Independent Investigation into the Care and Management of Patient D

Final Report
January 2010

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This independent investigation was commissioned by NHS West Midlands in keeping with the statutory requirement detailed in the Department of Health guidance "Independent Investigation of Adverse Events in Mental Health Services" issued in June 2005.
This requires an independent investigation of the care and services offered to mental health service users involved in incidents of homicide where they have had contact with mental health services in the six months prior to the incident, and replaces the paragraphs in "HSG (94)27" which previously gave guidance on the conduct of such enquiries.

The Investigation Team members were:

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- Dr Maureen Devlin, Associate, Consequence UK and Independent Healthcare Consultant
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Acknowledgements
The Investigation Team wishes to thank:

- The parents of the MHSU
- The sister of the deceased
- The medium secure forensic service currently caring for the MHSU
- Staff employed by Dudley and Walsall Mental Health Partnership Trust

Note: Mental health services in Walsall were provided by Walsall Primary Care Trust in 2006.

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EXECUTIVE SUMMARY

Incident overview and intention

This report sets out the findings of the independent Investigation Team (IIT) regarding the care and management of the mental health service user Patient D, here referred to as the "MHSU", by statutory mental health services in Walsall between January 2006 and 21 August 2006. The MHSU attacked and killed a gentleman who had befriended her, following her absconsion from acute psychiatric in-patient services, and had taken her back to his flat on the evening of 21 August 2006. The attack occurred sometime during that night or the early morning of 22 August 2006.

The MHSU was subsequently convicted of manslaughter on 22 June 2007 and sentenced to a hospital order and restriction order under Section 37/41 of the Mental Health Act (1983)[1].

Purpose

NHS West Midlands Strategic Health Authority's terms of reference for the IIT were to undertake a targeted review of the care and treatment provided to the MHSU by statutory mental health services in Walsall, and to identify whether there was any aspect of care and management that could have altered or prevented the events of 21 and 22 August 2006.

Outline of the review process

The team conducted:

- A detailed and critical analysis of the MHSU's clinical records using timelining methodology.
- A critical appraisal of the trust's internal investigation report.
- Interviews with staff working in adult mental health in-patient services.
- A review of Walsall Primary Care Trust's (PCT's) "Risk Assessment and Management Policy" and the current policy of Dudley and Walsall Mental Health Partnership Trust.

[1] If the special restrictions set out in section 41 of the MHA are imposed, it means that leave under section 17, transfer under section 19, and discharge under section 23 cannot take place without the consent of the Ministry of Justice. There are other implications, notably in relation to mental health review tribunal applications and discharge. Patients subject to a restriction order are known as restricted patients. The restrictions can be applied to s37 (hospital order) patients. Only the Crown Court can impose a restriction order. In deciding whether to impose a restriction order, the judge will consider the nature of the offence, the antecedents of the offender and the risk of his/her committing further offences if set at large, in deciding if it is necessary for the protection of the public from serious harm that a restriction order be imposed.

Main conclusions
The IIT has carefully analysed the MHSU's care and treatment by the statutory mental health service in Walsall. As a result it has drawn the following conclusions.

Positive feedback:

- It was exemplary practice that the community mental health team in Kent, who were caring for the MHSU up to the end of December 2005, attended a meeting with the MHSU's Walsall-based community mental health team to ensure an effective handover of care.
- The community management of the MHSU was very good in Walsall.
- The day-to-day care provided by the Walsall acute psychiatric inpatient service to the MHSU was very good in that staff responded to the MHSU's needs appropriately as they arose.
- The medical staff appropriately made contact with the MHSU's previous care providers in Kent to ensure that they were as well informed about her as they could be. They also made contact with the MHSU's previous consultant psychiatrist when she was not responding to treatment as expected.

Areas that could have been improved:

- The documentation of the MHSU's care plan. This should have been more structured and more detailed.
- The assessment of risk. In addition to the initial assessment of risk on 16 June 2006, risk assessment should have been repeated following the absence without leave (AWOL) incident on 15 August and again following the collapse of the MHSU on 18 August. The MHSU's tendency to invade the personal space of others should also have been considered in relation to risk vulnerability.
- The clozapine (Clozaril) prescribed for the MHSU on 10 July 2006 was not commenced. The MHSU was commenced on zuclopenthixol (Clopixol) depot injections instead. This appears to have been due to concerns raised by the MHSU's parents at the ward round of 24 July which was led by a locum consultant and not the patient's own consultant. There is no available information to say i) why the patient's own consultant did not lead the ward round, and ii) what the MHSU's wishes were at the time. Prior to the attendance of the MHSU's parents at this ward round the MHSU was noted to be "looking forward" to the clozapine, and all preparations required for its commencement had been completed.
- The information provided to the police on the morning of 21 August 2006 was not as detailed as it could have been. Although the police were informed at 11.22am that the MHSU was missing and that she was a detained patient under section 3 of the MHA, and the PCT policy for missing persons was followed, at the time there was an

over reliance on verbal communication and there was no requirement for detailed written information to be provided. The usage of a dedicated fax pro forma may have ensured greater robustness in the information exchange between the two services.

Predictability:
Although the MHSU's historical records show a degree of aggressive behaviour when unwell, she had no forensic history and her acts of aggression were not such that any professional would have considered her to present an immediate risk to members of the public when in relapse.

It was however predictable that this MHSU would go absent without leave from time to time. This risk was not appropriately managed by her inpatient care team in 2006 following her episode of leaving the ward on 15 August. Instituting 15 minute observations without proper consideration of the appropriateness of unescorted leave was not adequate.

Preventability:
Had this MHSU not been allowed off the ward unescorted on 21 August, the incident that subsequently occurred that night, or in the early hours of 22 August, would not have happened.

The MHSU's presentation between 15 August and 21 August was such that any reasonable risk assessment should have resulted in a decision for escorted leave only until her physical and mental health had properly stabilised. This perspective was shared by a number of staff interviewed by the IIT when they looked holistically at the MHSU's presentation in the six days preceding the incident. It is also shared by an independent group of inpatient nursing staff asked to consider the MHSU's presentation and whether or not she would be suitable for unescorted leave. All of the nurses asked said that they would not have allowed the MHSU off the ward unescorted.

Recommendations
The mental health service in Walsall has already invested heavily in improving the security of its inpatient services following this incident. It is now very difficult for service users to leave the hospital unescorted. IIT members walked around the hospital site and were shown a number of the security measures implemented. The measures instituted appear to be robust and the IIT therefore has no additional recommendations in relation to site security.

However, the IIT does have recommendations relating to policy and practice.

Recommendation 1: Nursing observation policy
The wording of the current nursing observation policy in use by inpatient staff at the Dorothy Pattison Hospital remains ambiguous with regard to the Trust's expectation regarding standards of practice, and the assessment required before allowing a patient to have unescorted leave.

The IIT recommends that the wording in relation to level 2 observations is altered to include the following:

"For service users placed on timed observations of 15 minutes (level 2) a risk assessment must be undertaken before any decision is made regarding their being able to leave the ward area unescorted. This risk assessment must be documented as part of the recorded care plan for the service user.

*Staff must note that service users on level 2 observations are **NOT** automatically granted 'unescorted leave' from the ward simply because they are on level 2 observations."*

Unless the wording of the policy document is tightened up the policy will continue to remain vulnerable to misinterpretation.

In addition to revising the wording of the policy document, the IIT suggests that:

- The risk assessment training provided to staff needs to emphasise that a clearly documented risk assessment should be an integral part of the decision making process regarding unescorted leave.
- All ward managers are required to highlight this element of practice at ward meetings as the IIT sensed a continuing lack of clarity amongst staff on this point.
- Future audits of nursing observation practice should include audit of the presence of an appropriate care plan and risk assessment, and a log of outcomes regarding escorted or unescorted leave.

Implementation:
Dudley and Walsall Mental Health Partnership Trust must be mindful that what the IIT has recommended represents a significant culture and practice change for the staff at the Dorothy Pattison Hospital. We do not know how much of a practice change the recommendation represents for other inpatient staff across the Trust.

Consequently how any change in practice expectation is communicated to staff will be important, as will the early monitoring of implementation to ensure that change occurs.

Timescale: The IIT can see no reason why the change in wording to the nursing observation policy document cannot have been accomplished prior to the publication of this report.

Dudley and Walsall Mental Health Partnership Trust must set out its methodology and the timescale for implementation in the action plan submitted to West Midlands Strategic Health Authority (SHA). How the Trust will test the effectiveness of implementation should also be detailed in this plan.

Target audience:
Dudley and Walsall Mental Health Partnership Trust Integrated Governance Group.

Recommendation 2: Audit of nursing documentation
The observation documents reviewed by the IIT do not show that a therapeutic encounter takes place at each observation for service users on level 2 observations. The IIT also found the content of the nursing progress notes to be variable in this respect. This needs to be remedied.
The IIT suggests that consideration is given to redesigning the observation record form so that every hour, space is provided for the observation nurse to record his/her perspective of how the service user is, their interactions, and mental state etc. The IIT believes that this is more likely to result in an improvement in the clinical record made, as opposed to reminding staff to making timely updates in their progress notes.

Timescale: The changes to the form used for documenting nursing observations should be achieved within four weeks of West Midlands SHA accepting this report. How Dudley and Walsall Mental Health Partnership Trust will implement the revised documentation, and its timescales for doing so, is for the Trust to set out in its action plan submitted to West Midlands SHA. How the Trust will test the effectiveness of implementation should also be detailed in this plan.

Target audience:
Dudley and Walsall Mental Health Partnership Trust Integrated Governance Group.

Recommendation 3: Obtaining medical records from previous mental health providers

Although the MHSU's previous mental health provider in Kent supplied the mental health service in Walsall with very good quality information, this did not replace the rich information that would have been obtained from a thorough review of her clinical records between 1993 and 2005. The chronology in Section 1 of this report provides a depth of information that would have been useful to the Walsall service. It is possible that had the previous records been requested by Walsall, and an historical overview compiled, then staff perceptions about the MHSU may have been different. That is, they may have better appreciated her risk factors and been less taken in by her immediate, childlike presentation.

The IIT therefore recommends that whenever a mental health service user is transferred into the Dudley and Walsall Mental Health Partnership Trust from another mental health provider, that consent is sought during the transfer process for the Trust to request copies of all previously created records. At the very least such a request should ask for copies of:

- all Mental Health Act assessments;
- all discharge summaries;
- all risk assessments;
- all Care Programme Approach (CPA) paperwork;
- all correspondence to GPs; and
- all admission assessments.

Timescale: The IIT considers that it should be achievable for Dudley and Walsall Mental Health Partnership to design an appropriate consent form and to request previous records routinely during patient transfers into the Trust within six months of the acceptance of this report by West Midlands SHA.

The detail of its plan for achieving this, and testing that implementation has been successful, should be set out in the action plan provided to the SHA.

Target audience:

Dudley and Walsall Mental Health Partnership Trust Integrated Governance Group.

Recommendation 4: Effective use of the Walsall "Patient Alert Procedure"

The IIT noted a very useful documentation tool called the "Patient Alert Procedure" when it reviewed the Walsall records pertaining to the MHSU. Unfortunately it had not been used. Had it been used there is the possibility that staff would have more easily grasped the increased vulnerability of the MHSU between 15 and 21 August 2006 and managed her more appropriately in relation to escorted leave from the ward. It would also have assisted in the information transfer to the police on the morning of 21 August.

