

An Independent Investigation
into the Care and Treatment
of Service User Mr L by
Sheffield Health and Social
Care NHS Foundation Trust

EXECUTIVE SUMMARY

October 2014



The **effective investigations** company

PO Box 336, Malvern WR14 9GN
01684 572455 www.consequenceuk.com
Registered name: Consequence UK Ltd
Company number: 04574895 VAT 803218760

This independent quality assurance process was commissioned by NHS England North as required by Health Services Guidance (HSG) (94)27.

The Independent Team members were:

- Ms Maria Dineen, Director, Consequence UK Ltd (CUK);
- Dr Robert Holmes, Consultant Psychiatrist, Coventry and Warwick Partnership NHS Trust;
- Mr Nick Chamberlain, Early Intervention Service Manager, South West London NHS Trust; and
- Mrs Wendy Huxley Marko, Associate, Consequence UK Ltd.

Acknowledgements

The Independent Team wishes to thank all those who assisted in the independent investigation conducted.

For Clarity

Throughout this investigation report, the NHS Trust's investigation team will be referred to as the 'In-house Team'.

The independent investigation team will be referred to as the 'Independent Team'.

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Incident overview

On 29 March 2011, Mr L was arrested for suspected involvement in three incidents:

- Threatening a man with a knife, screwdriver and handgun and slashing the tyres on his car.
- Injuring a number of pedestrians when driving recklessly through a red light in Sheffield City Centre.
- The suspected homicide of two individuals known to him.

Mr L is currently detained at Rampton High Security Hospital under Section 48 of the Mental Health Act (MHA).

On the morning before the incident (28 March), Mr L attended the South East Community Mental Health Team (CMHT) base, accompanied by a child he reported as his. Mr L requested to see his care co-ordinator or the psychiatrist involved in his care. He was seen and assessed by a duty community psychiatric nurse (CPN), who did not perceive him to pose a risk to himself or others. Mr L was advised to go home and his care co-ordinator would contact him on his return to work in 2 days time.

Purpose of this independent quality assurance review

The purpose of the quality assurance review is to provide NHS England North with independent validation that the Sheffield Health and Social Care NHS Foundation Trust:

- asked the right questions during its investigations;
- undertook a reasonable level of exploration/enquiry based on the gravitas of the incident;
- based the findings presented in its report on the evidence collected during its investigation;
- conducted a systems analysis (RCA) of any serious and significant lapses identified in the care and treatment of the patient; and
- formulated an appropriate range of recommendations that had a reasonable chance of:
 - reducing the risk of recurrence of the lapses identified to the lowest reasonable level;
 - delivering sustainable improvements in practice, quality, safety and systems performance; and
 - delivering interventions where the impact of their implementation could be measured or audited.

Main findings and conclusions

As a consequence of the quality assurance review undertaken, the Independent Team considers that the care and treatment of Mr L complied with the expected local and national standards in respect of the:

- Assertive attempts by EIS to re-engage Mr L with service between 24 August 2010 and 30 November 2010.
- Referral to a professor in sexual health medicine on 23 June 2010, following Mr L's repeated concerns regarding the impact of his medication.
- Care co-ordinator's liaison with general practitioner (GP) on 2 November 2010 in relation to Mr L's non-engagement with the early intervention service, and whether or not Mr L had been collecting his medication prescriptions.

The Trust also identified aspects of Mr L's care and treatment that ought to have been better at the time. The Independent Team agrees with the Trust that:

- There was a lack of comprehensiveness in the medical and nursing assessment of Mr L on Rowan Ward during his first admission. This meant that there was lost opportunity to have a complete picture of his past history, and contemporary and future risk.
- There were less recorded attempts to locate and contact Mr L between 1 December 2010 and 22 February 2011. There were no attempts to contact him in March 2011.
- The assessment of Mr L and the consideration of his risks when he presented at the CMHT base on 28 March 2011. This related to two key issues: i) the assessment of risk to the child who attended with Mr L; and ii) the assessment of risk to Mr L himself and members of the public based on his previously known behaviour of carrying a knife for protection when unwell.
- The depth of enquiry into Mr L's paranoid ideas and what was underpinning these on 28 March 2011 was not as thorough as the Independent Team considers it ought to have been.

