

The Executive Summary of an independent  
investigation into the care and treatment of a person  
using the services of  
NHS Barnsley

Undertaken by Consequence UK Ltd

FINAL REPORT MARCH 2013

This is the report of an independent investigation commissioned by the NHS Yorkshire and the Humber to conform with the statutory requirements outlined in the Department of Health (DH) guidance “Independent investigation of adverse events in mental health services”, issued in June 2005. The guidance replaces paragraphs 33-36 in HSG (94)27 (LASSL (94)4) concerning the conduct of independent inquiries into mental health services.

The requirement is for an independent investigation of the care and services offered to mental health service users involved in adverse events, defined as including the commission of homicide, where there has been contact with specialist mental health services in the six months prior to the event.

The Independent Investigation Team members were:

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- Dr Robert Holmes, Consultant Psychiatrist, CRHT Coventry; Associate Medical Director, Adult Mental Health, Coventry & Warwickshire PT;
- Mr Justin O'Brien, Head of Risk, South West London and St George's Mental Health Trust.

#### Acknowledgements

The Independent Investigation Team wishes to thank:

- The family of the service user and the deceased for their engagement in this process and the information shared with the Independent Team.
- The current healthcare provider for the service user for its assistance in making successful contact with the service user's family.
- The health, social care, and addiction professionals engaged with the service user, his mother and other family members between 2009 and 2010, for their openness and engagement with the Independent Team on issues requiring further clarification as a consequence of this quality assurance review process.

Throughout this executive summary and the full report:

- the Independent Investigation Team is referred to as the Independent Team;
- the internal investigation team appointed by Barnsley PCT is referred to as the PCT Team;
- the Service User is referred to as JK;
- the Service User's mother is referred to as JK's mother;
- Barnsley PCT is referred to as the PCT; and
- the new and current provider of mental health services in Barnsley, South West Yorkshire Mental Health Partnership Foundation NHS Trust is referred to as the Trust.

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## **EXECUTIVE SUMMARY**

### **Incident Overview**

In the autumn of 2010, a service user (JK) of Care Services Direct (Barnsley PCT) attacked his mother with a knife. As a consequence of her injuries, JK's mother died (RIP). In the thirteen months that Care Services Direct had been actively responsible for the care management of JK, there had been no indications that he might pose a current risk to his mother. His family have also confirmed to the Independent Team that, although they were concerned about him with regards to his vulnerability, they had not detected any of what they considered to be his early warning signs that might indicate a return of the aggressive (physical and verbal) behaviours which presented during his teenage years some four to five years previously. The Independent Team wishes to emphasise that, even had JK manifested his early warning behaviours, no-one could have predicted the incident that occurred.

### **Purpose Of The Investigation**

The purpose of this investigation was to conduct:

- an independent analysis of JK's care and treatment as received from Care Services Direct (Barnsley PCT);
- an historical review of JK's clinical and social care records prior to his transfer to Care Services Direct in 2007;
- an assessment of the internal serious untoward incident carried out by the PCT to determine whether or not it was sufficiently complete, fearless and searching, so as to make unnecessary further independent investigation of JK's care and treatment;
- an assessment of the recommendations by the PCT Team and the subsequent actions taken as a consequence of these.

In addition to the above, the Independent Team was tasked with making any additional recommendations considered necessary to ensure that identified lapses in the care and treatment of JK were appropriately addressed to reduce the risk of the identified lapses occurring in the future.

### **Conclusion**

Overall, the Independent Team is satisfied that the internal investigation conducted by NHS Barnsley was of a reasonable standard and that the PCT Team did undertake a 'fearless and searching' review of the care and service provided to JK between 2004 and 2010. The effort of undertaking 40 interviews to try and make sure that there was sufficient understanding of JK's and his mother's care and treatment can only be commended.

