BURY PRIMARY CARE TRUST

Report of the Inquiry into the Care and Treatment of Simon Rawcliffe by Mental Health Services of Bury

Executive Summary

NHS

Executive Summary

In September 1999, Simon Rawcliffe was living in bed & breakfast accommodation in Bury. There, he killed another resident. Simon Rawcliffe had recently been discharged from mental health services in Bury where he was an inpatient.

The Inquiry Panel were asked to examine the circumstances of the treatment and care of Simon Rawcliffe. In order to understand this, it was necessary to understand the development of his mental illness by reviewing his contacts with Mental Health Services from the very beginning. His first assessment by Mental Health Services was in 1993. Simon Rawcliffe was admitted to a number of inpatient Mental Health units across the North West, and had had more than one admission to Fairfield General Hospital, Bury.

Our independent external review was helped by the detailed internal inquiry report which was presented to Bury Health Care NHS Trust, the organisation responsible for Mental Health Services in Bury. However, we were able to take a broader view, which we believe is still of relevance today, even though some time has lapsed since the 1999 homicide.

It became clear to us that it was impossible not to address the whole system in our understanding of the events leading to the homicide.

As we set out in more detail in the body of this report there were, in our view, three important strands to the understanding of the care and treatment of Simon Rawcliffe:

i. The quality and effectiveness of the clinical care and decision making,
ii. the historical underfunding of the mental health service in Bury,
iii. and, the quality and effectiveness of management and decision making in the mental health service, Bury Health Care NHS Trust, and the relationship between the Trust and the Health Authority.

Whilst underfunding and management issues cannot excuse failures in clinical care, they help at least in part, to understand why the event that we reviewed occurred.

We have based our findings on the evidence of written and oral records from individuals and agencies. Those individuals that we interviewed, and the documents that we reviewed are referred to at the end of this report.

During our work, the most recent re-organisation of local health and social services took place, and mental health services in Bury were taken into the new mental health organisation, Pennine Care NHS Trust. It became clear that the new Trust is making progress in correcting a number of the deficits that we identified, both in clinical care, management structures, and financial investment. A progress report, prepared by the new Bury Borough Director, Pennine Care NHS Trust, is enclosed with the report as an Appendix, in recognition of this work. This report describes the changes in patterns of service delivery, processes, protocols and more recently management structural changes; that address some of the identified recommendations.

What we found striking, was that there still remained much to be done in Bury, despite the passage of four years since the homicide. We believe that this report can be used to encourage further positive developments within mental health services in Bury. We are hopeful that Pennine Care NHS Trust will be serious in translating the action plan that will flow from this report into meaningful improvements in mental health care that will make a difference for both users and carers.

We do not wish to be part of the "blame culture". It is for this reason that we agreed to the request made by the Strategic Health Authority to remove from this report the names of all of those professionals involved in the care of Simon Rawcliffe. However, we are assured that the action plans will focus on individuals where this is appropriate.

Findings

We found much that was good in Bury and there were examples of good practice. There are many individual members of staff who have remained loyal to the service. There are also excellent examples of team working, though it has to be said that medical staff were (and are) peripheral team players. This is discussed in more detail in the report.

A number of recurrent themes emerged from our inquiries that have influenced the recommendations contained in this report. These can be summarised as:-

- A lack of a consistent approach to and a poor understanding of Simon Rawcliffe mental illness leading to a lack of formulation of his case and inappropriate and inadequate risk assessment. Clinicians appear to have made no connection between Simon Rawcliffe's behaviour and the relationship to his illness.

- Frequent closure of episodes of care, incomplete medical and social notes made the transfer of the case less efficient. Concern is also consistently expressed about the lack of dating and signing of notes making them difficult to put into context. This also contributed to his care being uncoordinated.

- Early in his last period of care at Fairfield General Hospital, his complete set of notes went missing and no attempt was made to retrieve this information. The loss of this balanced history of his contact with other services, also contributed to the poor understanding of his mental health needs and risks.

