

**An independent  
investigation into the  
care and treatment of  
two mental health  
service users  
Mr A and Mr O  
in Lincolnshire**

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Author: **Naomi Ibbs, Senior Consultant**

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Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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Niche Health & Social Care Consulting Ltd  
4<sup>th</sup> Floor  
Trafford House  
Chester Road  
Old Trafford  
Manchester  
M32 0RS

Telephone: 0161 785 1001

Email: [enquiries@nicheconsult.co.uk](mailto:enquiries@nicheconsult.co.uk)

Website: [www.nicheconsult.co.uk](http://www.nicheconsult.co.uk)

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## 1 Executive Summary

- 1.1 Mr A had brief contact (from December 2016 to January 2017) with adult mental health services provided by Rotherham Doncaster and South Humber NHS Foundation Trust (the Trust hereafter). Mr O also had brief contact (January 2017) with adult mental health services provided by the Trust, but he had also been known to mental health service providers elsewhere.
- 1.2 In the early hours of 16 January 2017, Mr A entered Mr O's bedroom and attacked Mr O. Mr O was taken to a general hospital where he sadly died later that day. Following a criminal trial, Mr A was convicted of manslaughter on the grounds of diminished responsibility.
- 1.3 NHS England, (North) commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of two mental health service users; Mr A and Mr O. Niche is a consultancy company specialising in patient safety investigations and reviews.
- 1.4 The independent investigation follows the NHS England Serious Incident Framework<sup>1</sup> (March 2015) and Department of Health guidance<sup>2</sup> on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.
- 1.5 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.
- 1.6 The underlying aim is to identify common risks and opportunities to improve patient safety and make recommendations for organisational and system learning.
- 1.7 We would like to express our condolences to all the parties affected by this incident. It is our sincere wish that this report does not add to their pain and distress, and that it goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of Mr A and Mr O.

### Mental health history of Mr A

- 1.8 Mr A had first presented to adult mental health services provided by the Trust in December 2016. He was referred to the crisis team by staff at A&E where

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<sup>1</sup> NHS England Serious Incident Framework March 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf>

<sup>2</sup> Department of Health Guidance ECHR Article 2: investigations into mental health incidents <https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents>

he had attended complaining of abdominal and chest pain. He reported to A&E staff that he had been hearing voices.

- 1.9 Mr A was then placed under the care of the home treatment team and was seen by a number of different staff, over a period 21 December 2016 to 2 January 2017.
- 1.10 During this time a Mental Health Act assessment was conducted (on 28 December) when it was determined that Mr A would not be detained and that he should continue to receive care and treatment from the home treatment team.
- 1.11 A further Mental Health Act assessment was conducted on 4 January that resulted in Mr A being detained on Section 2. He was admitted to a mental health inpatient unit MHU1.
- 1.12 Two days later Mr A was transferred to a second mental health inpatient unit MHU2 where he continued to be detained until he assaulted Mr O.

### **Mental health history of Mr O**

- 1.13 Mr O first presented to adult mental health services provided by the Trust on 2 January 2017. He had been picked up by the police after he had been found in a confused state. Mr O was assessed by staff in A&E, detained on Section 2 Mental Health Act and admitted to a mental health inpatient unit MHU2.
- 1.14 Mr O made a number of allegations that triggered a safeguarding referral. He repeated these allegations a number of times during the first few days of his admission to MHU2.
- 1.15 Mr O was placed in seclusion on 3 January for a period of 23 hours and concerns remained about both his mental health and his physical health.
- 1.16 Mr O was involved in altercations with at least two other patients (neither of which were Mr A) and on 11 January he was placed on enhanced observations.
- 1.17 Mr O's mental health appears to have stabilised just prior to the assault by Mr A.

### **Relationship with the victim**

- 1.18 Mr A and Mr O were both being treated for mental health problems at the MHU2 at the time of Mr O's death. It is reported that Mr A and Mr O had struck up a friendship during the brief time that they knew each other. There is no indication that they knew each other prior to Mr A's admission to the MHU2 on 6 January 2017.



## Offence

- 1.19 During the early hours of 16 January 2017, Mr A entered Mr O's room on MHU2. It is unclear from Trust records exactly what Mr A did to Mr O, however Mr O was found underneath his bed mattress, with a belt around his neck. He was bleeding from his nose and was not conscious.
- 1.20 Staff called for an ambulance and attempted to resuscitate Mr O whilst waiting for paramedics to arrive.
- 1.21 Mr O was taken to a general hospital where he later died.