It is therefore somewhat unfortunate that the focus of the internal investigation was not always as balanced as it could have been, specifically with regards to the in-depth analysis of the aspects of practice and service delivery that fell below expected standards between 2007 and 2010, including:

- the actual process of JK's transfer from Children's Disability Services;
- the assessment of JK by general adult mental health services, including the lack of access to available and relevant informant history;
- the lack of a sufficiently detailed and comprehensive care plan;
- the lack of effective usage of CPA;

- the lack of an effective risk assessment and risk management plan;
- the ineffectiveness of the safeguarding strategy meeting;
- the lack of advocacy support provided to JK;
- the lack of relevant capacity assessment in August 2010.

However, the change in provider of mental health services in Barnsley since May 2011 from the PCT to South West Yorkshire Mental Health Partnership NHS Foundation Trust (the Trust), and the clear, tangible commitment to a wholesale improvement in services provided to individuals such as JK, including named Asperger's Champions, and access to specialist advice and supervision, means that the Independent Team can see little scope for further learning opportunity arising in addition to that achieved as a consequence of the quality assurance process, should further independent investigation occur.

The content of the internal investigation report, coupled with the content of this Independent Quality Assurance Analysis, provides sufficient information for the Trust, its partners and commissioners, to address outstanding issues.

The Independent Team asserts that, although JK had a risk history of verbal and physical aggression, and had on one occasion threatened his sister and brother with a knife, and on another brandished a cutlery knife in the school dining room, and that it was predictable that if he exhibited his previous early warning symptoms of scratching and head banging, and/or there were significant and sustained disruptions to his daily routine, then his behaviour may well deteriorate to the extent that he might "*hit out*" at his mother and be verbally aggressive towards her. However, based on its review of JK's documented social care and mental health records, the Independent Team does not consider that it was predictable that JK would go to the kitchen, take a knife and attack his mother.

Nevertheless, the Independent Team considers that there was opportunity for the potential avoidance of this incident on the day on which it occurred. The key to this potential was in the formulation of a family management plan, and also more assertively addressing JK's living circumstance. Because JK was an adult, no-one could have prevented him from living with his mother if that was his informed choice; however, the fact that his feelings about his mother's alcohol misuse were not explored, the fact that there was no family meeting, joint professionals meeting, or multi-agency family management plan, means that possible opportunity for a different sequence of events was lost.

The Independent Team has discussed this with JK's family, and they agree with the above assessment. However, they are also quite clear that JK always preferred to be with his mother and it is likely, even had Care Services Direct (Barnsley PCT), the substance misuse service, and the specialist day centre team, achieved a more co-ordinated approach to the management of JK and his mother (who was also in receipt of services), that JK would still have elected to be with his mother, and the incident would have occurred as it did. The difference for the family, however, would have been significant. They would have been able to take comfort from:

- being listened to;
- knowing that all services had done as much as they could and as much as they should in the provision of support and care services to JK and his mother.

## Recommendations

As a consequence of its quality assurance review, the Independent Team has eight recommendations in total. Seven of these are for the current provider of mental health services in Barnsley, South West Yorkshire Partnership NHS Foundation Trust. One is for Social Services (Recommendation 5), and one has relevance for the Third Sector Substance Misuse Agency (Recommendation 8).

### **Recommendation 1: The ‘Did not attend, not available for a planned appointment’ policy currently in place within South West Yorkshire Partnership Foundation NHS Trust**

Although the Trust was not the responsible provider of mental health services at the time of the JK incident, the Independent Team recommends that the Trust reviews its above identified policy document to ensure that it contains clear and unequivocal guidance with regards to the following:

- The range of actions required of staff if a service user is not available for a planned appointment, whatever its location. The range of actions might include:
  - Whether the case must be discussed at the next team meeting;
  - Who needs to be informed;
  - The conduct of an up-to-date risk assessment to appropriately inform any decision as to ‘the way forward’, or a review of the current risk assessment;
  - The appropriateness of leaving a note, sending a text, sending an email, contacting a family member, etc.
- The range of interventions that a care co-ordinator/CMHT would automatically be expected to consider in determining the way forward.
- Standards of documentation required following an unsuccessful home/community visit.

It is the perspective of the Independent Consultant Psychiatrist that *“in practice a clear published algorithm is helpful in both creating awareness and uniformity of response”*.