- A diagnosis of personality disorder was viewed by the inquiry as too simplistic and was considered to be a means of managing Simon Rawcliffe out of psychiatric service.

- Poor implementation of CPA and risk assessment and management.

- The need for clinical supervision of nursing staff is highlighted, and deficits in training are identified.

- We identified problems for individuals who moved from one area to another, and how social services respond, and take responsibility for individuals in this situation. We are also critical of the use of a bed and breakfast accommodation list for vulnerable adults with mental health problems.

- There were also problems in the use of the 1983 Mental Health Act which we comment on in our recommendations.

- We express concern over the lack of stability within the medical workforce and the loss of training status within Bury Health Care NHS Trust, which in turn has led to recruitment difficulties.

- The level of investment in mental health services comes under scrutiny, with a request to ensure that funding is reviewed.

- Poor and inconsistent strategic management following the initial incident report with a lack of transparency and openness.

- A failure to learn lessons from prior internal review process and inadequate systems to monitor the implementation of action plans.

We wish to thank all of those who agreed to be interviewed. At the end of our report we comment on the decision by the former Chief Executive of Bury Health Care NHS Trust not to meet the Panel.

Finally, the value of this process lies not in apportioning blame, but in identifying and driving sustained improvements in mental health services in Bury, which we hope this report will achieve.

Dr. Peter Snowden (Chair)

Recommendations

We acknowledge that there have been developments both before and during the work of this inquiry. We enclose, as an appendix, a progress report prepared for us by the Borough Director for Bury.

We have tried to list our recommendations under headings which relate to the body of the text. Each service heading has recommendations relevant to that service, but which may also have wider implications. It was tempting to produce a grid with recommendations on one side and all of the relevant services/professions on the other, but we thought that was unhelpful.

1. *Pennine Care NHS Trust*

i. In the development of the Action Plan that will follow the report, the Trust should draw together the recommendations of the other three incidents that occurred in 1999, to make absolutely certain that all lessons are learned.

ii. A progress system should be put into place to monitor the completion of action points and any remaining obstacles to progress.

iii. This process should be transparent to prevent a repeat of the lack of progress we noted following the internal inquiry and the Internal Inquiry report. However, it is important that this report should be widely shared in its entirety.

iv. We recommend that the Trust review the implementation of CPA, particularly in Bury, through a quality audit.

v. The Trust should be satisfied that the Borough Director in Bury has the necessary management support to enable her to progress the modernisation of Bury Mental Health services.

vi. We appreciate that the Trust has responsibility for Bury, Rochdale, Oldham, Tameside & Glossop and Stockport. The Trust clearly has a demanding and wide agenda, and all of these services will have their strengths and weaknesses. Nevertheless, from our perspective, the situation in Bury is in some respects unique. We, therefore, recommend that the Chief Executive considers how he could provide the leadership and presence required to move the services forward. We are not convinced that a base in Tameside will allow this to happen.

vii. We understand that there is an independent Mental Health Advocacy service in Tameside, where the Trust's Headquarters is based, but we are aware that independent advocacy input into Bury and Rochdale, for example, has been substantially reduced. We recommend that Bury (this is the focus for our enquiry) should receive a better advocacy service, so that patients and their carers can be empowered to make comments about the services that they receive. Also, this would allow their rights to be considered as part of the decision making process.

viii. In the handling of any serious incidents, when a person in contact with Mental Health services harms another, the Trust should consider their response to the victim and the victim's family. We cannot suggest what that response should be, as much will depend on the nature

of any injuries caused, and if the Criminal Justice System is involved, where, in the process, the individual with mental health problems is. The Trust should make certain that these considerations are part of any serious incident review.

ix. Patients in Bury must have access to an Intensive Care Unit facility.