It is recommended that Dudley and Walsall Mental Health Partnership Trust undertakes a review of all of the documentation tools provided to staff working within adult based inpatient services to determine how these tools are being used. If this review shows that staff are not using tools that the Trust considers to be of value, the Trust will then need to establish why this is and take remedial action such as training staff.

Subsequent audits to test out the effectiveness of any training intervention will also be required.

Timescale:

It is recommended that the audit of usage of Trust-provided documentation tools occurs on a ward-by-ward basis using a simple trust-designed audit tool. The audit needs to be completed and presented to the Adult Services Governance Committee within six months of the acceptance of this report by West Midlands SHA. What the Trust does thereafter will be determined by the audit results.

Target audience: Dudley and Walsall Mental Health Partnership Trust Integrated Governance Group.

Recommendation 5: Inclusion of fax pro forma in missing persons policy

Dudley and Walsall Mental Health Partnership Trust's policy for dealing with situations where a patient has gone missing must maximise the opportunity for effective communication with the police.

The IIT suggests that use of a fax pro forma for communicating information should be part of this policy.

The following represents the individual data fields that such a form might accommodate:

- name of service user (full name and 'likes to be called');
- description (height, weight / build, hair and eye colour, hairstyle);
- age and date of birth;
- diagnosis;
- detained patient: Yes/No;
- risk of harm to others;
- risk of harm to self;

- risk of vulnerability (neglect, exploitation, abuse, putting self into dangerous situations);
- other behaviours that may put the service user at risk;
- significant issues of concern in the days leading to AWOL (including physical health issues);
- next of kin details;
- known haunts; and
- any defining marks or features.

Timescale: The IIT suggests that this recommendation can be implemented within a relatively short period of time. Timescales for design and implementation must be clearly stated on the action plan submitted to West Midlands SHA.

Target audience:
Dudley and Walsall Mental Health Partnership Trust Integrated Governance Group.
The Police Liaison Officer for the Trust.

1.0 INTRODUCTION AND BACKGROUND

This Investigation was commissioned by West Midlands Strategic Health Authority to determine:

- the quality of care and management afforded the MHSU; and
- whether or not the MHSU's attack on the victim could have been prevented by different management of the MHSU by the specialist mental health services in Walsall.

At some time between the evening of 21 August and the morning of 22 August 2006, the MHSU attacked and killed a gentleman in his home. The gentleman was in his sixties and was previously unknown to the MHSU. However the police investigation showed that the gentleman befriended the MHSU during the day of 21 August and then took her to his home that evening. It is unclear as to what exactly happened in the gentleman's home in the time leading to the MHSU's attack on him. However it is known that sexual intercourse did take place.

The investigation undertaken is a statutory requirement under health circular guidance HSG(94)27.

Background

The MHSU first came into contact with specialist mental health services in 1993 when she was admitted to Runwell Hospital in Essex. At this time she had a labile mood, believed that her husband wanted to kill her and that her kidneys were not working. She was experiencing thought and auditory hallucinations. Her behaviour was also disturbed to the extent that she required to be detained on a compulsory basis under Section 2 of the Mental Health Act (MHA) 1983. She was treated with antipsychotic medication. Subsequently, after a period of successful home leave she was discharged home.

The MHSU had two subsequent hospital admissions in 1993, at these times she was preoccupied with vampires, God, and black magic. The religious theme and concerns about vampires continued to trouble the MHSU between this time and the date of the incident in 2006.

Between June 1993 and February 2000 the MHSU required nine admissions to hospital.

Between August 2000 and May 2003 the MHSU successfully lived in the community supported by her community mental health team (CMHT) and her family. Throughout this time she continued show signs of mental illness. On 19 February 2003 she was described as "always close to the psychotic world".

In May 2003 the MHSU was again detained under the provision of section 136 of the MHA. The antecedents to this were her stopping her medication and

smashing up her flat. She was eventually well enough to be discharged home on 31 December 2003.

Between February 2004 and December 2005 the MHSU required five further admissions to hospital. The precipitating factors were generally medication non-compliance, and a resurrection of her beliefs regarding being pregnant and being bitten by vampires.

Overview of Community Care and Treatment in 2006
The MHSU's care was transferred to Walsall, from Kent, when she decided to move there with her parents. The initial transfer paperwork was received by the Walsall Crisis Team at the end of December 2005 prior to the MHSU's relocation. The transfer arrangements were managed well, including a face-to-face transfer meeting between the Kent and Walsall community teams in Walsall on 8 February 2006.

The MHSU was managed successfully in the community between February and 16 June 2006. The MHSU's previous medication regime was maintained and compliance was achieved with the support of her family, especially her brother with whom she lived. Her medications were:

- olanzapine 20mg nocte (in velotab form);
- trimethoprim 100mg daily (prophylactic for urinary tract infection); and
- zopiclone 7.5mg nocte.

The community psychiatric nurse (CPN) and social worker (SW) worked with the MHSU to maximise her social well being taking her regularly to a day centre placement and encouraging her with other activities and pursuits.

On 16 June the MHSU became very unwell and required detention in hospital under section 3 of the Mental Health Act (MHA) (1983).

Overview of Inpatient care and management 16 June – 21 August 2006
The MHSU was admitted to an acute psychiatric inpatient unit on 16 June 2006. At the time of her admission she believed herself to be pregnant and bitten by vampires. This presentation was reminiscent of her presentations between 1993 and 2005.

Anti-psychotic medication was continued. However towards the end of June the MHSU's medical team were concerned at the lack of improvement in the MHSU's symptoms and contact was again made with the previous mental health team in Kent to find out if they had similar experiences with the MHSU. Furthermore, on 7 July 2006 a decision was made to commence the MHSU on clozapine (Clozaril) (an atypical anti-psychotic medication). The MHSU was agreeable to this change in medication and was reportedly looking forward to starting it. However on 24 July this decision was altered and Clopixol was commenced instead. (This is a typical anti-psychotic medication to be administered by depot). The rationale for the change in medication was an improvement in the symptoms displayed by the MHSU and concerns

raised by the MHSU's parents regarding the potential side-effects of clozapine.

The MHSU continued to remain well and in remission of her psychotic symptoms. Consequently between 11 and 13 August she had a period of home leave. This went well.

Following her return to the ward on 14 August the MHSU went missing on 15 August for a period of some 16 hours. As a result of this her section 17 leave[2] was rescinded.

It was also noted in the clinical records that the MHSU had again relapsed and was experiencing her delusions about pregnancy and also being bitten by vampires.

On the 17 August the MHSU was incontinent of urine in bed and also in the smoking room. She was distressed due to this. The nursing notes observed that she had a history of recurrent urinary tract infections and was on prophylactic trimethoprim for these. A urine specimen was taken for culture and sensitivity and a referral to the incontinence nurse made. Erythromycin (an antibiotic) was also prescribed.[3]

On 18 August the MHSU experienced two further episodes of incontinence. The MHSU's behaviours were also changeable with two episodes of verbal volatility and episodes of her being "touchy feely" with other patients. The MHSU was advised that she must not leave the ward and 15 minute nursing observations were commenced.

Following further deterioration in the MHSU's physical condition the medical staff were informed. Physical observations were also undertaken. Her olanzapine was also increased to 20mg per day.

At 8.45pm the duty doctor was asked to assess the MHSU. A member of the medical team attended to undertake this. During the assessment the MHSU had a respiratory and cardiac collapse, requiring three cycles of cardio-pulmonary resuscitation to re-establish spontaneous respiration and cardiac output. The MHSU was transferred to A&E by ambulance for assessment.

At around 11.45pm the MHSU was returned to the in-patient psychiatric ward as no cause for the collapse could be identified.

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[2] Section 17 of the Mental Health Act 1983 allows the responsible medical officer (RMO) to give a detained patient leave of absence from hospital, subject to conditions the RMO deems necessary. These can include a requirement to take medication while on leave and to reside at a particular address, among others. Although the RMO can require a patient to take medication while on section 17 leave, treatment cannot be forced on the patient while they are in the community. There is no limit to the duration of section 17 leave provided the original authority to detain remains in force. http://pb.rcpsych.org/cgi/content/full/31/7/241

[3] The MHSU had a sensitivity to penicillin which was why erythromycin was prescribed.

On 19 August the MHSU was noted to be more settled if somewhat over sedated. The MHSU was again assessed by the duty doctor. This doctor did contact the A&E department to find out what they considered to be the cause of the MHSU's collapse. He was advised it was an apnoeic episode. Examination of the MHSU, by this doctor, revealed no abnormalities except for a red rash around the inner thigh and lower abdomen. Consequently the MHSU was commenced on an antibacterial cream.

The following was also requested of the nursing staff:

- to monitor BP, pulse, respirations and temperature twice a day;
- to contact medical staff again if her physical health deteriorated; and
- to get the blood results from the patient management system (PMS) and file these in the MHSU's notes.

On 20 August it was noted that the MHSU experienced back pain although there appeared to be no identifiable cause for this. The MHSU was assessed by a member of the medical team at 12.30pm. No significant changes were noted.

On 21 August the MHSU was noted to have an uneventful morning. At approximately 10am she was seen by one of the nursing staff by the vending machine in the corridor on the floor below the ward.

At approximately 10.30am the MHSU's mother and father attended on the ward to visit their daughter and alerted the nursing staff that they could not find her. A local search was made including a visit to the nearby corner shop by the MHSU's father, to find out whether she had visited this store.

At 11.22am when it was clear that the MHSU was not within the grounds of the hospital the police, senior management and the duty medical staff were informed. The police were told that the MHSU was a detained patient under section 3 of the MHA and that she had gone missing on 15 August and that on that occasion she had visited a local supermarket.

At 3.15pm the police made their first attempt to contact the staff at the Dorothy Pattison Hospital. This attempt was not successful. Further attempts were made at 3.18pm and 3.25pm. None were successful as the ward phone was engaged on each occasion.

At 7.30pm the police succeeded in contacting the ward to find out if the MHSU had returned. They were informed that she had not.

At 7.58pm the police attended on the ward and completed a '*missing from home'* form with the staff. On leaving the hospital the police checked a number of local supermarkets to find out if the MHSU had been to any of these. She had not. The MHSU was classified, following consultation with Inspector C.M, as a medium risk.

Early on the 22 August the MHSU's mother called the ward and provided her mobile number and expressed ongoing concern for her daughter's well being.

Later that same day Walsall PCT was informed that the MHSU was in police custody on suspicion of murder. Police had been called to the home of the deceased at 8.30am that morning.

Please go to Appendix 1 page 51 for a more detailed chronology of the MHSU's contact with the specialist mental health service in Walsall

2.0 TERMS OF REFERENCE

The terms of reference for this independent investigation, set by West Midlands Strategic Health Authority (the SHA), were as follows.

1. To examine the circumstances and events relating to the treatment and health care of the MHSU by Walsall Primary Care Trust and any relevant organisation, and in particular the treatment and health care in the period leading up to the incident at 21/22 August 2006.

2. To identify any systemic or professional problems in the treatment and health care provided to the MHSU. For example the:

- quality of the assessed risk;
- assessment of risk of potential harm to herself; and
- assessment of risk of potential harm to others.

3. To consider the effectiveness of interagency working, including communications between the mental health services, police etc. with particular reference to the sharing of information for the purpose of risk assessment.

4. To review the internal investigations into the care of the MHSU already undertaken by the Walsall Primary Care Trust, any action plans that may have been formulated, including the immediate remedial action taken at the time of the incident, or action taken as a result of the internal inquiry, and assess the effectiveness of their implementation.

5. Where appropriate to employ root cause analysis principles and techniques to enable learning to be realised from the investigation.