There was a range of other learning opportunities identified by the Trust and also by the Independent Team, and these are set out in the main body of the report.

It is the opinion of the Independent Team that significant contributory factors to the above were:

- The lack of a multi-professional and holistic assessment process in the in-patient services and across adult services at the time. This has since been addressed.
- The lack of a clear and directive risk management plan for Mr L.
- The lack of any prioritised risk system within the early intervention service at the time that supported staff's awareness of the higher risk clients regardless of the reason for this categorisation (in this case lack of contact and un-medicated for seven months).
- The lack of clear guidance for staff regarding the minimum level of assessment that must be conducted on a service user presenting as unwell and as an unscheduled care contact.
- Safeguarding systems and processes in the Trust were not as established in 2011 as they are now in 2014.
- The duty CPN simply did not perceive Mr L to be psychotic or in full relapse at the time of her assessment on 28 March 2011. She did not detect anything untoward in his interactions with the child, or vice versa, and did not perceive him to pose a risk to himself or to others.

Although no physical harm befell the child who attended with Mr L on 28 March 2011, the matter of safeguarding children was a significant issue for the NHS at that time and the Independent Team would have expected the duty CPN to have paid more attention to the safety of the child at the time.

Incident Predictability

With regards to the predictability of the incident, the Independent Team considers that this incident was not predictable. There was nothing known to the mental health services at the time that could have forewarned them of the risk Mr L posed to the two individuals who died as a consequence of his attack on them. Even had the initial admission assessment been conducted to optimal standards, and the contact with Mr L on 28 March have been optimal, it is very unlikely that the risk of this incident was predictable. Mr L displayed no behaviour of such magnitude to have alerted anyone to such a risk. Furthermore, the Independent Team understands that, after leaving the CMHT base, Mr L spent the afternoon in the company of persons close to the deceased and nothing untoward in his behaviour was noted; this further underlines the inability of anyone to have predicted the violence that was to occur.

Preventability

With regards to preventability, this is often a grey area. The Independent Team is unified in its opinion that the assessment of Mr L and the management of the presenting situation on 28 March 2011 was suboptimal. However, even if the clinical management had been optimal, there were a range of avenues available to the assessing CPN, which, even if utilised, may not have prevented the incident.

These were:

- To find out if a male mental health professional was available to speak with and assess Mr L.
- To seek medical advice and/or a medical assessment of Mr L while he was at the community mental health team base.
- To assertively try and achieve re-medication.
- To offer home treatment, or next-day follow-up by the early intervention service.
- To seek an assessment under the Mental Health Act (1983).
- To have spoken with a responsible adult with regards to the child.

In relation to the above:

Medical Assessment: The Independent Team knows that obtaining a face-to-face medical assessment for Mr L was unlikely based on the information provided to it by all CMHT bases. Medical advice, however, was achievable.

Male Staff Member: Mr L is reported to have told the duty CPN on 28 March that he did not want to speak with a female member of staff. However, there was no guarantee that an appropriately qualified male member of staff was 'on duty' at the time Mr L presented at the CMHT base. The Independent Team is aware that two female staff members were 'on duty' that day, so immediate access to a male colleague was unlikely.

Timely Follow-up: Although the CPN on 28 March 2011 did not organise follow-up on 29 March for Mr L, the Independent Team knows that on 29 March, when she recounted Mr L's attendance at the CMHT base to a male colleague who knew Mr L, an assertive attempt to have located him late that day would have occurred. Had the incident not already happened, follow-up on 29 March would have represented reasonable practice.