2. *Bury Mental Health Service*

i. Medical

a. We recommend that the Medical Director of Pennine Care NHS Trust review with Consultant 3 the relevant sections in the report in order to support Consultant 3, and to agree an Individual Personal Development and Continuing Professional Development Plan. We make similar suggestions for Consultant 1.

b. The Medical Director will need to focus carefully on the appraisal of all the medical staff in Bury. In our view this means that the Medical Director will need to do all of the annual appraisals, for all of the medical staff, until he is satisfied that the Associate Medical Director in Bury is able to take on this task.

c. The Medical Director should monitor the use of annual leave and study leave for the Doctors in Bury to make sure that they are not working through their annual leave entitlement, and are making good use of their study leave entitlement.

d. Trust grade doctors and every non-training grade doctors should receive one hour protected and timetabled supervision each week. This should be over and above any other clinical advice.

e. Whilst we understand the pressures on the time of the Medical Director, we believe that until it is possible to appoint new Consultants to Bury, there will need to be time set aside to become more involved in the services in Bury. We cannot find evidence that the situation with regard to medical staff has changed dramatically. We leave it to the Medical Director and in discussion with the Chief Executive to decide how this recommendation can be translated into action.

f. The Medical Director should take the lead in ensuring that the necessary changes take place in Bury for an application to be made through the Local Training Scheme to the Royal College of Psychiatrists for approval to train psychiatrists.

ii. Nursing

a. A nursing clinical supervision system should be in place to support modern-day nursing practice. A reflective nursing model might be considered.

b. Nursing staff should receive regular training in managing difficult and aggressive behaviour, and therapeutic engagement with problem patients. Whilst control and restraint is a last resort there should be regular training in this also.

c. There should be a clear policy for close observation of patients, which reflects standards proposed by the Royal College of Nursing.

d. Consideration should be given to the appointment of a Nurse Consultant with a particular focus on inpatient services in Bury.

iii. Social Work including Social Workers seconded to Lancashire Care Trust

a. The recording of information should follow agreed guidelines. For example, those provided by the British Association of Social Workers on confidential and ethical recording.

b. Patients who move out of one area to another should remain the active responsibility of the original authority until a formal handover can be arranged. A formal handover implies real team to team discussion, nor merely a paper passing exercise, and which should be timely and include:

- Team to team discussions
- The provision of background information
- A contingency plan with, for example, a system of rapid transfer back to the original system if the patient moves.

c. The provision of an approved local authority list of bed and breakfast accommodation to vulnerable adults with mental health problems implies that the addresses on the list are suitable for this group of people.

We appreciate the difficulties of managing individual cases when there is a degree of non-cooperation. However, even when there is a lack of appropriate accommodation this practice (of providing the approved list) should be reviewed as a matter of some urgency.

iv. General Issues for the Mental Health Services

a. Training in dual diagnosis and in personality disorder is urgently required for all clinical staff. We recommend multidisciplinary training is set up on a regular basis to prevent mental health issues being obscured by either illicit drug use or personality difficulties.

b. We recommend that the Trust consider facilitating team-working development in Bury, with medical staff, in order to encourage efficient multidisciplinary processes and decision-making. The medical staff in particular, need to be included in these proposed team-working developments.

c. We recommend the review of the skill mix and training needs for all staff not just nursing staff.

d. We do not support the continuation of separate nursing notes and would strongly suggest that multi-disciplinary integrated notes is the model that Bury services (proposed all services) should move towards.

e. The Trust should develop standards for record keeping consistent with national agreed standards for mental health.

f. Similarly, the Trust should develop a procedure for the retrieval of appropriate clinical and other information in circumstances where the original records have been lost, stolen or damaged.

g. All staff, particular including medical staff, should receive regular training in CPA. Which should emphasise the real benefits of the care planning process to individual patients, and stress that it is not just a form filling exercise.

h. All staff should receive training in clinical risk assessment and management. For example, a clinical base tool such as HCR20 is of use. This is not to suggest that all patients require such a risk tool, but the structure and questions asked in the HCR20 are to help in assessing risk in all patients.

i. The use of CPA in Bury should be regularly audited.

v. 1983 Mental Health Act

a. All staff should have regular training on the use of the Act and Code of Practice, including any changes in case law, which may affect their professional practice. Wherever possible, training should be multi-disciplinary and multi-agency.