6. To prepare and produce a report on the above, including any recommendations for future action the panel finds it appropriate to make, for publication by the SHA.

3.0 CONTACT WITH THE FAMILY OF THE VICTIM AND THE FAMILY OF THE MHSU

The IIT first made contact with the family of the MHSU on 20 February 2009. Subsequent telephone communication occurred and a director of Consequence UK and the appointed lead investigator met with the MHSU's parents during the first week of April 2009.

In relation to the sister of the deceased, a director of Consequence UK wrote to her in November 2008. Following subsequent telephone communications it was agreed that on completion of the investigation process one of the investigation team and/or a director of Consequence UK would meet her at her home.

There was further written communication with the sister of the deceased in August 2009 following unforeseen complications with the delivery of the investigation.

Letters were sent to the parents of the MHSU and the sister of the deceased so that arrangements to meet them and take them through the findings and recommendations of the investigation could be made. Both families did subsequently meet with the IIT and were taken through the report and its findings.

4.0 FINDINGS OF THE INVESTIGATION

In undertaking the independent investigation into the care and management of the MHSU, the IIT sought to provide answers to the following questions:

- (4.1) Was the overall care and management of the MHSU reasonable following her move to Walsall from Kent?
- (4.2) Were appropriate risk assessments undertaken? Were those risk assessments appropriately detailed and documented with accompanying risk management and relapse prevention plans?
- (4.3) In the two weeks preceding the incident, was the care and management of the MHSU reasonable in relation to:
  - staff perspectives of her risks;
  - staff awareness and attention to her physical health needs; and
  - the mental health nursing observations prescribed and carried out.
- (4.4) Was it reasonable to allow the MHSU off the ward unescorted on 21 August 2006?
- (4.5) Were the actions taken by staff on the inpatient ward following the MHSU's absconsion on 21 August 2006 appropriate?

As a result of its investigation the IIT can report that up until the morning of 21 August 2006, the care and management of the MHSU was reasonable and in many respects of a very good standard. The three areas of concern that the IIT has are in relation to:

- The non-commencement of clozapine before the consultant psychiatrist for the MHSU went on annual leave on 3 August 2006. The decision to commence clozapine was made on 7 July 2006.
- The decision of the locum consultant to commence the MHSU on zuclopenthixol (Clopixol) instead of clozapine (Clozaril) on 24 July without liaising with her existing consultant psychiatrist.
- The MHSU being able to leave the ward unescorted on the morning of 21 August in light of her unstable presentation in the days prior to this.

The only concern critical to the potential preventability of the incident is the last of these.

The IIT's understanding of the above concerns, and those aspects of practice that it believes constituted good practice, are presented in its responses to each of the questions stated at the start of this section. Each is addressed in sequence in the following pages.

4.1 Was the overall care and management of the MHSU reasonable following her move to Walsall from Kent?

Overall the IIT found the care and management of the MHSU to be of a good standard. Of particular note are:

- The handover between the MHSU's care team from Gravesend in Kent, and the community mental health team (CMHT) in Walsall. The team in Kent faxed to Walsall on 23 December 2005, before the MHSU moved to Walsall, copies of her up-to-date care plan and risk assessment. Kent team members then also travelled to Walsall for a face-to-face CPA handover meeting with the Walsall team taking over the care and management of the MHSU. This constitutes excellent practice.
- In March 2006 the MHSU told her social worker (SW) that she was being abused by the brother who was living with her. The SW and her colleagues acted appropriately following the receipt of this information and the Adult Protection Procedure was activated. The outcome of this was that adult protection was not required and monitoring of the situation by the CMHT was sufficient.
- The attention paid to the MHSU's social needs by the community psychiatric nurse (CPN) and SW responsible for the MHSU.
- The appropriate management of her relapse in June 2006 and instigation of assessment and admission under Section 3 of the Mental Health Act (MHA) 1983.

4.1.1 Community management

The MHSU moved to Walsall in January 2006. At the end of December 2005 her mental health team in Kent advised the relevant CMHT in Walsall that the MHSU was coming to the area and on 23 December provided copies of the most up to date CPA documentation relating to the MHSU. This included the most recent risk assessment which was comprehensively completed. The standard of documentation was very good (see section 4.2 page 27 for a detailed analysis of the risk assessments undertaken with the MHSU in Walsall and the associated risk management plans).

The MHSU was offered her first outpatient appointment (OPA) with a locum staff psychiatrist on 8 February 2006. The MHSU was advised that one of the social workers would collect her and take her to this appointment. The impression following this appointment was that the MHSU was in remission of her illness on "her current medication" which was olanzapine 20mg nocte.

The clinical records show that following this assessment the MHSU received visits from her CMHT on a weekly basis until 16 June, when she was found to be very unwell and in relapse of her schizophrenic illness, requiring compulsory admission to hospital under section 3 of the MHA. This represented a total of 20 visits of which 17 were successful, that is the community staff saw and assessed the MHSU.

The analysis of the CMHT's notes during this period revealed a very good standard of record keeping and a very good standard of care. Examples of this are:

- On 7 March the CMHT recognised that the MHSU was new to the area and also that she needed to build her confidence and self-care skills. She was therefore referred to the occupational therapists. Consequently on 11 April the MHSU was visited at home by her CPN and two occupational therapists. At this visit the MHSU was advised about a range of activity centres in the area that may be beneficial to her. She opted to attend the Schoolhouse project (a drop-in centre) and arrangements were made to transport her to this on a weekly basis and also to accompany her during the time of her attendance until the professionals believed she could manage independently.
- On 16 March the MHSU made accusations about her brother's treatment of her to the community team. The professionals present made contact with the MHSU's previous care providers to ascertain whether such accusations had been made before and whether or not there was believed to be any substance to these, or whether they had been found to be a feature of the MHSU's presentation when unwell. On learning that the previous mental health care provider did believe that there may have been substance to previous allegations, the community mental health professionals in Walsall correctly activated the adult protection procedure which culminated in an adult protection strategy meeting on 21 March. The outcome of this was that the community mental health staff would continue to monitor the MHSU on a weekly basis but that no further adult protection measures were required at that time.
- On 8 May the CPN and SW attended at her outpatient appointment, as is good practice, and also met the MHSU's mother.
- On 16 June when the CPN attended at the home of the MHSU it was evident that she was very unwell. The community mental health professionals undertook all necessary communications and actions to ensure that the MHSU was appropriately assessed. These activities culminated in her compulsory admission to hospital under Section 3 of the MHA .

The only issue that could have been improved was the length of time it took her then locum consultant psychiatrist to respond to the consultant psychiatrist in Kent following his letter of transfer of the MHSU on 9 January 2006. The response to this from Walsall was dictated on 9 May 2006, and not typed until 27 June 2006. This letter stated Walsall's acceptance of the MHSU and requested copies of "relevant medical correspondence relating to her previous treatment under [her previous consultant psychiatrist]".

Although the IIT can see no evidence in this case that the time delay adversely affected the care and management of the MHSU, because of

previous information already sent from Kent, one cannot assume that for another service user such a delay would not disadvantage their care.

4.1.2 Inpatient management: positive feedback

Following her admission to the acute psychiatric ward the care and management of the MHSU were largely unremarkable. There were however a number of notable elements, as follows.

- There was proactive communication between the MHSU's consultant psychiatrist and the MHSU's previous consultant psychiatrist to ensure that the Walsall team were as fully informed as possible about her past treatment and also the usual course of her relapses. This occurred at the time of her admission and again when the medical and nursing staff were concerned about the lack of progress in the MHSU's mental state in early July 2006. This willingness to check back with past professionals represents a very good standard of care and concern for the MHSU.[4]
- It was appropriate to maintain the medication regime commenced in Kent until the MHSU was better known by the Walsall team, and until it became clear in July 2006 that a change in medication was required to try and bring her mental illness under control.
- Staff response to the episodes of incontinence experienced by the MHSU was timely and appropriate. The first episode was on 15 August and the second and third on 17 August 2006. As a result staff obtained a urine sample for culture and sensitivity testing, and also referred the MHSU to the continence nurse. On 19 August following continued complaints of back ache and deterioration in the MHSU's physical health, erythromycin 250mg qds[5] was also prescribed for her in addition to her maintenance dose of trimethoprim.
- Between 17 and 18 August the MHSU's physical health deteriorated. The nursing staff appropriately informed the medical staff about this. Following further concerns about her physical health the duty doctor was asked to assess her at 7.30pm on the same day. During this assessment at approximately 8.45pm the MHSU collapsed and was without respiration or a heart rate. Cardiac massage was undertaken and a 999 call to paramedics initiated. The MHSU was revived by the duty doctor and transferred to A&E for a full physical assessment. The management of this episode by the doctor and nursing staff on the scene was very good, and the immediate post-incident management was good.

[4] Note: had the letter dictated by the MHSU's consultant on 9 May have been typed and sent in a more timely manner the Walsall inpatient team may have been in possession of the information they required. Nevertheless this does not detract from the team's good practice of seeking it more urgently in July.

[5] QDS means four times a day.

4.1.3 Concerns over medication management

It was agreed on 7 July 2006 that the MHSU would be commenced on clozapine, a newer, “atypical” antipsychotic medication. This did not occur and instead the MHSU was commenced on depot injection of zuclopenthixol (an older, “typical” antipsychotic) from 24 July 2006. Initially the rationale for the change in plan was not adequately explained. The impression the IIT had was that the MHSU’s consultant psychiatrist was on leave and the locum consultant psychiatrist changed the plan and no one knew why. In light of the MHSU’s consent for clozapine and her reported eagerness to commence this medication this did not seem an adequate explanation.

The IIT therefore explored the matter further with the MHSU’s substantive consultant. This professional told the IIT that he cannot remember why his ward round was covered by a locum consultant on 24 July as he did not go on annual leave until 3 August some 10 days later. However he was able to advise the IIT that on 17 July, the day of his ward round, the MHSU was not available for the ward round. The notes say “[MHSU] missing awaiting her return”. Consequently her consultant psychiatrist was not able to assess her. The next ward round was on 24 July. This was undertaken by a locum consultant psychiatrist and the MHSU’s parents were present. The MHSU’s consultant psychiatrist understands that they expressed concern about the plan for clozapine because of the side effects associated with it. In light of the MHSU’s more settled presentation and the absence of any psychotic thoughts, also validated by the nursing staff who confirmed that she was much better, a decision was made to prescribe Clopixol instead. The IIT are advised that this decision was made in consultation with the MHSU and her parents. The next ward round was on 31 July. This was also conducted by the same locum consultant psychiatrist and the MHSU’s parents also attended. The MHSU remained well, with no evidence of psychosis, and six hours’ section 17 leave was agreed following her and her parents’ request for this.
By 11 August the MHSU was well enough to have home leave over the weekend.

The IIT did consider trying to find the locum doctor but decided that the likelihood of him remembering why he/she prescribed a drug different to that planned by another doctor three years ago was so remote that it was not judicious use of public funds to attempt to do so.

As a result of its analysis the IIT considers the decision to have altered the MHSU’s medication plan to have been a reasonable one. However it notes that the views of the MHSU are not recorded in the clinical records, only that her parents were present.

4.1.4 Quality of the MHSU’s care plans

The community care plan for the MHSU was reasonable, even though no timescales were identified for the completion of specific actions. The care plan also addressed needs that were specific to the MHSU such as her need to become more socially active.

With regard to the MHSU's in-patient care plans there was one care plan dated 16 June 2006 which was the date of admission, and a second dated 30 July 2006.