## Sentence

- 1.22 Mr A was found guilty of manslaughter on the grounds of diminished responsibility. Mr A was sentenced to 12 years in custody and started his sentence at a secure mental health hospital where he currently remains.

## Conclusions

- 1.23 It is our view that the staffing levels and skill mix on the ward had a significant impact on the conditions in place at the time of the incident. However, the most significant was the observation policy. If the observations had been carried out differently it would have reduced the likelihood that Mr A would have been able to go into Mr O's room and be undisturbed for 15 minutes.
- 1.24 We heard that staff had been anxious about risk assessment and risk levels within the unit. There were examples of:
- patients being brought to the unit without adequate consideration of their motivations for admission or previous criminal activity;
  - staff raising concerns that a particular part of the ward was not safely staffed;
  - differences in how risk assessments and risk ratings were applied.
- 1.25 This in practice meant that risks were not adequately controlled and caused staff to be anxious about their own and patients' safety. Staff reported that they did not feel safe, particularly on nights and on the part of the ward where they had raised concerns about staffing.
- 1.26 In our view the most significant contributory factor is the culture of safety on the ward. The tolerance of uncontrolled risk meant that staff did not have the resources or plans in place to manage risks effectively. We cannot say that Mr A would not have subsequently killed someone, but we can say that promoting a culture that is less tolerant of risk will reduce the likelihood of patient harm in the future.

- 1.27 It is our view that the Trust could not have predicted that Mr A would assault Mr O or that the assault would result in Mr O's death. Neither do we consider that the Trust could have prevented Mr O's death.
- 1.28 However, as we have indicated elsewhere we do consider that there were actions that the Trust should have taken that would have resulted in better quality care and treatment being provided to both Mr A and Mr O.

## Recommendations

- 1.29 This independent investigation has made seven recommendations to improve practice, five of which relate to the incident and the subsequent management of it, and the two remaining recommendations are findings that were incidental to the event that would improve the provision of health care and treatment.

### Recommendations related to the incident and subsequent management

#### Recommendation 6

The Trust must ensure that observations form part of a patient's electronic record.

#### Recommendation 3

The Trust must assure itself and its commissioners that front line staff receive appropriate support from managers both in hours and out of hours, when dealing with serious incidents.

#### Recommendation 1

NHS England must clarify the responsibilities of a Trust in relation to Duty of Candour and Being Open when the incident relates to a criminal offence.

#### Recommendation 2

The Trust and their commissioners must ensure that serious incident investigation reports make clear the links between the issues identified and the recommendations being made.

#### Recommendation 7

The Clinical Commissioning Group must ensure that the revised serious incident management policy provides clarity about the assurance and monitoring processes and how these are to be evidenced.

## Recommendations relating to incidental findings

### Recommendation 4

The Trust must ensure that clinical staff have the skills and knowledge to be able to provide appropriate physical healthcare (in particular acute alcohol withdrawal), or be able to access appropriate physical healthcare from other organisations (in particular community dental services) in a timely fashion.

### Recommendation 5a

The Trust must ensure that staff are fully aware of and execute their responsibilities for safeguarding when there are concerns about the vulnerability of patients.

### Recommendation 5b

The Trust and the Clinical Commissioning Group must work with the Local Adult Safeguarding Board and its members to develop a robust process for escalation, oversight and follow up both immediately and after a serious incident (where Safeguarding concerns are identified), and in the longer term, to ensure that learning from such events is fully captured and shared.

## Good practice

- 1.30 When Mr A was assessed in police custody on 3 January the liaison nurse was extremely concerned about his mental state. So much so that she made two follow up telephone calls to the access team to ensure that Trust services remained engaged in Mr A's care and treatment. It is our view that this was the first time that any clinician involved in Mr A's care and treatment responded appropriately in effectively managing his risks.
- 1.31 When Mr A was admitted to MHU1 on 4 January 2017 staff received and filed a copy of Mr A's Person Escort Record (PER). This had been completed by the police for the journey via ambulance from police custody to hospital. We rarely see this information recorded in clinical records.