b. All leave for detained patients must be authorised in accordance with Section 17 of the Act and Chapter 20 of the 1983 Mental Health Act Code of Practice. All leave should be documented on the Trust's Section 17 Leave Form, which should contain all the information requested on each occasion when leave is authorised.

c. Audit systems should be put in place to monitor compliance.

d. Senior Managers and staff working on the wards should be made aware of the provisions of Chapter 19 of the Code, which relates to the management of patients presenting particular problems, as a result of their disturbed behaviour. This chapter gives guidance on the response of the clinical team to a serious incident.

e. The patient's nearest relative should be actively involved in aftercare planning, if the patient consents, and their views must be documented and properly taken into consideration by the care team.

f. Aftercare planning, including the granting of leave and discharge arrangements, should comply with paragraph 27.6 of the Code of Practice.

g. The patient's Responsible Medical Officer should discharge their responsibilities as set out in paragraph 27.6 of the Code, in particular the assessment of any risk to the patient or third parties and the consideration of the criteria for supervised discharge or guardianship.

h. The Trust and the local social services authority must strengthen their Section 117 procedures. Individuals who are entitled to aftercare should not be discharged from hospital before appropriate aftercare facilities have been identified. Once discharged, the patient's progress must be actively monitored. Regular Section 117 meetings should be held, with a contribution to those meetings from the patient's Responsible Medical Officer.

i. The Trust's Supervised Discharge Policy needs to be re-written to better reflect the Department of Health's Guidance. Staff should receive training on the use of supervised discharge and guardianship.

j. Although a patient, subject to Section 117 cannot be compelled to accept those services, a failure to engage with services should not be seen as an early opportunity to rescind Section 117. Rather, such failure should trigger an action plan, which seeks to address the patient's non-compliance with aftercare and, if necessary, allows for a reassessment of the patient's mental state in order to ascertain whether admission to hospital is indicated.

k. The Trust and social services authority should give active consideration to the provision of an independent mental health advocacy scheme to assist patients and their carers make comments about the service they receive, and to articulate their own needs and preferences.

3. *Bury Primary Care and Pennine Care NHS Trust*

i. Urgent agreement on the allocation of resources from Bury Acute Trust to Pennine Care Trust needs to be reached. It is clear that not all of the funds were fairly distributed between the two Trusts.

ii. A review of funding for the Mental Health Service in Bury is, in our view, necessary so that there can be proper consideration of the years of under-funding that the service has had to endure. We accept that the service in Bury will not be able to catch up in one leap, and that progress is being made, but from our understanding of the financial situation, the chronic under-funding problems have still not been resolved. We recommend that an agreement be reached between the Pennine Care Trust, the Primary Care Trust, and the Strategic Health Authority.

4. *Forensic Mental Health Services*

i. We recommend that the three North West Medium Secure Units and the Secure Commissioning Team consider how to manage, from a service perspective, a North West patient admitted to a North West Medium Secure Unit who is out of their catchment area.

In our view, the Forensic Service needs to consider:

- Involving the local catchment area MSU in the discharge discussions and arrangements
- Using the local catchment area MSU for its knowledge of services and community facilities
- Copying discharge details to the local catchment area MSU
- Whether the local catchment area MSU should have any active involvement with the patient, for example, by sending the member of staff to attend clinical team meetings.

ii. We suggest that the lead clinicians in each of the three MSUs should come to some agreement about how to manage such cases and this agreement should be supported by the Secure Commissioning Team.

5. ***Department of Health, Strategic Health Authority, and the Commissioning for Health Audit & Inspection***

i. We appreciate that there will be changes in how enquiries, following the homicide committed by an individual in contact with Mental Health Services, will be set up and arranged in the near future. However, any review of clinical decision-making, and the organisation, will be hampered if the senior staff use retirement as a means of absenting themselves from the process. In our view this is particularly serious if a Chief Executive takes this stance. We therefore recommend that the Department of Health should consider issuing advice to all Mental Health Trusts on how individuals in contact with one Mental Health and Social Care services are handed over to new services. Good practice in this area should be highlighted.

ii. We suggest that consideration be given to more general advice in relation to l (viii) in the above recommendations.