The plan dated 16 June did not and does not constitute a care plan. Although the IIT understands that at the time of admission the MHSU was very non-communicative, one would have expected her initial care plan to have included elements such as:

- To liaise with the MHSU's community mental health team to find out about her normal communication abilities and her self-care abilities.
- To liaise with the MHSU's parents and brother to gain a full appreciation of her background and her behaviours, likes and dislikes.
- To liaise with the occupational therapy team or the Schoolhouse project with the aim of collecting further background information about the MHSU.
- In light of previous absconsion attempts in other inpatient units, for the MHSU to be placed on close observations in the immediate post admission period.

On 19 June there was clear evidence in the community records that a member of the community team attended the inpatient ward round. This record makes explicit the plan for "enquiries to be made with her previous care team (in Kent) to establish her previous treatment regime and to obtain copies of medical correspondence. Care coordinator to be contacted to help to facilitate this."

The community records also show community team presence on the inpatient ward rounds on 3 July, 24 July and 31 July 2006. This means that there was adequate opportunity for the ward staff to be well informed about the MHSU and to develop a personalised plan of care for her in advance of 31 July.

It is disappointing that there is no evidence to suggest that contact with the MHSU's parents occurred, or that the inpatient team undertook to obtain the MHSU's consent to make contact with them, in the early weeks of her admission.

The care plan of 31 July was of much better quality and was shared with the MHSU. It is noted in her records that she was "very pleased and signed the care plan".
The care plan addressed:

1. Working with the MHSU to help her understand better her diagnosis of schizophrenia.
2. The need to develop a therapeutic relationship with the MHSU.
3. Exploring with the MHSU her illness and the recognition of early warning signs of relapse.
4. Educating her about her medication to achieve concordance.

5. Administering medication as prescribed.
6. Reporting any changes in her mental state at the multi-disciplinary weekly team meeting.

Useful additions to this would have been:

- Engaging the MHSU in activities that facilitated her social skills.
- Encouraging the MHSU in all self-care activities and being alert to any signs of self-neglect.

The main omission in the MHSU's care plan was any description of the activities that would be undertaken to deliver the plan, i.e. how the plan was to be achieved.

With regard to the day-to-day progress notes overall, the quality of these was reasonable with a number of very good quality entries. The challenge for all professionals is that daily progress notes create dense narrative material to read through and information about priority care needs is rarely easy to extract. The care plan should have served this function and on 31 July the IIT believes that it did so. However the content of the care plan did not keep up to date with the changing presentation for the MHSU between 15 and 21 August 2006.

The following should have formed part of her plan of care over this period:

- The minimisation of her absconding risk following absconsion on 15 August.
- The exploration with the MHSU of the re-emergence of her beliefs regarding being pregnant and being bitten by vampires and what had triggered this.
- The need to institute testing for substance misuse in light of the sudden and rapid deterioration in her mental state following her absconsion on 15 August.
- The management of the MHSU's incontinence following the second episode of this on 17 August.
- Monitoring of her physical health following a clear deterioration in this from the night of 17 August.

To have developed a living care plan for the MHSU would have enabled all staff to have quickly familiarised themselves with her core care needs without having to read through a number of days' worth, or even weeks' worth, of progress notes.

This being said the IIT wishes to emphasise that overall the progress notes for the MHSU were of an acceptable to good standard. The IIT:

- Obtained a good sense of the MHSU from the progress notes.
- Noted regular records of the ward rounds and decisions made regarding ongoing management.
- Found evidence of the MHSU having one-to-one time with the nursing staff.

- Found evidence of communication with the MHSU's parents in the period leading to her home leave, and subsequent to this when the MHSU was unwell in the week prior to the incident (see note below).
- Found evidence of appropriate communication with medical staff about the MHSU's progress.
- Found evidence of appropriate actions following two episodes of incontinence experienced by the MHSU. The inpatient team's referral of the MHSU to the continence specialist nurse on 17 August was particularly notable.

Note: Communication with the MHSU's parents did occur in the time leading to her home leave on 11 August, and on a regular basis after this, once they had expressed their dissatisfaction to the acting ward manager about communications with them and the lack of invitation to ward-based reviews. The notes prior to 24 July reveal a distinct lack of communication with the MHSU's parents given their central role in providing support to their daughter.

Communication with the MHSU's family should have formed a component of the overall plan of care for this MHSU.

4.2 Were appropriate risk assessments undertaken? Were those risk assessments appropriately detailed and documented with accompanying risk management and relapse prevention plans?

Risk assessment is an important element of effective and safe mental health care. National director of mental health, Professor Louis Appleby, has stated in the Department of Health guidance "Best practice in managing risk" (June 2007) that "a good therapeutic relationship must include both sympathetic support and the objective assessment of risk" (page 5). Although this document was published after the incident involving this MHSU, the sentiment expressed has long been espoused.

In the case of this MHSU, risk assessments were performed on 3 March 2006 and 16 June 2006. The Investigation Team's analysis of each is presented below.

4.2.1 The risk assessment conducted in March 2006

This risk assessment was appropriately completed by the Walsall CMHT responsible for the MHSU. There is also clear recording of the MHSU's and her brother's participation in the risk assessment process. This represents good practice. The risk assessment document also makes clear that the date for risk review was November 2006, i.e. in six months' time, which was an acceptable time period.

The design of the risk assessment tool used combined an actuarial and narrative approach which enabled staff to clarify the most significant issues and also to provide contextual information about the risks identified. A common criticism of mental health risk assessments can be the lack of contextual information recorded. The investigation team cannot make this criticism here.

The risk assessment undertaken in March 2006 evidenced that important information was obtained from the MHSU's brother regarding the MHSU's previous history of violence. The assessment states:
"The MHSU's brother said his sister has been violent in the past when relapsing due to her non-compliance with medication. Police have been involved a number of times as the ambulance staff would not take her to hospital. She has fought with her brother and her parents."

This risk assessment also shows evidence of referring to the information provided by the previous mental health provider in Kent:
"From previous risk assessment (23/12/05) it is mentioned that the MHSU became verbally aggressive towards staff on the ward and other patients while in Essex." It was also noted that she attacked another patient and that she had attempted to abscond on two occasions.

The risk assessment also stated that the historical information provided said that the MHSU had used cannabis in the past.

The risk assessment also detailed past abuse suffered by the MHSU from her son.

Given the diligence with which appropriate information was extracted from the information given by the previous mental health provider, and the MHSU's brother, it was somewhat disappointing that there was no documented contingency, or risk management and relapse plan for the MHSU. The development of both of these plans is the natural progression following the completion of a risk assessment. Good practice states that these plans should be developed in partnership with the service user and also any substantive carer(s).

4.2.2 The risk assessment conducted in June 2006

The IIT was pleased to find that this was completed on the day of the MHSU's compulsory admission to hospital under Section 3 of the MHA.

As with the risk assessment completed in March 2006, the June assessment makes reference to information provided by the mental health service in Kent in December 2005.

Direct comparison with the assessment completed in March showed that most of the same issues were noted.

Unfortunately, as with the March assessment, the assessment in June did not result in the development of any risk management plan for the period of time the MHSU was an inpatient.

With the MHSU's history of previous absconsion from inpatient units, and also the level of uncertainty regarding her alcohol and substance misuse, it would have been prudent for a risk reduction and risk management plan to have been clearly formulated and documented. The IIT suggests that such a plan might have included the following:

1. "The MHSU has a past history of absconding when an inpatient. Therefore the plan is for:
    - Timed observations of 15 minutes during the initial assessment phase so that a more realistic assessment of her absconsion risk can be achieved.
    - The MHSU not to leave unescorted until she has stabilised on the ward.
    - Clear boundaries should be set with the MHSU, when staff consider it acceptable for her to leave the ward unescorted, regarding where she can go."

2. “Staff need to try and find out whether the MHSU continues to use cannabis and to what extent. In addition:
   - If the MHSU does abscond, then on return to the ward efforts should be made to obtain a urine sample for drug screening.

   - If the MHSU gives her consent for ward staff to liaise with her parents and brother, then efforts need to be made to sensitively explore the MHSU’s possible past and current alcohol and cannabis use with them. “

3. “In light of the previous violence and aggression incidents experienced by previous inpatient units, until stabilised, and out of her acute psychotic state, the MHSU will be nursed in a room where she can be easily observed. An observer will also be required in the communal area to enable accurate assessment of how the MHSU interacts with other service users.”

4. “In view of the MHSU’s non-communication with the ward team and doctors, the team needs to consider whether it is in her best interests to communicate proactively with her parents and brother even though we do not have her express consent to do so. The team’s decision about this needs to be clearly documented in the progress notes.”

4.2.3 Interviews with staff about the MHSU

At interview the ward staff were consistently able to recall information about the MHSU that showed that they were aware of:

- her previous history of absconding;
- the violence and aggression on other units;
- the history of medication non-compliance;
- the MHSU’s neglect of herself when unwell;
- the support provided to the MHSU by her brother and her parents; and
- the potential past history of substance misuse.

However, there appeared to be no recognition in the staff that a risk management plan might have been required. The IIT can understand why staff may not have considered a plan necessary. The information they provided revealed that as they got to know the MHSU they did not see any evidence of violence and aggression in her. The consistent recollection of staff was that she had childlike qualities, and was malleable and open to persuasion. However the “at the time” recollections did not negate the need for a well thought out risk management plan given the unpredictable nature of the MHSU’s illness, her behaviour when unwell, and her vulnerability.

A number of staff interviewed told the IIT that she could transgress the personal boundaries of others which made her vulnerable on at least one occasion to physical attack. They also recalled an occasion where she was

wearing another patient's shoes and was not amenable to leaving the smoking room and level one restraint was required to escort her to her room. Over and above this, the staff did not recall this MHSU being a risk to anyone. There were, in the opinion of staff, other patients on the ward at the time with significantly greater risk issues.

It is fair to say that the staff were shocked by what subsequently happened as there were no indications that this MHSU could or would pose such a risk of harm to another person.

4.2.4 Comment by IIT

Although the two risk assessments undertaken were reasonable, there should have been updates made to the inpatient risk assessment following the MHSU's absconsion on 15 August.

The MHSU's mental health state was markedly better in the time leading to her home leave, and the report from her parents was that her home leave had gone well. Following her return from home leave on 14 August and subsequent AWOL on 15 August, there was a marked deterioration in her mental state and then in her physical health.

As previously identified, at the time of admission to inpatient services in Walsall the MHSU was relatively unknown to inpatient staff, and therefore the inpatient team should have erred on the side of caution in relation to:

- measures instituted to minimise the risk of absconding; and
- measures to test out whether or not the MHSU continued to misuse alcohol and cannabis, including a plan for drug testing following any AWOL incident.

The IIT knows from its interviews with staff that they did not even consider a drug screen for this MHSU.

With regard to the MHSU's absconsion risk, bar level two (15 minute) observations being implemented, there was no real consideration of this risk at all by staff as far as the IIT can ascertain.

At the time:

- The ward was an unlocked ward where service users could come and go. They were expected to sign a signing out book when leaving the ward and the ward staff tried, where possible, to place a sentry at the door to prevent those service users who should not leave the ward unescorted from leaving. However, this was not always achievable owing to staffing difficulties and ward pressures.
- The whole hospital site was open. A service user could walk out of the hospital easily. There was nothing to stop them. This situation was not unique to Walsall.
- The custom and practice in across inpatient services was that all service users on level two observations were allowed off the ward unescorted and could wander freely in the hospital grounds, including up to the shop at the end of the hospital road. During the

investigation staff, including senior management staff, asserted that this was in keeping with the Trust's policy at the time. It was not. The policy ratified in 2002 and in use in 2006 said, "subject to an appropriate risk assessment, a service user on level 2 observations could leave the ward unescorted". The overwhelming impression given to the IIT is that the requirement for risk assessment had been forgotten by all.