**Target Audience:** Recommendation co-ordinators for South West Yorkshire Partnership NHS Foundation Trust: Director of Nursing, Clinical Governance and Safety and the Assistant Director, Practice Effectiveness.

**Timescale:** Recommendation 1 should not require substantial time investment; therefore, the Independent Team considers that the Trust should be able to address this recommendation within six weeks of the publication of this report.

## **Recommendation 2: Training and 'skills, rule and knowledge'-based performance regarding Autistic Spectrum Syndrome Disorders**

The Independent Team fully acknowledges the strides made with regards to developing a clear care pathway for individuals with Asperger's Syndrome who are provided with care, support and treatment via the specialist mental health service.

However, in addition to the implementation of the new care pathway and diagnostic service, the current provider of mental health services in Barnsley must achieve a situation where it has clarity regarding those staff for whom baseline knowledge about Autistic Spectrum Disorders (ASD) is a core competency, and for whom an enhanced level of skill and expertise is required. The Independent Team considers that mental health practitioners working as care co-ordinators within the community mental health team setting ought to have a baseline understanding of ASD, and issues that require specific consideration in relation to the delivery of an effective care plan. Consequently, the Trust must determine what constitutes the baseline skill and knowledge for ASD it requires of its care co-ordinator staff. This can then be used within the management and clinical/professional supervision framework, and in the professional development planning for these staff, so the competencies are attained where they are identified as lacking.

In addition to the above, because the effectiveness of training relies on the extent to which the trainee absorbs, interprets and then practises, it is essential that in the short term there is a robust audit framework surrounding the care and management of the service user with ASD. This will enable the Trust to determine the extent to which its staff have understood the disorder, and also the care planning needs. The Independent Team would expect the Trust to involve the staff working in its ASD diagnosis and treatment service to conduct case-note reviews in the first instance, so that an experience-based and robust audit tool can be developed.

**Target Audience:** Recommendation co-ordinators for South West Yorkshire Partnership NHS Foundation Trust: Director of Nursing, Clinical Governance and Safety and the Assistant Director, Practice Effectiveness.

**Note:** This recommendation requires Trust wide implementation.

**Timescale:** The above recommendation requires careful consideration and a hurried response will be counterproductive. The Independent Team suggests, therefore, that the Trust ought to be able to produce an action implementation plan on how it is going to approach this recommendation, with full implementation being achieved within six to nine months of the publication of this report.

### Recommendation 3: Safeguarding

To date, the main focus of two out of three audits undertaken around Safeguarding Vulnerable Adults have been quantitative in nature and therefore have not assessed the quality of safeguarding practice, or the quality of documentation around safeguarding interventions. A case file audit was undertaken in 2010 but none has been conducted since then.

The Barnsley Safeguarding Adults Board (SAB) sub group for Performance and Quality Assurance has now taken the responsibility to oversee the audit programme using data from areas such as the recent audit NHS Barnsley Safeguarding Adults Clinical Audit Report which went to the Safeguarding Adults Board on Tuesday 5 March 2013, and service user feedback to identify areas for further investigation. (The excerpt from a recent action plan below demonstrates its commitment to this.)

Objective	How to be delivered	Time frame	Responsible person or group
To ensure audits take place to ensure staff are following safeguarding policy and procedures and that the quality of safeguarding practice is maintained and improved.	To compile a directory of audits and monitor outcomes making recommendations to Practice Learning Sub Group or Safeguarding and MCA/DOLS Training Sub Group as necessary	To compile a register by June 2013, and to monitor this on a monthly basis.	Performance Management and Quality Assurance Sub Group

The Independent Team also understands that each provider organisation is to become responsible for its own safeguarding vulnerable adult audits. Because safeguarding vulnerable adults is such an important issue the Independent Team recommends that Barnsley PCT, (or its successor) as the commissioner of mental health services, along with its partners South West Yorkshire Mental Health Partnership NHS Foundation Trust, and Barnsley Metropolitan Borough Council, commit to a timeframe for the implementation of the qualitative audit of practice and sets out clearly how they are to achieve this.