Appendix

Progress Report

Re: External Inquiry into the Care and treatment of Mr. S.R. by Mental Health Services of Bury.

Introduction

Having concluded their inquiries into the care and treatment of Mr. S.R. by Mental Health Services in Bury, in line with the original terms of reference, the Panel noted that improvements in service delivery had been made since the original incident in 1999.

This paper details the progress made by staff working in the service since the time of the incident and latterly under the management and direction of Pennine Care NHS Trust.

The paper draws on the draft recommendations produced by the Inquiry Panel in June 2003 as an appropriate framework for reporting such progress.

Recommendations

Systems for monitoring action points arising from Serious and Untoward Incident Reviews (Rec. l:i, ii, iii, viii)

Pennine Care NHS Trust has implemented a rigorous policy for all Serious and Untoward Incident Reviews, based on the Root Cause Analysis methodology. The implementation of the policy is supported by robust I.T. systems with reports to the Trust Board via the Borough's Governance Group and the Trust's Governance Sub-Committee. The policy also makes provision for contact with victims and victims relatives as appropriate.

The Borough's Governance Manager is developing a reporting process for monitoring progress locally and the Borough is in the process of appointing an audit-co-ordinator, funded through Tier II monies, to further strengthen the monitoring process.

Implementation of CPA (Rec: I iv,)

The Trust has produced a comprehensive CPA policy, which details minimum standards of service provision for both standard and enhanced levels of care. A Trust wide group chaired by the Director of Service Development is leading the implementation.

The Trust in partnership with Bury MBC have agreed a project plan, funded through Supplementary Credit Approval to develop a mental health module within the RAISE Information System operated across Local Authority Services. The projected timescale for implementation is October 2003.

The RAISE System (Referral; Assessment; Information, System and Environment) is an integrated computerised system that tracks service provision (activity and outcomes) for an individual from referral through to discharge or closure. This will significantly improve both the quality and accuracy of CPA data, will increase access to timely information for clinicians and will improve service monitoring.

Record Keeping (Rec iv,e)

The Trust has established a Clinical Records Management Group and is in the process of agreeing a protocol for record management in keeping with National standards.

Risk Assessment and Management (Rec iv,h)

Staff in Bury have had access to risk assessment training since this review. Since Pennine Care was established, a Risk Management Policy has been agreed and training to support its implementation.

The Borough is in the process of appointing a training co-ordinator jointly funded by Pennine Care and Bury Social Services who will take forward training initiatives within the Borough.

Mental Health Act (Rec v)

The Trust has appointed a Mental Health Act Manager who is in the process of reviewing and standardising all Mental Health Act policies to ensure compliance with the Code of Practice.

Management Arrangements

Following the appointment of the Borough Director, the Trust and Local Authority have agreed to formally integrate the management of mental health services in Bury. The management structure has been approved and the process of implementation is being overseen by a Strategic Steering Group comprising of Senior members of the key partner agencies, Bury PCT, Bury MBC and Pennine Care NHS Trust. This group is responsible for ensuring that mental health has a high profile on the agendas of all local agencies.

Summary

Whilst significant progress has been made since 1999 the Trust is not complacent and acknowledges that there are many issues still to be addressed. It is recognised that both the pace and extent of progress has been inhibited by limited funding and that the progress to date is a measure of staff's commitment to deliver a high quality service. The Trust is equally as committed in supporting staff in this ambition. Whilst further progress in some areas will be entirely dependent on additional funding being made available, the Trust accepts its responsibility in ensuring that the performance and practice of staff working in the service is of a high quality and in keeping with the standards of the relevant professional regulatory bodies.

It is also our view that the action to date and the development of the integrated management structure presents a solid foundation from which Mental Health Services in Bury will go from strength to strength.

Bury Borough Director, Pennine Care NHS Trust
June 2003