In the case of this MHSU although her day-to-day care was good in that staff were attentive to each presenting need, their awareness of the need for objective risk assessment on a daily basis was absent.
Furthermore that none of the information detailed in the risk assessment plan on admission was formulated into a risk management plan, or included in the MHSU's care plan, constitutes a lapse in the standard of care expected.

For the most part the lack of a risk management plan had no adverse affect on the MHSU's care and treatment because emerging issues were managed appropriately as they arose.

The exceptions to this, as previously stated, were:

- The absence of a clear plan to manage the MHSU's absconsion risk.
- On 21 August had this MHSU had a risk plan, and an up-to-date care plan where all the adverse occurrences that had occurred between 15 and 18 August were clearly documented, then there would have been an increased likelihood that she would not have been allowed to leave the ward unescorted. As it was staff did not appreciate at all her increasing risk profile in relation to her vulnerability.

The impact of the lack of ongoing objective risk assessment for this MHSU is detailed in sections 4.4 (page 37) and 4.5 (page 38) which deals specifically with the events of 21 August.

4.3 In the two weeks preceding the incident was the care and management of DE reasonable in relation to:

- **staff perspectives of her risks?**
- **staff awareness and attention to her physical health needs? and**
- **the mental health nursing observations prescribed and carried out?**

The lack of structured risk assessment notwithstanding, between 7 July and 22 August 2006 the MHSU received a very good standard of care from the mental health service in Walsall. The evidence for this is as follows.

- All appropriate preparations were undertaken in readiness for her extended home leave period between 11 August and 14 August.
- Following her absconsion from the ward on 15 August the missing persons procedure was activated appropriately including timely notification to the police, and senior Trust management staff.
- As already stated, following two separate episodes of incontinence, the nursing and medical staff took appropriate action to investigate the cause of this. That is, ward-based urinalysis was performed and also a specimen of urine was collected for culture and sensitivity testing. Furthermore the MHSU was referred to the continence specialist nurse.
- The nursing staff were mindful of the MHSU's sensitivity/allergy to penicillin and raised this correctly with the medical staff who had prescribed this following the second episode of incontinence. Erythromycin was subsequently prescribed as an alternative. (The MHSU was already on trimethoprim for long standing and recurring urinary tract infections).
- When clear evidence of a relapse in her mental state presented itself, she was assessed by her medical team and an immediate dose of olanzapine 10mg was administered. In addition to this her regular dose was also to be administered at 10pm.
- On 18 August when beginning to neglect her hygiene needs, an indicator of relapse in this service user, staff assisted and encouraged her with her hygiene.
- Also on 18 August when the MHSU was noted to be looking "quite unwell, with puffy eyes and expressing feeling unwell" physical observations were undertaken which showed tachycardia but in all other respects her observations were normal. The records state "Medics are aware of her physical and mental health deterioration. Olanzapine is to be increased to 20mg olanzapine today".
- At 8.45pm on 18 August, the duty doctor was asked to assess the MHSU as she continued to appear unwell. During the doctor's assessment the MHSU collapsed. Three cycles of cardio-pulmonary resuscitation (CPR) were required to re-establish respiration and cardiac output. The MHSU was correctly placed in the recovery

position and 2% oxygen was administered. She was then transported to the nearest A&E department by ambulance.

- The MHSU was accompanied at all times by a member of her ward team while she was in A&E. (The MHSU returned to the ward at approximately 10.15pm the same night. A&E could not find any cause for her collapse).
- On 19 August nursing staff asked for further medical input as the MHSU had a prominent groin rash.
- On 19 August at approximately 10am, the assistant ward manager spent time with the MHSU's parents explaining the events of the past 12 hours to them. This individual also told the MHSU's parents the times their daughter's reviews were to be held, as they advised that they had not yet been invited to any[6]. The nursing records show subsequent regular communication with the MHSU's parents.
- On 19 August, there was a good quality medical review and the assessing doctor communicated with A&E to ensure that he had a complete understanding of the tests conducted and their findings. The records clearly state "they found all physical examinations as normal apart from low air entry at lung bases".
  This doctor also noted all of the blood results for the MHSU in the records. These were all within normal range except for the white blood cell count which was 13.4, with her neutrophil count at 8.3. Her chest x-ray and ECG were also noted as normal.

  The doctor's physical examination states "pt fully conscious, able to walk with little discomfort, breathing normally, communicating well."

  The plan was to:
  - commence her on an anti-fungal ointment for the rash in her groin area and lower abdomen;
  - undertake physical observations of pulse, blood pressure, respirations and temperature twice a day; and
  - to ensure all blood culture results were entered into her notes.
- On 20 August the MHSU reported lower back pain and was sick after having a bath. The medical staff were, again, asked to assess her. The MHSU's mother was also updated on progress and current presentation as agreed on 19 August. The MHSU was seen by a member of the medical team within an hour of the request being made. She confirmed the continuation of back pain, but the doctor found her overall presentation to be improved from the day before: "brighter more communicative and smiling appropriately". The medical plan was enhanced to include erythromycin 250mg four times a day to address suspected infection shown by blood results.

[6] The clinical records show that the MHSU's parents did attend the ward rounds of 24 and 31 July.

The doctor also asked for the evening dose of olanzapine to be omitted due to the drowsiness being experienced by the MHSU.

- On 21 August the nursing records show that the MHSU was tearful at around 7am but was comforted with "good effect". It was noted that she had breakfast and at 10am the records note that she had been seen in the corridor outside one of the wards by the vending machine.
  This was the last time the MHSU was seen by ward staff.

4.3.1 Comment by IIT

Although the clinical records and the additional information shared by nursing staff at interview shows that the MHSU received a good standard of care in the two weeks preceding the incident, the IIT needs to highlight a number of concerns:

- The lack of an up-to-date and appropriate care plan for the MHSU following her absconsion from the ward on 15 August. (This has already been highlighted in this report in section 4.2).
- The lack of any documented plan of nursing care following the deterioration in the MHSU's physical health.
- The lack of evidence that physical observations occurred twice a day from 19 August.
- The lack of any care plan pertaining to the need for mental health nursing observations.
- The lack of risk assessment regarding the appropriateness of the MHSU being able to leave the ward unescorted as per guidance in the Trust's observation policy of September 2002. (This has already been highlighted in this report).

In highlighting these concerns the IIT is not saying that had the care plans been documented, care would have been markedly different to that actually delivered. However, staff might have perceived the MHSU differently and had a better picture of how ill she really was.

At interview the IIT did identify some ambivalence regarding the MHSU's physical ill health, and a complete lack of appreciation in at least one member of staff of the significance of her physical health problems. This the IIT found concerning, especially when the majority of staff were able, when presented with the collection of events between 15 and 18 August 2006, to see that this was not a woman who should have left the ward unescorted by virtue of the uncertainty around her physical health.

A lack of appreciation among staff of the global picture for the MHSU meant that on 21 August there was not a full appreciation of her needs, or the levels of risk she posed both from a mental health and physical management perspective.

4.3.2 Why were care and risk plans not formulated?

Three years after the event it is unreasonable to expect staff to recall precisely why expected activities did not happen. However all of the staff the IIT interviewed had good recall about the circumstances of their working environment at the time. The consistent messages communicated to the IIT were:

- The ward was constantly busy. They felt stretched all the time.
- The ward had opened a four-bedded, locked-door high dependency unit for female patients, at the end of the ward, following the closure of the intensive care ward that had previously managed this type of patient.
- The staff recalled feeling constantly stressed and overwrought. Anxiety levels were also high regarding their ability to manage the female patients who had previously been cared for on the intensive care ward. Staff did not feel confident with this type of higher risk patient.
- Staff told the IIT that they did not have as much time for the "traditional" inpatient because of the needs of the intensive care patients they were now caring for. It was all, in the opinion of staff, quite unsuitable. The IIT had a real sense of frustration from the staff interviewed. In fact a number of staff became quite emotional when recalling their working situation in 2006. It was clear to the IIT that the staff were deeply unhappy about it at the time, and for some this unhappiness remains.

To summarise, it seems to the IIT that the staff on the MHSU's inpatient ward were stretched to the limits during the summer of 2006. Organisational changes had occurred which meant that part of their ward had been converted to accept female patients who had a higher level of risk and care need than was customary for the ward. Indeed the "new" patients[7] required a locked door facility and constant observation. The resulting increased workload, coupled with an increase in staff anxiety regarding their ability to manage the higher risk patients was (the Investigation Team believes) a significant contributory factor to staff not being able to maintain expected standards in relation to care planning and risk assessment.

One cannot suggest however, that the delivery of good and appropriate care was not in the minds of the staff, or that they did not deliver a good standard of care on a day-to-day basis. The care delivered to this MHSU shows that they did.

However, the lack of a dedicated risk assessment following a significant change in the circumstances of the MHSU, and of a clearly defined plan of care during this period of ill health for the MHSU, did (the Investigation Team

[7] That is "new" patients for the general adult in-patient ward rather than new patients to the mental health service per se.

believes) influence the sequence of events on 21 August. This was the day the MHSU went AWOL from the ward (see the following section 4.4).

4.4 Was it reasonable to allow the MHSU off the ward unescorted on 21 August 2006?

This aspect of the IIT's analysis of the MHSU's care and management proved to be the most contentious amongst the ward staff interviewed. It is the opinion of the investigation team that the MHSU should not have been allowed to leave the ward unescorted on 21 August 2006.

The reason staff allowed the MHSU off the ward was because she was on "level 2" mental health nursing observations and staff believed that individuals on this level of observation were allowed to leave the ward. The only requirement was for them to remain on hospital grounds.

The IIT reviewed the "Observation Policy and Procedure September 2002" which was the policy document staff were working to in 2006. The policy document states under "Level 2 Observations":

"The patient may leave the ward subject to appropriate risk assessment and as part of a defined care plan".

The interpretation of this by all of the staff the IIT met during one-to-one interviews and via round-the-table discussion was that service users could leave the ward if they were on level 2 observations. These meetings included front line staff and senior managers responsible for the delivery of mental health services at the time the incident occurred. This is not what the policy says at all.

Because wrongful interpretation of the policy was so widespread it is difficult to be overly harsh with the nursing staff on duty on 21 August. They were doing what they always did. However, it is the IIT's view that to a large extent it should have been common sense for staff not to allow the MHSU off the ward unescorted. The IIT's rationale for this is that although the local acute hospital A&E department had returned the MHSU to the psychiatric in-patient unit, they had been unable to find a cause for her collapse on 18 August. Consequently one reasonably would have expected some degree of caution in the ongoing care management of the MHSU until time showed that her health had improved and that the risk of a further unexplained collapse had reduced.

Interestingly, at interview when all of the features of the MHSU's presentation between 15 and 19 August were set out for staff to reflect on, at least three of the nursing staff were able to say immediately that had they considered her presentation in such a logical manner then they would not have entertained the thought of the MHSU leaving the ward unescorted on 21 August.

The IIT also tested the MHSU's scenario with in-patient staff working in a city-based adult services inpatient unit[8]. All of these staff said they would not have allowed the MHSU, given the history of the previous week, to go off the ward unescorted.