## 2 Independent investigation

### Incident

- 2.1 Mr A and Mr O had both been admitted to hospital under Section 2 of the Mental Health Act and were detained at MHU2.
- 2.2 In the early hours of 16 January 2017, Mr A entered Mr O's bedroom and attacked Mr O. Mr O was taken to a general hospital where he sadly died later that day. Following a criminal trial, Mr A was convicted of manslaughter on the grounds of diminished responsibility.

### Approach to the investigation

- 2.3 The independent investigation follows the NHS England Serious Incident Framework<sup>3</sup> (March 2015) and Department of Health guidance<sup>4</sup> on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.
- 2.4 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services are required which could help prevent similar incidents occurring.
- 2.5 The overall aim is to identify common risks and opportunities to improve patient safety, and to make recommendations about organisational and system learning. Where possible we have applied Root Cause Analysis principles endorsed in the NHS England Serious Incident Framework referred to above. Root cause analysis usually commences with evidence gathering which is then formulated into a chronology of events. The events and actions of people involved are then compared with what should have happened, either according to guidance, policy or best practice. This stage identifies care or service delivery problems.
- 2.6 Care delivery problems are where an incorrect or inappropriate act or omission has occurred during the process of direct care delivery, for example if a nurse does not give prescribed medication. A service delivery problem is where the way that a service is designed or delivered has resulted in an incorrect act or omission that is not direct care delivery, for example if a policy excludes a patient from accessing a service. Our report sets out the chronology of care for both patients, which includes identification of care or service delivery problems that we have identified during our investigation.

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<sup>3</sup> NHS England Serious Incident Framework March 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf>

<sup>4</sup> Department of Health Guidance ECHR Article 2: investigations into mental health incidents <https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents>

- 2.7 The investigation was carried out by:
- Naomi Ibbs, Senior Consultant for Niche (lead author);
  - Dr Mark Potter, Consultant Psychiatrist;
  - Chrissie Cooke, Governance, Safeguarding and Assurance Advisor;
  - Paul Watts, Acute Inpatient Nursing Advisor.
- 2.8 The investigation team will be referred to in the first-person plural in the report.
- 2.9 The report was peer reviewed by Nick Moor, Partner, Niche.
- 2.10 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.<sup>5</sup>
- 2.11 NHS England contacted Mr A at the start of the investigation, explained the purpose of the investigation and sought his consent to access relevant records. Mr A's treating doctor advised that Mr A was too unwell to be able to consent to his clinical records being released. NHS England therefore sought authorisation from the Trust Caldicott Guardian for Mr A's clinical records held by them to be released. The Caldicott Guardian for the GP practice gave authorisation for Mr A's GP records to be released.
- 2.12 We used information from the Trust, Mr A's GP surgery, North Lincolnshire Council, North Lincolnshire Clinical Commissioning Group, Mr A and Mr A's mother to complete the investigation into Mr A's care and treatment.
- 2.13 We used information from the Trust, North Lincolnshire Council, North Lincolnshire Clinical Commissioning Group, and Mr O's partner to complete the investigation into Mr O's care and treatment.
- 2.14 We understand that Mr O had an ex-wife and son from whom he was estranged. NHS England wrote to Mr O's ex-wife on two occasions, on the second occasion the letter was sent by recorded delivery. The second letter was eventually returned to NHS England by Royal Mail, because the letter was not signed for and was not collected. We have therefore not had any contact with Mr O's ex-wife.
- 2.15 As part of our investigation we interviewed:
- Lead Investigator and clinical advisor to the internal investigation (joint interview);
  - Interim Director of Nursing;

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<sup>5</sup> National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

- Care Group Director;
  - Associate Nurse Director;
  - Lead Professional Safeguarding Adults;
  - Nurse in Charge of the shift at the time of the incident;
  - Associate Medical Director;
  - Modern Matron.
- 2.16 All interviews were digitally recorded, and interviewees were subsequently provided with a transcript of their interview. Interviewees were invited to review the transcript and to “add or amend it as necessary, then sign it to signify that you agree to its accuracy and return it to Niche”. Interviewees were further advised that if we did not receive the signed transcript within two weeks, we would assume that the interviewee accepted the contents as accurate. We undertook eight interviews and four transcripts were returned to us.
- 2.17 A full list of all documents we referenced is in Appendix B, and an anonymised list of all professionals is in Appendix C.
- 2.18 The draft report was shared with affected families, NHS England, the Trust, the GP surgery and North Lincolnshire Clinical Commissioning Group. This provided opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.
- 2.19 We delivered the findings of the report at a meeting with members of the Trust Executive Team.