In addition, the organisations listed above may wish to consider the merits of conducting a multi-agency Failure Modes and Effects Analysis<sup>1</sup> of the Safeguarding process to determine if there are any contemporary 'hot spots' that would benefit from further control measures, to minimise the risk of omissions occurring within the process.

Both of the above recommendations supports the commitment of the the Barnsley Safeguarding Adults Board (SAB) sub group for Performance and Quality Assurance to broadening and deepening the audit of safeguarding adults practice for the residents of

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<sup>1</sup> Failure Modes and Effects Analysis (FMEA) is a systematic, proactive method for evaluating a process to identify where and how it might fail and to assess the relative impact of different failures, in order to identify the parts of the process that are most in need of change. FMEA includes review of the following:

- Steps in the process
- Failure modes (What could go wrong?)
- Failure causes (Why would the failure happen?)
- Failure effects (What would be the consequences of each failure?)

Reference: Institute for Healthcare Improvement Cambridge, Massachusetts, USA

(<http://www.ihl.org/knowledge/Pages/Tools/FailureModesandEffectsAnalysisTool.aspx>)



Barnsley so that meaningful assurance regarding adherence to expected policy and practice standards can be achieved.

**Multi-Agency Target Audience:** Recommendation co-ordinators South West Yorkshire Partnership NHS Foundation Trust – Director of Nursing, Clinical Governance and Safety and the Assistant Director, Practice Effectiveness, Assistant Director of Nursing Safeguarding Lead

Recommendation co-ordinators BMBC: The Assistant Executive Director, Vulnerable Adults, BMBC and the Safeguarding Adults Service Manager, BMBC.

**Timescale:** As with Recommendation 2, the above requires careful thought, so that the qualitative audit approach agreed on delivers a meaningful retrospective assessment of safeguarding practice. The Independent Team is aware that the Trust's current outlook on its audit of the Care Programme Approach may provide the necessary framework to facilitate the required development in the audit of Safeguarding Adults practice. However, even though each provider is to be responsible for its own audits it would be optimal if the Trust and BMBC both signed up to a common approach. Therefore, the Independent Team suggests that a period of four months is allowed for the exploration of this recommendation and a pilot process to be developed. At this stage, the Trust, in partnership with BMBC, should be able to provide the relevant Clinical Commissioning Group with a more detailed action implementation plan regarding how the pilot phase will be progressed through to the final agreed audit process, including timescale and audit frequency.

#### **Recommendation 4: Investigation practice**

The Independent Team identified a number of aspects where investigation practice did not meet recognised good practice standards within the conduct of the PCT's investigation. It is essential that in future investigations the current mental health provider can be assured that its investigators have the following competencies and can demonstrate these:

- *Formulation of the investigation team*  
The lead investigator must work with a team of relevantly qualified specialist advisors. In this case, relevant advisors would have come from the following disciplines:
  - Social Care
  - Safeguarding
  - Substance misuse services
  - Medical – consultant psychiatric input
  - Specialist Asperger's advice
  - Advocacy

Although there was 'at a distance' input from most of the above, and social care was actively involved in the conduct of the JK investigation, the specialist advisor input was not as comprehensive as it could or should have been. Although 'virtual' involvement can be effective, it is essential that relevant specialists are present at the right staff interviews so that detailed and relevant professional and practice exploration can be achieved.

- *Preservation of information*  
The practice of deleting the working versions of the timeline once the investigation team considers it to be complete must stop with immediate effect.

Each iteration of the timeline should be saved, with strict adherence to version control numbering and dating.

The working timeline(s) provide a clear and auditable framework for assessing how an investigation team came to ask questions of interviewees at interview.

An independent team conducting a quality assurance review must be able to assess the whole process undertaken by an internal investigation team.

- *Investigative interview skills*, specifically:  
In the JK case, the interviewers did not listen sufficiently to what they were told, did not use the practice of 'reflect back' and did not adhere to the following well-published good practice in investigative interviewing:
  - Cognitive interviewing skills (speak less, listen more, use of reflect back);
  - Use of open, non-leading and non-judgemental questions;
  - Objective, detached, un-opinionated.