Mental Health Act Assessment: The only action that would have guaranteed incident avoidance was the admission of Mr L to an in-patient facility on a voluntary or compulsory basis. However, there is no information available to the Independent Team that suggests that Mr L would have been detainable under the Mental Health Act (1983). In fact, having met with the family of the deceased and heard the information reported to them by family and friends who did spend the afternoon with Mr L, the Independent Team is as certain as it can be that Mr L would not have been detainable and would not have been assessed for in-patient treatment at that time.

Speaking to a responsible adult: Because Mr L was clearly unwell at the time of his attendance at the CMHT base, and because he was in charge of a young child, the Independent Team considers that effort ought to have been made to contact a responsible adult, and/or to have determined what Mr L's subsequent plans were for himself and the child. The Independent Team is informed by the family of the deceased that, to their knowledge, Mr L was never left with the child on his own. Another family member or close friend was always present or nearby. Mr L, himself confirmed that there were occasions when his ex-partner did not allow him unsupervised access to his child. However, the 28 March 2011 was not one of these occasions.

Although the duty CPN could not have known whether or not Mr L was left in sole charge of the child, had she made an enquiry about his plans, or the identity of the child's mother or other responsible adult, there would be no question as to the potential lost opportunity for the subsequent sequencing of events to have been different.

The Independent Team emphasises that 'different' in the context of this incident does not necessarily mean the incident was preventable.

Recommendations

Sheffield Health and Social Care NHS Foundation Trust made 11 recommendations as a consequence of its internal investigation process. It has demonstrated to the Independent Team that most of these recommendations have been implemented and measures have been taken to test the impact of these.

Although the Trust has not been able to confirm it has attended to each and every recommendation its own In-house Team made, the Independent Team is satisfied that all of the main issues it was concerned about regarding the care and treatment of Mr L have been addressed.

The recommendations below are to supplement the work already undertaken by the Trust and to assist the Trust in ensuring a consistent and robust approach to the investigation of future serious incidents.

No individual delivery time has been assigned to each recommendation, as Sheffield Health and Social Care Trust will need to consider each recommendation carefully, reflect on other current work streams to determine whether any of the following can be joined with these, and to devise dedicated action implementation plans for each.

The Independent Team considers it is reasonable for Sheffield Health and Social Care Trust to present its local commissioners, the local area team, and NHS England North, with its detailed response to the recommendations made within one month of receiving the final validated report.

Recommendation 1: To maximise the impact of the Trust's focus on record-keeping standards, the Independent Team recommends that a more traditional peer review audit approach is instituted. Such an approach aims to deliver consistently high quality record keeping and regular opportunity for reflective practice.

A Peer Review model includes:

- Staff in and across CMHTs meeting together and auditing a 'fixed' number of each other's records and providing real-time feedback.
- Collecting qualitative data as part of the process so that it contributes to the global information-gathering process.
- Training for staff identified as facilitators for the 'peer review' in how to conduct a peer review. Band 6 staff and/or Senior Practitioners might be considered for this.
- Facilitation of the process at least until it is established and working well.

Note: Once a peer review process is embedded, it may not be necessary to maintain skilled facilitation of this as staff will become accustomed to doing it, and a simple guidance/rules of engagement framework may be sufficient.

In addition to the above:

Given the central importance of access to accurate and complete information in order to deliver safe and effective care, the Independent Team remains unclear as to how the Trust's adult community and inpatient services utilises the results of its record-keeping audit activity to:

- Benchmark documentation standards across its service.
- Inform learning, development and supervision requirements.

The Independent Team therefore recommends to each management team for these services that it ensures there is transparency with regards to this component of its commitment to enhancing quality, and assuring consistency of practice standards.

Recommendation 2: The Community Services Directorate must agree core components of the assessment process, including risk assessment that must be conducted for all unscheduled care contacts regardless of an individual practitioner's perspective about a patient. This will deliver a consistent approach to the assessment of these service users and enhance the defendability of decisions made.