### Contact with Mr O’s family

- 2.20 Contact for the victim’s family was with Mr O’s long-term partner, Mr C. We met with Mr C (who was accompanied by a representative from the charity Hundred Families) at the start of the investigation so that we could explain the process of the investigation and invite him to share any specific concerns about Mr O’s care and treatment.
- 2.21 Mr C expressed great concern at the fact that Mr O had been killed whilst in a place of safety and said that he remained distraught at Mr O’s death. Mr C asked us to clarify why Mr O’s care and treatment was being reviewed as part of this investigation. We were later able to confirm that this was at the request of the Local Adult Safeguarding Board, because Mr O had died as a result of injuries sustained whilst detained in hospital.
- 2.22 Mr C was Mr O’s partner, but Mr O also sometimes referred to Mr C as his carer. This reference was used interchangeably in clinical records but Mr C has asked that we refer to him in our report as Mr O’s partner.

2.23 We met with Mr C (who was again accompanied by a representative from the charity Hundred Families) at the end of the investigation to discuss our findings and respond to any questions. Where it was appropriate to do so, we made some minor amendments to the report following this meeting.

### Contact with Mr A's family

2.24 Contact with the perpetrator's family was with Mr A's mother, Mrs E. We met with Mrs E at the start of the investigation so that we could explain the process of the investigation and invite her to share any specific concerns about Mr A's care and treatment.

2.25 Mrs E told us that Mr A had been very unwell in the weeks prior to his admission to hospital in January 2017. She explained that Mr A was living with his girlfriend at the time and both Mr A's girlfriend and Mrs E had tried to get help for Mr A from mental health services.

2.26 Mrs E told us that she had not been involved in the internal investigation and that she had not seen a copy of the internal investigation report. Mrs E said that she did want to see a copy of the internal investigation report and we agreed that we would liaise with the Trust on her behalf to enable this to happen. The Trust did subsequently make attempts to contact Mrs E and we deal with this in more detail in Section 6.

2.27 We met with Mrs E at the end of the investigation to discuss our findings and respond to any questions. We made a minor amendment to the report where Mrs E advised that a pet name reference was incorrect.

### Contact with Mr A

2.28 We contacted Mr A's treating team at the start of the investigation and were advised that Mr A was too unwell to meet with us. However, in September 2018 Mr A's treating team told us that his mental health had improved a little and that he was keen to talk to us about his mental health care and treatment.

### Limitations

2.29 One of the objectives of this investigation was to try to establish the reasons behind certain courses of events (why things happened). Part of this is to consider the human factors that affect decision-making in clinical care. Human factors is the discipline concerned with uncovering and addressing areas of mismatch between people, the tools they have available to work with and the systems in which they work. Human factors analysis focuses on changes to technologies and systems to support people and does not try to change the human condition.<sup>6</sup> By correcting these areas of mismatch, we can

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<sup>6</sup><http://www.patientsafetyinstitute.ca/en/education/PatientSafetyEducationProgram/PatientSafetyEducationCurriculum/Pages/Module-2-Human-Factors-Design.aspx>

improve patient safety, effectiveness and the user experience. A simple way to assess human factors is to think about three aspects: the job, the individual and the organisation and how they impact on people's health and safety-related behaviour.

- 2.30 We have attempted to conduct this investigation applying root cause analysis principles. Our objective has not been to apportion blame but to identify areas where the services could learn from this event and put changes in place that may prevent a re-occurrence.
- 2.31 There have been some limitations to this investigation; one of which was that the Trust appointed an independent lead investigator who did not follow Root Cause Analysis principles. This meant that some of the questions and key lines of enquiry that good practice in investigations would normally have been followed were not by the internal investigation team. For example, applying 'Five whys' analysis to the reasons why some aspects of care were not carried out effectively. As a result, we took extra care to check and corroborate some of the factors covered in the internal investigation. We also only spoke with a key people with responsibility for aspects of care or management of the service. This offered a narrower perspective of the possible human factors in place at the time.
- 2.32 In addition, the interviews we carried out took place at least 18 months after the event. This means that, as memory degrades over time, their recollections of what happened may be less accurate than if they had been interviewed closer to the event. Another limitation was the clinical records do not always indicate the role the author of clinical entry. We have been able to identify some of the author roles from other paperwork or the detail of other clinical entries.

