of Wards' Audit template.
Impact. Able to identify positive practice and areas for development. Able to develop individual plan for the wards/teams. Able to use information to triangulate with CQC review, Service user experience questionnaire and themes from SI's, complaints and SVA's.
Lead – Matron and Ward Managers
- 2. Review of CQC PCA's-**
Impact Identify areas needing improvement.
Lead – Nurse Consultant
- 3. Review of Complaints, SI's, SVA's Incident reports, complements for common themes and trends.**
Impact– Identify themes and learning
Lead – Nurse Consultant

4. **Completion of Service User Questionnaire** (Trust Template) of service users currently admitted to LGH. (? could as Peer Support workers to complete this via CAPITAL).
Impact- Provide a baseline measure of the service users perception of the care and treatment.
Lead – Nurse Consultant

5. Completion of carer experience questionnaire.
Impact- Provide a baseline measure of carer perception of the care and treatment.
Lead - TBC

6. Focus groups with staff to engage in the process and gain view of how to improve the quality of care.
Impact – building on the commitment of staff and engaging them in the process.
Lead – Acute Clinical Services Manager, Acute Clinical Lead and Nurse Consultant

7. Completion of full notes audit –
Impact - Additional measure of quality. This can also be compared against the notes audit report completed in June 2013.
Lead – Ward Managers - Nurse Consultant to collate results.

8. Review of Current vacancies and Bank recruitment
Impact – Recruitment and retention needs clearly understood.
Lead Acute Clinical Services Manager.

9. Review of Sickness/absence
Impact – Sickness/absence needs clearly understood.
Lead Acute Clinical Services Manager.

10. Review of current HR issues
Impact – HR issues clearly understood.
Lead Acute Clinical Services Manager

11. **Review of supervision provision** utilizing the Trust Supervision audit tool –
Impact – understand current provision
Lead - Matron

Timescale – Late January through February 2014.

Late February /Early March 2014

Workshop

Workshop to be attended by Ward Managers, Matron, Acute Care Services Manager, Acute Care Clinical Lead, Nurse Consultant

Aim - Review the audit results and data and agree and engage in a plan to take the care and treatment forward.

Phase 2 – Implementation of the Service Development Plan

1. Develop a specific plan for each ward and team.

Impact – measureable progress.

Team aware of good practice and areas for improvement.

Team ownership of issues.

Identify support, training needs to implement change

Lead – Various but monitoring to sit with Acute Clinical Services Manager, Acute Clinical Lead, Nurse Consultant and Matron.

Strategies/ Innovations/Training to support the development of the wards, teams and leadership skills.

1. Safe Wards – This focuses on reducing conflict and containment. Workshop booked for 7th February facilitated by Geoff Brennan, Kings College London
2. Acute care pathway – focus on achieving consistent standards within the wards and teams. Ensuring wards/teams are well organised and have clear systems in place for communication, handovers etc..
3. Therapeutic Day – Review the current provision and develop a plan to take it forward
4. Triangle of Care – Best practice in working with carers.
5. Development of Leadership skills – focus initially on the ward managers. date booked for the 31st January 2014 with monthly dates to be arranged after this.
6. Development of the Ward Manager/Team Leaders management skills
 - Increasing confidence in using HR policies –
 - Management of complaints and incidents.
 - Managing staff
 - Project /change management
7. Training and development –
 - N/A's – Roles and responsibilities –
 - Charge Nurses – Development of role
 - Risk Assessment and Risk Management Module (May 2014)
 - Skills of supervision
 - Workshop on the 3 A's – Developing an enquiring culture
8. Working with the teams to develop and implement individual initiatives.

Phase 3 – Re- audit in July 2014 to measure progress

1. Clinical review of the wards
2. Service user questionnaire
3. Carer questionnaire
4. Notes audit
5. Review of incidents, SI's SVA's and complaints since March 2014

Phase 4 – Continued implementation of the Service development Plan.

As for phase 2 but in addition

1. Staff groups to report back on progress

Phase 5 – Re- audit in September 2014 to measure progress

Cycle of change continues