The Independent Team understands that the CMHT sub-team (Access/Recovery Home Treatment) has been developing individual operational policies that are currently in draft format and close to being agreed and finalised. It is unclear whether these provide clear guidance regarding baseline expectations of the quality and content of unscheduled care contacts.

Therefore to achieve the stated objective of this recommendation the Directorate is recommended to ensure that it sets out clear measurable standards that make explicit the minimum requirements of what constitutes an acceptable depth of assessment for all unscheduled care contacts. In the case of Mr L, clearer clinical direction at the time would have supported a more appropriate depth of probing into his paranoias than that which occurred.

In addition to the above:

The revised operational policies need to make clear:

- Where all unscheduled care contacts are to be documented, e.g. in the progress notes, in the 'review section of Insight', etc.
- How all unscheduled care contacts are to be documented, e.g. using SBAR (situation, background, assessment and recommendation).
[http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/sbar - situation - background - assessment - recommendation.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/sbar_-_situation_-_background_-_assessment_-_recommendation.html)

Recommendation 3: The Trust must ensure that all of its lead investigating officers for serious incidents, complaints and professional performance reviews know how to apply the National Patient Safety Agency's Incident Decision Tree. The purpose of this is to achieve transparency and consistency across the organisation about how recommendations stating that an individual professional performance review is necessary are made.

Note: The NPSA's interactive Incident Decision Tree is currently unavailable. However the Independent Team believes that this will become available again online as an interactive tool in 2015 via:

<http://www.nrls.npsa.nhs.uk/resources/patient-safety-topics/human-factors-patient-safety-culture/?entryid45=59900>

A useful online article about using the incident decision tree can be found at: <http://www.ncbi.nlm.nih.gov/books/NBK20586/>

Recommendation 4: The Trust must ensure that all of its Senior Practitioners have in place up to date job descriptions which make clear the remit of the position and the essential features against which the success of the post holder will be measured. If this is achieved there should be clarity amongst this group of professionals regarding common goals and values regardless of the team they are working with and those goals that are specific to the team they are working with.

The Trust has invested in the development of its senior practitioner role that was clearly apparent to the Independent Team when it visited four CMHT bases in July 2014. However, it did not leave with the confidence that there were up-to-date job descriptions in place for all of these professionals which set out:

- The commonly expected role and responsibility of the senior practitioner, regardless of which part of the acute care pathway he/she was working in.
- Those aspects of job role and responsibility that were unique to the specific part of the pathway to which the post is attached.

Consequently, the management team for adult service community and in-patient is recommended to review the current position with regards to the job descriptions of these post-holders and to ensure:

- That the core deliverables, regardless of the team a senior practitioner is assigned to, are clear and transparent.

- That the job descriptions and performance framework for all senior practitioners at present in post actually reflect the requirements of the job they are currently delivering.

Recommendation 5: The Trust needs to be consistently confident that its serious incident reports demonstrate:

- **Where practice met and/or exceeded expected practice standards**
- **Where practice seriously fell below expected practice standards**
- **A systems analysis of each serious practice lapse identified so that it properly understood**
- **That the findings, conclusions and recommendations set out in an investigation report are evidence based**

The achievement of the above should deliver:

- **Reports that stand up to scrutiny**
- **Reports that demonstrate the Trust's compliance with the principles of 'Being Open'**
- **Recommendations that lead to systems focused, S.M.A.R.T action plans with outcomes that can be measured.**

To ensure it is in a position to do this, the Trust is encouraged to explore how it can develop a 'top team' of investigators who have the following competencies:

- Competent construct of an analytical timeline and/or safety control process map.
- Effective investigative interview skills.
- Knowledge about a range of other effective information-gathering techniques such as observational studies, surveys, etc.
- Know-how to conduct an auditable and repeatable information analysis of all data (evidence) gathered.
- A good understanding of human factors/systems analysis and understands how to apply this to the analysis of any serious lapses identified in the care and treatment of the patient.
- Understands what constitutes a robust recommendation.
- Understands the 'fail-safe' attributes of the recommendations made.
- Effective report-writing skills (plain English as a minimum).