## Structure of the report

- 2.33 Section 3 provides detail of Mr A's background; Section 4 sets out the details of the care and treatment provided to Mr A with detailed information provided at Appendix D.
- 2.34 Section 5 provides details of the care and treatment provided to Mr O with detailed information provided at Appendix E.
- 2.35 We have included an anonymised summary of those staff involved in Mr A's and Mr O's care for ease of reference for the reader. These can be found at Appendix C.
- 2.36 Section 5 examines the communication the Trust had with Mr A's family after the death of Mr O and Section 6 examines the communication the Trust had with Mr O's family.
- 2.37 Section 7 provides a review of the Trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.



- 2.38 Section 8 examines the issues arising from the care and treatment provided to Mr O and Mr A and includes comment and analysis.
- 2.39 Section 9 sets out our overall conclusions and recommendations.

## 3 Background of Mr A

### Childhood and family background

- 3.1 Mr A told staff that he did not like school because he was bullied at both primary and secondary school. Clinical staff noted that Mr A referred to the bullying as being quite severe but did not give details. Mr A said that the bullying led to him losing interest in academic activities at school.
- 3.2 Mr A had displayed some challenging behaviours at school and admitted to staff that he had been aggressive towards teaching staff and disrespectful towards school property. Mr A said that towards the end of Year 11 (final year of secondary school) his attendance was only about 12%. When he left school he did not have any qualifications apart from a grade C in religious education.

### Relationships

- 3.3 Mr A had been in a long-term relationship with Ms L at the time of the incident. There are reports in Mr A's clinical records that he and Ms L had separated prior to Mr A's admission to hospital, however the Panel has not been able to clarify this in more detail because we have not had any contact with Ms L.

### History of violence

- 3.4 Mr A did not have a history of violence with the police prior to his first contact with mental health services on 20 December 2016. However, he did later admit to staff that he had been involved in a number of fights with fellow pupils (when at school) and with his siblings. Mr A also later told staff that he had been part of a gang culture when he was 14 or 15 years old that resulted in him coming to the attention of the police on one occasion.
- 3.5 Mr A also admitted being involved in two incidents of arson when he was aged between 15 and 17 years old. He was inconsistent in his accounts with staff about whether he was influenced by his peers, or he was the influencer.
- 3.6 Over the period of Christmas 2016 to New Year 2017 Mr A became increasingly threatening towards his partner Ms L. Mr A and Ms L were the subject of a MARAC meeting<sup>7</sup> on 3 January 2017 when it was noted that Mr A had threatened to kill himself if he did not get the help that he felt he needed. The Panel has not seen any evidence of the outcome of the MARAC meeting despite asking for copies of relevant records from the local authority.

### Mr A's views of his care and treatment

- 3.7 A member of the Panel met Mr A in November 2018 who was being treated in a secure hospital. Mr A told us that he was feeling different from a year previously.

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<sup>7</sup> Multi-Agency Risk Assessment Conference (MARAC). The MARAC is a monthly risk management meeting where professionals share information on high risk cases of domestic violence and abuse and put in place a risk management plan.

- 3.8 We asked Mr A about his early contact with his GP, he described feeling unsupported not knowing whether he was suffering a mental or physical illness. When his mental state became worse and he was referred to the crisis team, he said that he was unclear what their role was. Mr A said that he felt he was in a “black hole” at this time, which the team said they would get him out of, but Mr A does not recall being told by them as to how they would help.
- 3.9 When he was admitted to MHU1 Mr A said he felt safe and understood, with staff taking an interest in him, wanting to help him and explaining things to him. Mr A did not find the transfer to MHU2 helpful; he inferred to us that if he had stayed on MHU1 this incident would not have happened.
- 3.10 Mr A described several times that MHU2 felt chaotic and that he felt unsafe. He told us that he was open and honest with ward staff about how he was feeling, but felt ignored, with the stock phrase being “go and rest on your bed”. He told us that he was not aware that he had one-to-one time available to him and does not recall ever seeing or discussing his care plan.
- 3.11 Mr A told us he was clear about his need for medication and said that he was surprised that he was not prescribed medication for at least ten days. Mr A said that he does not recall any staff (nursing or medical) having a conversation with him about this.
- 3.12 He explained to us that during his time on MHU2 the paranoid feelings and thoughts began to intensify, but he was never asked about these and no one explored what was going on with his thought processes.
- 3.13 Mr A told us that he felt frightened by the room he was allocated and despite asking about observation levels again, they were not explained to him and that he was seen every 45 to 60 minutes.
- 3.14 Mr A said that he generally feels let down by MHU2 and that his motivation to contribute to our investigation was to ensure things change and that this does not happen to someone else.