4.5 Were the actions of staff appropriate once it was discovered that the MHSU had gone missing?

Although the police were notified once it was discovered that the MHSU was missing from the hospital grounds, it does not appear that the police were advised of the following when they were notified of the AWOL:

- that the MHSU had collapsed three days previously, required three cycles of CPR and that no cause had been identified;
- that there had been a deterioration in her mental health;
- that she was delusional and easily frightened;
- that she could behave inappropriately with others and that this made her vulnerable;
- that she had gone AWOL on 15 August and was only returned to the ward when she called an ambulance and the ambulance staff subsequently called the police because she was aggressive with them; and
- that she was a vulnerable person.

Had good quality information been provided to the police at the time the MHSU went missing then a more urgent response from the police may have been elicited. However, this does not mean that she would have been located. The circumstances of what is known to have occurred following the MHSU's absconsion suggests that better information exchange between mental health services and the police would not have made a material difference.

The Trust's "Policy for Dealing with Missing and Absconding Patients/Residents" (2004) was reviewed by the IIT. It appears that staff did act in accordance with this on 21 August.

However in its review the IIT identified a lack of criteria for distinguishing category 1, 2 or 3 patients in terms of actions to be taken.

The defined categories at the time were:
Category 1:

- Any patient who is detained under Section 37/41 of the Mental Health Act.
- Any patient who has a history of violent conduct towards others.
- Any patient who has a history of serious sexual abuse.
- Serious risk of self harm or suicide.
- History of paedophilia.
- Vulnerable due to confusion.

[8] Note: none of these staff were informed of the subsequent incident that occurred.

Category 2:

- Missing from ward. Responsible for own actions. Not considered at serious risk. Staff may be aware of where patient is or where they are going to.

Category 3:

- No cause for concern. Only reported in line with policy.

The IIT considers that Category 1 should have included:

- "any detained patient" not just those on section 37/41. The hospital is responsible for all detained patients – by default they are not responsible for their own actions; and
- patients who are vulnerable persons - not just vulnerable due to confusion. This MHSU was a vulnerable person and her behaviour when unwell increased this. Her "lovingness" towards others, belief that others may be vampires, etc, made her very vulnerable.

The IIT also identified that although a missing person's form was provided there was no fax pro forma for onward transmission to the police. The practice and expectation was, and remains, that staff provide verbal information to the police "providing general details and risk history". The policy at the time stated:
"The Team Leader (bleep holder) will ensure that all relevant information is communicated to the police. The tPCT communication office and Risk Manager need to be advised by the Team Leader (bleep holder)."

This is insufficient to ensure that a consistent standard of information is communicated. The IIT suggests that at minimum the following information should reliably be communicated:

- name of service user (full name and `likes to be called');
- description (height, weight/build, hair and eye colour, hairstyle);
- age and date of birth;
- diagnosis;
- detained patient: Yes/No;
- risk of harm to others;
- risk of harm to self;
- risk of vulnerability (neglect, exploitation, abuse, putting self into dangerous situations);
- other behaviour that may put the service user at risk;
- significant issues of concern in the days leading to AWOL (including physical health issues);
- next of kin details;
- known haunts; and
- any defining marks or features.

4.6 Comment on the internal investigation conducted by Walsall PCT

The risk manager for the then Walsall PCT undertook an investigation following the incident involving the MHSU. This investigation identified four key concerns:

- Integrated care documentation not fully completed.
- No evidence of care plan being amended following patient's mental health deteriorating.
- Current treatment/medication for urinary tract infection not reviewed.
- No effective procedure in place to monitor patients leaving the ward.

Although the independent investigation concurs with all bar one of these observations we do not agree that they constitute care management concerns. Bullet points one and two are in fact contributory factors to staff not properly appreciating the increased complexity of risk presented by the MHSU by 21 August.

With regard to the management of the MHSU's urinary tract infection (bullet point 3), the independent investigation team found this to be as good as one would hope for from inpatient psychiatric services. Staff showed good attention to the MHSU's medication and she was placed on appropriate additional antibiotics in additional to her routine prescription of trimethoprim.

With regard to the "no effective procedure in place to monitor patients leaving the ward" (bullet point 4), the only way to guarantee absolute monitoring of this on a busy inpatient psychiatric ward would be to lock the ward, and for service users to ask for access/egress. At the time there was no lock on the door to the ward and Walsall PCT did not have a locked door policy at the time of this incident. It remains the case today that there is no lock on the ward door. Dudley and Walsall Mental Health Partnership Trust does not lock the doors of its inpatient wards[9].

The individual staff appointed by Walsall PCT to conduct the investigation did utilise two appropriate investigation tools, namely the timeline (simple not tabular[10]) and control or barrier analysis (see glossary page 59), and this is to be commended.

However, the timeline was not as detailed as it could have been. Insufficient attention was given to the MHSU's inpatient chronology in June and July 2006. Had a more detailed timeline been created Walsall PCT may have had the opportunity to have explored more fully, and at a time where the relevant

[9] It is important to note that the mental health trust now has a very secure environment and even though service users can leave the confines of the ward area it is not easy for them to walk out of the hospital and into public space.

[10] A simple timeline is one where the date, time and relevant part of the chronology is noted. A tabular timeline provides space for these fields and the additional fields of good practice, care delivery and/or service delivery concerns, and questions that need to be asked. (Walsall PCT did include potential care delivery concerns in its timeline).

staff remained under the employ of the PCT, the reason why this MHSU did not receive clozapine as was the clinical plan on 10 July 2006.

A more detailed timeline coupled with a critical analysis of the existing policies and procedures would also have highlighted the significant gap in understanding between staff interpretation of the nursing observation policy and what it actually says.

With regard to the control/barrier analysis conducted, this was good. The internal investigator identified that having an individual based as “door sentry” when staffing levels and the demands on the ward allowed was a weak intervention. A range of other measures was therefore identified to enhance the reliability with which inpatient services can be aware of service users leaving the ward environment.

These were to:

- Relocate the ward office nearer to the ward entrance.
- Review the security mechanisms for controlling access and egress.
- Increase the ward clerk role and hours to support enhanced security.

On 17 October 2006 the Chief Executive Officer of Walsall PCT requested further investigation into the care and management of the MHSU. The two individuals tasked with a more in-depth investigation were the Director of Nursing and Community Services and one of the Directors of Mental Health.

The IIT had no access to the formal investigation report that was generated as a result of this until 12 October 2009 when feedback was provided to the IIT on its report. This report did not reveal any additional information to that highlighted by the initial investigation conducted by the then risk manager.

5.0 What action the former PCT, and Dudley and Walsall Mental Health Partnership Trust, have taken following the recommendations of the PCT's internal report published in 2007

As already highlighted in this report considerable physical alteration was made to the hospital site as a consequence of the incident involving this MHSU.
These included:

- The relocation of the Outpatient Department with its own entrance directly from the car park. This immediately reduced the number of people accessing the main part of the hospital.
- Access to the Outpatient Department from the main part of the hospital is also restricted so that it cannot be used as a thoroughfare.
- The main entrance to the hospital was redesigned to incorporate an "air lock" system, requiring all visitors and patients entering or leaving the building to do so under control. All staff now use an electronic swipe card system to gain entry to the hospital.
- CCTV cameras were re-sited as recommended by the police.
- Entry to staff-only areas is restricted by use of keypads.
- The garden area has been enclosed.
- Windows in the duty area and on corridors are now reinforced, and suspended ceilings in Windermere Ward at the Dorothy Pattison Hospital have been removed and replaced by plaster ceilings in the main patient areas, bedrooms and bathrooms.

The PCT also introduced a locked door policy on 22 March 2007. This makes clear the right of the ward manager of an open ward to lock the doors whenever he/she believes it is the best interests of the patients. Unfortunately none of the wards have locks on the doors so the policy document provides for an activity that cannot take place.

With regard to audit of the standard of record keeping, Dudley and Walsall Mental Health Partnership Trust believes that it now has a robust three stage audit cycle in place. This is led by the inpatient clinical lead. The deputy ward manager on each ward conducts an audit on a two weekly rota and ward managers conduct the same on a six weekly rota. The whole process is overseen by the clinical lead.

In addition to the above the Head of Governance and Partnerships at Dudley and Walsall Mental Health Partnership Trust advised the IIT that:

- Staff are aware that service users on 15 minute observations should not leave the ward without being risk assessed.
- Biometric testing has been installed as an additional safety measure.
- There is now weekly monitoring of the level of observations introduced so that risks and staffing capacity to carry these out can be monitored.
- There is now a system in place to check that risk assessments are in place and up-to-date. This system is incorporated into the ward

reviews. The clinical lead for inpatients has responsibility for monitoring that this process is working.

6.0 Conclusions

The IIT has carefully analysed the MHSU's care and treatment by the statutory mental health service in Walsall. As a result it has drawn the following conclusions.

6.1 Positive feedback

- It was exemplary practice that the community mental health team in Kent, who were caring for the MHSU up to the end of December 2005, attended a meeting with the MHSU's Walsall-based community mental health team to ensure an effective handover of care.
- The community management of the MHSU was very good in Walsall.
- The day-to-day care provided by the acute psychiatric inpatient service to the MHSU was very good in that staff responded to the MHSU's needs appropriately as they arose.
- The medical staff appropriately made contact with the MHSU's previous care providers in Kent to ensure that they were as well informed about her as they could be. They also made contact with the MHSU's previous consultant psychiatrist when she was not responding to treatment as expected.

6.2 Areas that could have been improved

- The documentation of the MHSU's care plan. This should have been more structured and more detailed.
- The assessment of risk. This should have been repeated after the AWOL incident on 15 August and following the MHSU's collapse on 18 August. Her tendency to invade the personal space of others should also have been considered in relation to risk vulnerability.
- The clozapine (Clozaril) prescribed for the MHSU on 10 July 2007 was not commenced. The MHSU was commenced on zuclopenthixol (Clopixol) depot injections instead. This appears to have been due to concerns raised by the MHSU's parents at the ward round of 14 July which was led by a locum consultant and not the patient's own consultant. There is no available information to say i) why the patient's own consultant did not lead the ward round and ii) what the MHSU's wishes were at the time. Prior to the attendance of the MHSU's parents she was noted to be "looking forward" to the medication.
- The information provided to the police on the morning of 21 August 2006. Although the PCT policy was followed, the use of a dedicated fax pro forma may have ensured greater robustness in the information exchange between the two services.

6.3 Predictability

Although the MHSU's historical records show a degree of aggressive behaviour when unwell, she had no forensic history and her acts of aggression were not such that any professional would have considered her to present an immediate risk to members of the public when in relapse.

It was however predictable that this MHSU would go absent without leave from time to time. This risk was not appropriately managed by her inpatient care team in 2006 following her episode of leaving the ward on 15 August. Instituting 15 minute observations without proper consideration of the appropriateness of unescorted leave was not adequate.

6.4 Preventability

Had this MHSU not been allowed off the ward unescorted on 21 August the incident that subsequently occurred that night, or on the early hours on 22 August, would not have happened.

The MHSU's presentation between 15 August and 21 August was such that any reasonable risk assessment should have resulted in a decision for escorted leave only until such time as her physical and mental health had properly stabilised. This perspective was shared by a number of staff interviewed by the IIT when they looked holistically at the MHSU's presentation in the six days preceding the incident. It is also shared by an independent group of inpatient nursing staff asked to consider the MHSU's presentation and whether or not she would be suitable for unescorted leave. All of the nurses asked said that they would not have allowed the MHSU off the ward unescorted.