Note: The Trust has already agreed with the Independent Team that it will organise for training to be delivered to staff most likely to be conducting moderate to high impact incidents within six months of the independent report being published.

Recommendation 6: The Trust needs to achieve a situation where each directorate management team has a common approach and standard when it comes to following-up on professional performance recommendations arising from a serious incident investigation.

This recommendation is related to recommendation three and recommendation five.

In the case of Mr L, the execution of the in-house recommendations made was left to the local team managers, one of whom was also involved in the case. Consequently, the depth of professional performance review conducted, and the degree of reflective practice achieved by the individuals involved and the wider team, was insufficient. Appropriate questions were neither asked nor answered.

To minimise the risk of this occurring again, and to enable the Trust to deliver the intent of this recommendation it is suggested that:

Across all directorates:

- A Team Manager unconnected with the team involved in the incident, or Associate Director, should be appointed to facilitate the 'deep dive' into an individual's reflection on his/her practice.
- Clinical supervision following a lapse in professional practice standards is never provided by a colleague who was also involved in the same incident scenario.

Corporately: There is a clear and auditable process for logging and monitoring recommendations made as a consequence of board-level serious-incident reports, so that the Trust can provide an account, when asked:

- For all recommendations with regards to implementation and/or non-implementation.
- Of the impact of recommendations implemented in terms of improvements in practice, safety and quality, i) within the local team, ii) across an entire directorate, and iii) across a range of directorates where the recommendation is relevant to more than one service.

Note: The Independent Team is aware that the Adult Service Directorate – Community has already undertaken measures to ensure that appropriately senior staff unassociated with the team involved in a serious incident are appointed to conduct any ‘deep dive’ required into the practice of individuals or teams.

Recommendation 7: The process of risk assessment must enable the classification of riskiness of service users across a range of indicators using an approach that supports the maintenance of team focus on clients who do not meet classical high-risk criteria

A traffic light system is one approach to achieving the above. However, it is not universally applied in all mental health services. However, because of the benefit it can bring to classifying the riskiness of service users across a range of indicators, and its effectiveness in maintaining team focus on clients who do not meet classical high-risk criteria, it and other similar type processes (where these exist) need to be re-evaluated by the Trust and a decision made about implementation of a tracking/alert system in its community mental health teams.

Note 1: Mr L constituted a service user who did not meet classical definitions of risk. The Independent Team considers that Mr L would have at least been an amber, and possibly a code red, client for the early intervention service had such a system been utilised at the time. This it believes would have enhanced the opportunity for a more thorough assessment of him on 28 March 2014.

Note 2: The Assistant Team Leader for the Mr L’s CMHT has already volunteered to undertake research into the experience of traffic light systems in use in other mental health trusts, and to research its possible benefits and challenges for Sheffield Health and Social Care Trust.

Note 3: The Director and Assistant Director of the Community Services Directorate are asked to take lead responsibility for this recommendation.

Recommendation 8 – Medical Staff

There are two distinctly separate components to this recommendation.

Firstly: The Independent Team recommends that the Trust provides the Clinical Commissioning Group with the assurance it needs that trainee doctors are supervised in line with current RCOP guidance.

Secondly: The Independent Team recommends that the Trust devise an audit method to capture the frequency with which a request is made for duty psychiatrist in-put, the availability of the duty psychiatrist and his/her ability to respond when advice about and/or an assessment of a service user is requested. The Trust must have a clear understanding of the sufficiency of current duty psychiatric provision, and challenges experienced in the provision of this that may introduce a patient safety risk.

In addition to the above, the Independent Team considers that there is merit in the Trust exploring how it can capture information highlighting the occasions where medical advice ought to have been sought but it was not sought, and the reasons for this.