## 4 Care and treatment of Mr A

### 20 to 31 December 2016

- 4.1 Mr A first presented to Trust services on 20 December 2016 after attending A&E at a general hospital. He was complaining of abdominal and chest pain, he felt weak, nauseous and feverish and told staff that he took cannabis to manage his pain. Mr A reported that he suffered from anxiety and depression, that he had been hearing voices and staff noted he appeared delirious, pale and he was tachycardic. He was referred to the Trust's crisis team who assessed him and noted that Mr A had no significant risk history, but that he was at high risk of relapse and that his presentation at that time may indicate an early phase of a serious mental illness. It was felt that Mr A would benefit from treatment and further assessment at home. No appropriate plan was completed at this time
- 4.2 Follow up was provided by the home treatment team on 21, 23, and 24 December. Staff recorded that visits should be undertaken by two members of staff and that Mr A may be more settled around males "especially as he cited [a] strong but dysfunctional attachment to [his] father". A physical health check form was present in Mr A's records, but it had not been completed. Mr A was given assessment paperwork to complete for the next visit. The plan was for the home treatment team to call Mr A on 26 December and visit again on 27 December to collect the assessment paperwork and assess his mental state. Staff would also discuss Mr A's case with medical team and arrange a medical review. We can find no evidence that staff attempted to contact Mr A on 26 December, as planned.
- 4.3 On 27 December Ms L informed them that she was concerned about Mr A's declining mental health, as he had grandiose beliefs and was paranoid about government control being present in household items. Home treatment team staff then saw Mr A who said he was feeling content, happy and elated and that he had found God. He said that he believed that all his sins had left him, but that it was human nature to be bad. Mr A had not completed any of the documents staff had left with him previously and said that God did not want him to do so. Staff attempted to explain to Mr A that it would be helpful for him to continue to engage with mental health services and to see the doctor. It was noted that Mr A appeared to lack insight into his mental health and that staff would call him in a few days. Later Ms L called the home treatment team to express concern that Mr A had said he didn't want medical intervention and he was told by the staff that visited that morning that this would not be forced on him. Ms L said she was concerned that Mr A was unwell but that he did not see it and said that he had been hearing voices the previous night. It was noted that AP1 and AP2 would be informed of Ms L's call. Staff later contacted Ms L to reassure her that they had not discharged Mr A and would continue to engage with him. A screening tool was completed but it is unclear who completed the form because it was not signed. The form contains handwritten, disjointed notes that include a reference to a relative of Mr A's with schizophrenia, and another relative with query autistic spectrum disorder.

- 4.4 On 28 December Ms L called the home treatment team to say that Mr A had had a disturbed night, and that he had told her he was moving away as he needed to see the Pope in Rome. Ms L said that Mr A had said God was talking to him and she was concerned he might act on ideas in relation to hurting himself. AP1 who took the call noted that he would discuss this information with the team and asked Ms L to keep an eye on Mr A (who was asleep in bed at that time) and call again if she needed any further support. Mr A's case was discussed in the clinical review meeting when staff noted a marked change from his initial presentation. A plan was made to visit Mr A the following day and there was a query about whether Mr A needed to have an assessment under the Mental Health Act. It was agreed that if anything more acute happened in the meantime, a more immediate response should be considered.
- 4.5 That afternoon Ms L contacted the Home Treatment Team because she was increasingly concerned about Mr A's behaviour. Ms L said Mr A had said "he will not kill her as god has not told him to". Staff advised that Mr A had been discussed in the clinical review meeting and that the plan was to make a home visit the following day. Ms L was unsure whether this was satisfactory and expressed concerns that Mr A had become aggressive towards her saying she "had the devil in her". Ms L formally requested that a Mental Health Act assessment was undertaken and was advised that her request would be passed to the on-call AMHP<sup>8</sup> who would make contact later. Ms L was advised to contact the home treatment team if anything else arose in the meantime.
- 4.6 That evening a Mental Health Act assessment was completed by S12D1 (Section 12 doctor), S12D2 (Section 12 doctor) and AMHP1 (approved mental health practitioner). The assessing team found no evidence of mental disorder that required admission that night. It was acknowledged that Mr A may become ill again but that he had agreed to accept help from the home treatment team. The plan was for the home treatment team staff to visit the following day to assess the situation. Mr A had completed the questionnaire staff had left with him previously and therefore he handed it over.
- 4.7 On 29 December Mr A's GP completed a fit note at Mr A's request. The GP noted that Mr A had been under the care of mental health services since his attendance at A&E on 20 December but so far, the GP had only received a notification from A&E and had received no information from mental health services.
- 4.8 HTT2 (mental health nurse, home based treatment team) discussed Mr A's case with CP1. It was agreed that HTT1 (mental health nurse, home based treatment team) would contact Mr A to suggest he attend an appointment with CP1 the following day. A member of staff from the home treatment team noted that Mr A's RAG rating had been reduced from red to amber. It is unclear as to why the agreed plan was changed at this point. The Panel could