7.0 Recommendations

The mental health service in Walsall has already invested heavily in improving the security of its inpatient services following this incident. It is now very difficult for service users to leave the hospital unescorted. The IIT walked around the hospital site and was shown a number of the security measures implemented. The measures instituted appear to be robust and the IIT therefore, has no additional recommendations in relation to site security.

However, the IIT does have recommendations relating to policy and practice.

Recommendation 1: Nursing observations policy
The wording of the current nursing observation policy in use by inpatient staff at the Dorothy Pattison Hospital remains ambiguous with regard to the Trust's expectation regarding standards of practice, and the assessment required before allowing a patient to have unescorted leave.

The IIT recommends that the wording in relation to level 2 observations is altered to include the following:

"For service users placed on timed observations of 15 minutes (level 2) a risk assessment must be undertaken before any decision is made regarding their being able to leave the ward area unescorted. This risk assessment must be documented as part of the recorded care plan for the service user.

*Staff must note that service users on level 2 observations are **NOT** automatically granted 'unescorted leave' from the ward simply because they are on level 2 observations."*

Unless the wording of the policy document is tightened up the policy will continue to remain vulnerable to misinterpretation.

In addition to revising the wording of the policy document, the IIT suggests that:

- The risk assessment training provided to staff needs to emphasise that a clearly documented risk assessment should be an integral part of the decision making process regarding unescorted leave.
- All ward managers are required to highlight this element of practice at ward meetings as the IIT sensed a continuing lack of clarity amongst staff on this point.
- Future audits of nursing observation practice should include audit of the presence of an appropriate care plan and risk assessment and a log of outcome regarding escorted or unescorted leave.

Implementation:
Dudley and Walsall Partnership Mental Health Partnership Trust must be mindful that what the IIT have recommended represents a significant culture and practice change for the staff at the Dorothy Pattison Hospital. We do not know how much of a practice change the recommendation represents for other inpatient staff across the Trust.

Consequently how any change in practice expectation is communicated to staff will be important, as will the early monitoring of implementation to ensure that change occurs.

Timescale: The IIT can see no reason why the change in wording to the nursing observation policy document cannot have been accomplished prior to the publication of this report.

Dudley and Walsall Mental Health Partnership Trust must set out its methodology and the timescale for implementation of the other parts of this recommendation in the action plan submitted to West Midlands Strategic Health Authority (SHA). How the Trust will test the effectiveness of implementation should also be detailed in this plan.

Target audience:
Dudley and Walsall Mental Health Partnership Trust Integrated Governance Group.

Recommendation 2: Audit of nursing documentation
The observation documents reviewed by the IIT do not show that a therapeutic encounter takes place at each observation for service users on level 2 observations. The IIT also found the content of the nursing progress notes to be variable in this respect. This needs to be remedied.
The IIT suggests that consideration is given to redesigning the observation record form so that every hour, space is provided for the observation nurse to record his/her perspective of how the service user is, their interactions, and mental state etc. The IIT believes that this is more likely to result in an improvement in the clinical record made as opposed to reminding staff to making timely updates in their progress notes.

Time scale: The changes to the form used for documenting nursing observations should be achieved within four weeks of West Midlands SHA accepting this report. How Dudley and Walsall Mental Health Partnership Trust will implement the revised documentation, and its timescales for doing so, is for the Trust to set out in its action plan submitted to West Midlands SHA. How the Trust will test the effectiveness of implementation should also be detailed in this plan.

Target audience:
Dudley and Walsall Mental Health Partnership Integrated Governance Group.

Recommendation 3: Obtaining medical records from previous mental health providers

Although the MHSU's previous mental health provider in Kent supplied the mental health service in Walsall with very good quality information, this did not replace the rich information that would have been obtained from a thorough review of her clinical records between 1993 and 2005. The chronology in Section 1 of this report provides a depth of information that would have been useful to the Walsall service. It is possible that had the previous records been requested by Walsall, and an historical overview compiled, then staff perceptions about the MHSU may have been different. That is, they may have better appreciated her risk factors and been less taken in by her immediate, childlike presentation.

The IIT therefore recommends that whenever a mental health service user is transferred into the Dudley and Walsall Mental Health Partnership Trust from another mental health provider that consent is sought during the transfer process for the Trust to request copies of all previously created records. At the very least such a request should ask for copies of:

- all MHA assessments;
- all discharge summaries;
- all risk assessments;
- all Care Programme Approach (CPA) paperwork;
- all correspondence to GPs; and
- all admission assessments.

Timescale: The IIT considers that it should be achievable for Dudley and Walsall Mental Health Partnership to design an appropriate consent form and to request previous records routinely during patient transfers into the Trust within six months of the acceptance of this report by West Midlands SHA.

The detail of its plan for achieving this, and testing that implementation has been successful, should be set out in the action plan provided to the SHA.

Target audience:
Dudley and Walsall Mental Health Partnership Integrated Governance Group.

Recommendation 4: Use of the Walsall "Patient Alert Procedure"
The IIT noted a very useful documentation tool called the "Patient Alert Procedure" when it reviewed the Walsall records pertaining to the MHSU. Unfortunately it had not been used. Had it been used there is the possibility that staff would have more easily grasped the increased vulnerability of the MHSU between 15 and 21 August 2006 and managed her more appropriately in relation to escorted leave from the ward. It would also have assisted in the information transfer to the police on the morning of 21 August.

It is recommended that Dudley and Walsall Mental Health Partnership Trust undertakes a review of all of the documentation tools provided to staff working within adult based inpatient services to determine how these tools are being used. If the review reveals documentation tools that are not being used and the Trust determines that they are tools that should be retained, then it will need to establish why the tools are not being used and educate its staff in their use.

Subsequent audits to test out the effectiveness of any training intervention will also be required.

Timescale
It is recommended that the audit of usage of Trust-provided documentation tools occurs on a ward-by-ward basis using a simple trust-designed audit tool. The audit needs to be completed and presented to the Adult Services Governance Committee within six months of the acceptance of this report by the West Midlands SHA. What the Trust does thereafter will be determined by the audit results.

Target Audience: Dudley and Walsall Mental Health Partnership Integrated Governance Group.

Recommendation 5: Inclusion of fax pro forma in missing persons policy
Dudley and Walsall Mental Health Partnership Trust's policy for dealing with situations where a patient has gone missing must maximise the opportunity for effective communication with the police.
The IIT suggests that use of a fax pro forma for communicating information should be part of this policy.
The following represents the individual data fields that such a form might accommodate:

- name of service user (full name and 'likes to be called');
- description (height, weight / build, hair and eye colour, hair style);
- age and date of birth;
- diagnosis;
- detained patient Yes / No;
- risk of harm to others;
- risk of harm to self;

- risk of vulnerability (neglect, exploitation, abuse, putting self into dangerous situations);
- other behaviours that may put the service user at risk;
- significant issues of concern in the days leading to AWOL (including physical health issues);
- next of kin details;
- known haunts; and
- any defining marks or features.

Timescale: The IIT suggests that this recommendation can be implemented within a relatively short period of time. Timescales for design and implementation must be clearly stated on the action plan submitted to West Midlands SHA.

Target audience:
Dudley and Walsall Mental Health Partnership Integrated Governance Group. The Police Liaison Officer for the Trust.

APPENDIX 1 CHRONOLOGY

3 March 1993: The MHSU first came into contact with specialist mental health services on 3 March 1993 when she was admitted to Runwell Hospital in Essex. At this time she had a labile mood, believed that her husband wanted to kill her and that her kidneys were not working. She was experiencing thought and auditory hallucinations. Her behaviour was also very disturbed to the extent that she required to be detained on a compulsory basis under Section 2 of the Mental Health Act (MHA) 1983. She was treated with antipsychotic medication and her condition appeared to improve. Consequently after a period of successful home leave she was discharged home.

The MHSU had two subsequent hospital admissions in 1993, one in late March and the other early June. Both were as a result of medication non-compliance and subsequent deterioration in her mental state.

At this time she was preoccupied with vampires, God, and black magic. The religious theme and concerns about vampires continued to trouble the MHSU between this time and the date of the incident in 2006.

June 1993 - February 2000: the MHSU required nine admissions to hospital during this period.

27 February 2000: the MHSU again deteriorated requiring further hospital admission. It is noted that she had issues of aggression in the period leading up to her admission. The aggression was towards her son (who was 16 years old). Her delusions with vampires were also a feature. The clinical records report that she was often suspicious, aggressive, and agitated and that her thoughts were disorganised. Treatment with depot antipsychotic medication resulted in an improvement in her symptoms. She was eventually discharged on 29 August 2000. However, some of her delusional beliefs persisted as they had since 1993.

August 2000 - May 2003: the MHSU successfully lived in the community supported by her community mental health team (CMHT) and her family. Throughout this time she did show signs of mental illness. On 19 February 2003 she was described as “always close to the psychotic world”.

27 May 2003: the MHSU was again detained under the provision of section 136 of the MHA. The antecedents to this were her stopping her medication and smashing up her flat. She was eventually well enough to be discharged home on 31 December 2003.

At the time of this discharge her CMHT changed because she had moved to Gravesend to be near to her parents who had moved there.

20 February 2004: the MHSU again became unwell. She was admitted to hospital. Her mental state remained very abnormal initially but eventually she was discharged on 19 May 2004.

May 2004 - December 2005: the MHSU required four further episodes of hospital care. The precipitating factors were generally medication non-compliance, and a resurrection of her beliefs regarding being pregnant and being bitten by vampires.

Care and Management In Walsall

30 December 2005: a fax was sent to the Mental Health Crisis Team in Walsall advising that the MHSU was moving to the area but had yet to be allocated a GP. The social worker who sent the fax noted that once a GP was allocated then the outgoing team would be able to make further contact with the new CMHT and a proper transfer of care could be achieved.

Attached to the fax was:

- The most recent risk assessment dated 23 December 2005. The risk assessment was comprehensive and the quality of information was good.
- The most recent Care Programme Approach (CPA) review, also dated 23 December.

9 January 2006: the Walsall Mental Health Crisis Team made contact with the Gravesend CMHT and advised that a consultant psychiatrist had been allocated to the MHSU.

8 February 2006: There was a CPA meeting for the MHSU. Present were her community psychiatric nurse (CPN), her social worker, and the locum staff psychiatrist. Also present were representatives from her previous CMHT in Kent. At this time the MHSU was living with her brother.

9 May 2006: The MHSU was seen in outpatients by a locum consultant psychiatrist. She was accompanied by her mother. At this time the MHSU was no longer living with her brother but had a one-bedroom flat of her own. Her brother however continued to support her.

The management plan was to continue with the prescribed medication of:

- olanzapine 20mg nocte (in velotab form);
- trimethoprim 100mg daily (prophylactic for urinary tract infection); and
- zopiclone 7.5mg nocte.

May 2006 to 16 June 2006: This period was relatively settled for the MHSU. There was one incident where she made a complaint about her brother that was explored under the auspices of adult protection but there was no subsequent activation of ongoing adult protection activities. The Adult Protection Strategy meeting concluded that support and surveillance via the MHSU's CPN and social worker was sufficient.

16 June 2006: The MHSU was admitted to a local acute inpatient psychiatric ward on a compulsory basis under section 3 of the MHA.

On admission the MHSU was uncommunicative with the medical and nursing staff. The records also note that she was "looking suspicious and quite hostile" and "agitated + but contained".

Inpatient Nursing Progress Records
16 – 21 June 2006
There are frequent nursing entries during this time. These show that staff did interact with the MHSU and give her one-to-one time. However the MHSU was largely uncommunicative with the staff.