In addition to the above, the Independent Team expects the Trust's lead investigators to understand how to formulate an interview validation grid as a core component of the preparation for interview.

- *Data Analysis Skills for analysing complex information*  
An unstructured non-repeatable approach was taken to the analysis of the JK interviews. This was less than ideal. It is important that the current provider of mental health services in Barnsley is confident that its investigators understand the principles of:
  - Content analysis for each significant concern or serious lapse in standards/care/treatment;
  - Affinity mapping;
  - Human Factors frameworks, including the NPSA framework and the 'fishbone';and can apply these principles consistently in investigations conducted on the Trust's behalf.

**Target Audience:** Recommendation co-ordinators for South West Yorkshire Partnership NHS Foundation Trust: Director of Nursing, Clinical Governance and Safety and the Assistant Director, Practice Effectiveness.

**Timescale:** The Independent Team is aware that the Trust has recently appointed a dedicated team of serious untoward incident investigators within the Trust to ensure a consistent standard of investigation. The Independent Team considers it appropriate that the Trust considers the above in relation to its current developments and provides the relevant Clinical Commissioning Group with its response to this recommendation and a position statement within six weeks of the publication of this report.

### **Recommendation 5: Case Transfer Protocol**

The current Case Transfer Protocol is significantly more robust than its predecessor. However, it is essential that the Case Transfer Process is subject to scrutiny via case file audit against the published standards. Some consideration of target percentage compliance with each standard would also be of merit.

The Independent Team also recommends that consideration is given to conducting a failure modes and effects analysis of this process, particularly at the stage where a young person is being transferred out of social care to another partner agency. The Independent Team considers that the JK case could be used as the 'back-drop' for the failure modes and effects analysis, thus involving Children's Disabilities Service, Continuing Care, the specialist day centre attended by JK, and community mental health services (ideally the team involved with JK).

**Multi-Agency Target Audience:** Recommendation co-ordinators for South West Yorkshire Partnership NHS Foundation Trust: Director of Nursing, Clinical Governance and Safety and the District Director of South West Yorkshire Partnership NHS Foundation Trust's, Barnsley Business Unit;

Recommendation co-ordinators BMBC: The Assistant Executive Director, Safeguarding, Health and Social Care from the Directorate for Children, Young People and Families and the Head of Service, Mental Health & Professional Support, BMBC,

**Timescale:** The Independent Team does not consider it appropriate to impose a delivery timescale for this recommendation. However, it does expect the relevant agencies to be in a position to present to the appropriate Clinical Commissioning Group their response to this recommendation within six weeks of the publication of this report.

### **Recommendation 6: Risk Assessment Practice**

There was a significant lapse in standards with regards to information transfer and risk management practice in the case of JK. The current provider of mental health services must satisfy itself and its commissioners that its CMHT staff have the relevant knowledge and competencies to deliver effective risk assessments and risk management and contingency plans that are cognisant of the whole person and his/her social circumstance for all CPA patients, regardless of his/her diagnosis and why he/she is on the team's caseload.

**Target Audience:** Recommendation co-ordinators for South West Yorkshire Partnership NHS Foundation Trust: Director of Nursing, Clinical Governance and Safety and the Assistant Director, Practice Effectiveness.

**Timescale:** Because this recommendation requires addressing on a Trust wide basis the Independent Team suggests that a period of six to nine months is allowed for implementation. However the Trust should be able to set out in detail how it will address this recommendation in its action plan along with milestones to be achieved.

### **Recommendation 7: Advocacy**

The Independent Team considers that there was little attention given during the internal interviews as to the staff's appreciation of the need to support JK's self-actualisation, including the omission of staff to find an advocate for him. For staff to have relied on the day centre to have fulfilled this role was not appropriate. There are published standards in relation to advocacy; the Royal College of Psychiatrists report 171 on advocacy has standards set out in the appendix of this report, and the Quality Performance Mark "*Assessing the Quality of Advocacy Provision*" 2nd edition contains a complete assessment framework.

To assure itself and its commissioners that the lapse in advocacy support in the JK case is not a continuing issue, the current provider of mental health services should benchmark itself against these standards and provide its commissioners with the report of its findings, including proposed plans to address areas where remedial action is shown to be required.

Initially this audit should be delivered within Barnsley and then on a planned basis, which takes account of any pre-existing audit timetable, the audit ought to be rolled out corporately.

**Multi-Agency Target Audience:** Recommendation co-ordinators for South West Yorkshire Partnership NHS Foundation Trust: Director of Nursing, Clinical Governance and Safety and the Head of Involvement and Inclusion.

This recommendation also applies to Barnsley PCT (or its successors), commissioners of mental health services (Barnsley):

**Timescale:** The Independent Team suggests that the availability of published standards with regards to advocacy means that the development on an in-house audit approach should not be challenging. There may also be scope to incorporate relevant advocacy standards into pre-existing audits such as CPA and safeguarding. With this in mind, the Independent Team considers it reasonable to require the Trust to have set out its response to this recommendation within eight-ten weeks of the publication of this report.

### **Recommendation 8: Working with complex families and substance misuse**

The JK case demonstrated a lack of insight by the CMHT and the Third Sector substance misuse agency of the complexity JK's mother's substance dependency brought to the home environment and the increased risk to JK himself. There was no evidence in the clinical records, or in the internal investigation report, that anyone explored with JK how he was coping with his mother's substance misuse or how it made him feel. Furthermore, there is no evidence that alerts raised by other family members were afforded the consideration they should have been in respect of JK, and in respect of his mother's capacity to remain a Carer for him.

Consequently, it is the recommendation of the Independent Team that:

- Professionals working in substance misuse services must be required to work proactively with families to find out from family members, particularly those 'living with' the person with the substance misuse problem, how the situation is affecting them and to provide guidance on coping strategies, support groups and self-help groups that can assist them in addressing the impact that the 'substance misuser' is having on them.
- There is always a joint professionals meeting where it is known that there are two family members living in the same household and both are receiving mental health and/or substance misuse services.
- All professionals and agencies involved in this case need to reflect on how they approach the care and case management of individuals with substance misuse when there are other family members who have a mental health disorder and/or are vulnerable, because of other reasons, to the negative impact alcohol dependency can bring to day-to-day living, including an increased risk of abuse.

The Independent Team expects that this reflection forms a formalised component of the professionals/management supervision for each member of staff concerned and that the wider messages are incorporated into existing training programmes, such as:

- Dual Diagnosis;
- Risk Assessment and Management;
- Care Planning/Care Programme Approach;
- Substance misuse-specific workshops.

**Multi-Agency Target Audience:** Recommendation co-ordinators for South West Yorkshire Partnership NHS Foundation Trust: Director of Nursing, Clinical Governance and Safety and the Assistant Director of Human Resources.

Recommendation co-ordinators for BMBC: the Head of Service, Mental Health & Professional Support;

And, Barnsley Drug & Alcohol Action Team (DAAT).

**Note:** With regards to the first bullet point the Independent Team suggests engaging with the public information leads in self help organisations such as ‘families anonymous<sup>2</sup>’ and ‘Al-Anon’ would be advantageous.

**Timescale:** Substance misuse is a complex area, as is family management within this context. The above recommendation requires careful consideration by all involved agencies and needs to be addressed on a multi-agency basis. Consequently, the Independent Team considers that an initial multi-agency response to this recommendation might be expected within two months of the publication of this report, with a clear commitment as to how the principles of this recommendation are to be addressed.

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<sup>2</sup> Families Anonymous and Al-Anon are registered self-help charities that are self-supporting aligning themselves with no other entity or organisation. The group members are all individuals whose lives have been affected by the addiction of someone close (child, brother, sister, mother, father, spouse, partner). The sole aim of the self help group is the provision of mutual support and recovery from the affects of another’s addiction on the life of the group member. The groups adhere to a strict code of anonymity.