21 – 30 June 2006
The nursing notes suggest that the MHSU's condition remained the same. She continued not to interact very much with others, and continued to believe she was pregnant, but she did not pose a management problem. There was no evidence of violence or aggression.

3 July 2006: the MHSU was noted to have tried to leave the ward with another patient. She was asked to return by staff and did so with little resistance.

6 July 2006: medical staff reflected on the lack of progress in the MHSU's condition. The plan was to review her medication and also to liaise with her previous medical team in Kent.

8 July 2006: the MHSU's mother raised concern about the lack of recovery or progress in her daughter.

10 July 2006: there was a ward round and the benefits of depot treatment were discussed. The MHSU did not want injections but she did agree to commence clozapine. She was also happy to have blood tests each week.

12 July 2006: a pregnancy test was performed which was negative. However the MHSU continued to claim that there was something moving in her stomach.

14 July 2006: it was noted in the nursing records that the MHSU was looking forward to commencing clozapine as she felt dopey most of the time and unable to do much. She thought the new drug would be good for her. It also appeared that the MHSU had formed some close relationships with other patients even though her interactions with staff remained minimal.

16 July 2006: the MHSU had spent some periods of unescorted leave in the hospital grounds.

17 July 2006: the weekly ward round was conducted. The MHSU was not on the ward at the time this occurred.

20 July 2006: it was noted that the MHSU was making small improvements daily and that today there was no evidence of psychotic symptoms. Over the next few days she was noted to be "bubbly and bright in mood".

24 July 2006: the weekly ward round was conducted. The MHSU's parents were present. There was discussion between the parents and the locum consultant psychiatrist conducting the ward round. As a result of this and the improvement in the MHSU's presentation, Clopixol depot injection was commenced instead of clozapine.

30 July 2006: the care plan for the MHSU was discontinued and a new plan devised with the MHSU's participation. She also signed the care plan and was noted to be pleased with it.

31 July 2006: there was a medical ward round. The MHSU's parents were present. The MHSU was noted to remain well with no symptoms of psychosis. A request was made for leave. Section 17 leave was given for an initial period of six hours with the CPN to coordinate leave arrangements. The MHSU's medications were adjusted:

- Clopixol was increased to 200mg
- olanzapine was reduced to 10mg.

S17 leave was also agreed for 6 hours with the MHSU's CPN tasked with coordinating the leave arrangements.

31 July - 7 August 2006
The MHSU was noted to be well, expressing no psychotic thoughts, interacting with others and to have had a good day with her family on 1 August.

At the ward round on 7 August it was agreed that the MHSU could have overnight leave to her parents' home. Section 17 leave and "take out" medications were also agreed for a period of seven days.
It was also planned to increase her dose of Clopixol to 300mg by depot injection on a weekly basis, to be given on 8 August.

The plan was for her to return to the ward on Friday and if all was going well she could have another period of leave.

The MHSU was provided with the telephone number for the ward. A message was also left for the MHSU's CPN regarding the leave arrangements.

9 August 2006: the CPN came to the ward to see the MHSU.

11 August 2006: the MHSU commenced her period of leave from the ward.

14 August 2006: the MHSU returned to the ward as planned. The family reported that the leave period had gone well.

Her medication was adjusted and the olanzapine reduced to 5mg. The rest of her treatment was to remain the same.

15 August 2006: it was noted that the MHSU was missing from the ward. All relevant action was taken in relation to missing persons. The police attended the ward during the afternoon to obtain full details about the MHSU. All relevant missing person forms were completed.

16 August 2006: The MHSU was returned to the ward at 11.45pm on 15 August. She said she had gone shopping to Sainsbury's. She was returned to the ward by police officers, having called an ambulance then been aggressive towards the ambulance staff. She had calmed down quickly. She is noted to have told the ambulance staff she was pregnant.

17 August 2006: the MHSU was incontinent of urine in bed and in the smoking room. She was distressed due to this. The nursing notes observed that she had recurrent urinary tract infections and was on prophylactic trimethoprim for these.

A urine specimen was taken for culture and sensitivity and a referral to the incontinence nurse made. All staff were made aware and "home contacted". A broad spectrum antibiotic was also prescribed. Initially this was co-amoxicillin but this was changed to erythromycin as the MHGSU had a sensitivity to penicillin.

The notes say: "If she tries to leave the ward, gets agitated or confrontational it is advised to increase her observation level to level two. The nursing staff agreed to this."

18 August 2006

6am: it was noted that the MHSU had had two further episodes of incontinence.

10am: it was also noted that she woke feeling agitated and tearful believing that she was going to die. She was also verbally volatile on two occasions but then apologised for this. She was noted to "remain touchy feely" with other patients and "getting up close".

The MHSU was advised that she must stay on the ward for the present time and 15 minute observations were commenced.

There was an altercation in the smoking room involving the MHSU – she was carrying another person's shoes. Staff intervened. However when they encouraged the MHSU to leave the smoking room she became resistant and wanted to push her way back in, Level one restraint was used and she was escorted to her bedroom. When the MHSU was seen by her medical team she said she was not trying to kiss anyone, but was frightened because there were vampires that were trying to bite her and she was pregnant.

12pm: it was noted that the MHSU was looking quite unwell with puffy eyes and expressing that she felt unwell. Physical health observations were

undertaken which revealed: blood pressure, 120/70 (normal), temperature 37 degrees (slightly raised), blood sugar 4.0 mmol/litre, pulse 102 (tachycardic), respirations 17 (normal).

The medical staff were advised of the MHSU's general physical ill health and the deterioration in her mental health.

Olanzapine was increased to 20mg per day.

8.45pm: the duty doctor was asked to assess the MHSU as staff remained concerned about her presentation. The duty doctor attended to assess the MHSU. Shouting was then heard from the MHSU's room. She had collapsed and the doctor was performing cardiac massage. She had no respirations or cardiac output. Three cycles of cardio-pulmonary resuscitation (CPR) were required before spontaneous respiration and cardiac rhythm were restored. The MHSU was placed in the recovery position and given oxygen. An ambulance was called to take the MHSU to A&E for assessment by the medical team.

11.15pm: the MHSU was returned to the ward via taxi with a member of the ward team. It appears that no cause for the collapse could be identified. It was noted in the nursing records that she was in good spirits.

19 August 2006: at 10am it was noted that the MHSU appeared to be over sedated. The plan was to assess her with the senior house officer when she was "up and about".

It was also noted that the MHSU's parents were extremely upset by their daughter's presentation and deterioration. They reported that they had never seen her so unwell.

The duty doctor contacted A&E to find out precisely what the outcome was of the MHSU's assessments. It was reported that all physical assessments were normal except for low air entry at the bases of her lungs. The working diagnosis was an apnoea episode. Examination by this doctor revealed no abnormalities except for a red rash around the inner thigh and lower abdomen. Consequently the doctor commenced the MHSU on an antibacterial cream.

The following was also requested of the nursing staff:

- to monitor BP, pulse, respirations and temperature twice a day;
- to contact medical staff again if her physical health deteriorated; and
- to get the blood results from the patient management system (PMS) and file these in the MHSU's notes.

20 August 2006: The MHSU was assisted with having a bath. It was noted that she continued to experience back pain although there appeared to be no identifiable cause for this. The MHSU was assessed by a member of the medical team at 12.30pm. No significant changes were noted.

21 August 2006
The early part of the morning was noted to be uneventful. The MHSU had been assisted with bathing and nothing untoward was noted excepting her rash.

10am The nursing records say the MHSU was "seen in corridor outside Langdale at vending machine.

10.30am The MHSU's mother and father had come to visit their daughter and alerted the nursing staff that they could not find her. A local search was made including a visit to the nearby corner shop by the MHSU's father, to find out whether she had visited this store.

11.22am When it was clear that the MHSU was not within the grounds of the hospital the police, senior management and the duty medical staff were informed. The police were told that the MHSU was a detained patient under section 3 of the MHA and that she had gone missing on 15 August and that on this occasion she had visited a local supermarket.

3.15pm The police made their first attempt to contact the staff a\t the Dorothy Pattison Hospital. This attempt was not successful. Further attempts were made at 3.18pm and 3.25pm. None were successful as the ward phone was engaged on each occasion.

7.30pm The police succeeded in contacting the ward to find out if the MHSU had returned. They were informed that she had not.

7.58pm The police attend on the ward and completed a '*missing from home'* form with the staff. On leaving the hospital the police checked a number of local supermarkets to find out if the MHSU had been to any of these.
The MHSU was classified, following consultation with Inspector C.M, as a medium risk.

22 August 2006 The MHSU's mother called the ward and provided her mobile number and expressed ongoing concern for her daughter's well being.

22 August 2006: Walsall PCT was informed that the MHSU was in police custody.

APPENDIX 2 INVESTIGATION METHODOLOGY

The investigation methodology was structured and embraced the key phases detailed in the National Patient Safety Agency's e-learning toolkit. Key activities were:

- Critical appraisal of the MHSU's clinical records and the identification of areas that the IIT needed to understand better.
- Document analysis.
- Face-to-face and interviews and discussions with staff who cared for the MHSU.
- Liaison with the commissioner responsible for the Independent Police Complaints Commission report into the police response to the MHSU going missing on 21 August 2006.
- Liaison with the MHSU's current consultant psychiatrist.

The investigation tools utilised were:

- Structured timelining.
- Triangulation and validation map.
- Investigative interviewing.
- Affinity mapping.
- Qualitative content analysis.

The primary sources of information used to underpin the findings of this investigation were:

- The MHSU's mental health records.
- The psychiatric report compiled for the MHSU's defence solicitor.
- The PCT's own internal investigation report.
- Interview with the MHSU's consultant psychiatrist.
- Interviews with a range of nursing staff working on the inpatient ward where the MHSU was cared for between June and August 2006.
- A round-the-table meeting with a cross section of nursing staff and managers working within adult inpatient mental health services between 2005 and 2006.
- A meeting with the parents of the MHSU.
- A review of key policies and procedures.

APPENDIX 3 GLOSSARY

Barrier Analysis:
A barrier is a control measure designed to prevent harm to people, buildings, organisations and communities. Other common terminologies for 'barriers', in this sense, are 'defences' or 'controls'. Barriers can be physical, natural, human action or administrative in nature. Physical barriers are the most reliable in terms of providing a failsafe solution to safety problems followed by barriers of time and place. Both human action barriers and administrative barriers tend to be weak in terms of failsafe. This is because they rely upon human performance for their success and humans are always fallible. This is not to say that we should not consider and use human action and administrative barriers, rather we should be more aware of their inherent dangers and ensure that we put in place other mechanisms to support the effectiveness of this control measure. For example, if one way of preventing future failure is to implement a training programme this in itself is weak in terms of failsafe. However one can make the measure more effective by ensuring it is targeted at the right people, that those for whom the training should be mandatory attend, and that the programme incorporates an assessment of understanding and competency following the programme. Finally the implementation of routine updating or refreshment in the skill may also strengthen this barrier against failure. An example of good practice in this area is in the ambulance service where paramedics must demonstrate not only competence but also the frequency with which they use their skills. If skill usage is below that required to maintain competence then refresher training and assessment is mandated for skill maintenance.

Barrier Analysis is the critical analysis of the control measures in place in terms of their effectiveness in preventing harm. This can be a pro-active or reactive process. In incident investigation work it is usually a reactive process following the collapse of a control measure. Once recommendations for safety and quality improvement have been made and implemented then a more proactive approach can be instigated to test the ongoing effectiveness of the safety controls.