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<sup>8</sup> Approved Mental Health Practitioner (AMHP) is a mental health professional who has been approved by a local social services authority to carry out specific duties under the Mental Health Act. They are responsible for coordinating assessments, and admissions to hospital.

find no reason to reduce the risk rating from red to amber, there was no record that Mr A's presentation during the telephone call indicated a change in risk.

- 4.9 On 30 December Mr A was seen by CP1 and HTT4 (home treatment team). CP1 noted that Mr A presented as complex with several co-existing conditions, a recent psychotic episode that sounded “**affective, marked by grandiose delusions and agitated behaviour**”. Mr A was seen with his mum (Mrs E) and his partner (Ms L) both of whom reported that over the previous 48 hours Mr A had settled back almost to normal but both Mrs E and Ms L were concerned Mr A would have another episode. CP1 noted that Mr A continued to express delusional sounding beliefs but that he displayed no hostility or agitation and recognised that he had some form of mental disorder. CP1 noted that his impression was that Mr A had experienced an acute psychotic episode that had multiple triggers, but the episode appeared to be resolving. Mr A had reported possible lower level auditory hallucinations over the previous five to six months and CP1 noted some personality and neurodevelopmental issues. Mr A's RAG rating was noted as amber. The plan was for a home visit on 1 January, zopiclone<sup>9</sup> to be tried for three nights in view of Mr A' recent poor sleep pattern, and a referral to the early intervention team to be made after the weekend. CP1 noted there was “**no rush to start antipsychotic meds**”, but that Mr A's experiences should continue to be monitored because he was at high risk of further episodes of psychosis.
- 4.10 On 31 December Ms L reported to home treatment team staff that Mr A was missing. Several hours later Ms L left a voicemail to say that Mr A had been found, but no other information was left on message.

### 1 to 3 January 2017

- 4.11 HTT2 later Mr A at home, accompanied by AP2 (STR Worker for the Access Team) and PC1. Ms L reported that Mr A had slept in the spare room the previous night and when she had checked on him that morning she could see that he had drawn all over his face. Ms L said that following his appointment with CP1, Mr A's mental state had deteriorated. Mr A reported that he had gone to the church and climbed on the roof, he had experienced fleeting thoughts of self-harm, had thought about jumping off the church roof but realised he was “**acting crazy**” so climbed down. He had then walked to a friend's house. Mr A said that he had not been sleeping, and that he had tried zopiclone, he had taken half a tablet, but it had no effect, so he took another and another and eventually had taken all three tablets. Mr A became tearful at times, and asked for admission to hospital to get away from Ms L. A referral to the early intervention team was discussed, but there is no indication of the outcome of that discussion. HTT2 noted that there was no evidence of mental disorder or risk to self or others to require admission to hospital. The plan was to provide Ms L with information about carer support, call Ms L to arrange a

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<sup>9</sup> Zopiclone is a medicine used for short periods of time to treat insomnia

home visit on 3 January, refer Mr A to the early intervention team and arrange a joint visit with them.

- 4.12 Later that day Mr A contacted home treatment team staff in a distressed state and said that he and Ms L had split up and that she had thrown him out. Mr A said he had nowhere to stay. Ms L came on the line to speak to HTT3, Ms L said that Mr A had not been thrown out of the house, but they had indeed split up. HTT3 suggested that Mr A might find it helpful to stay somewhere else. HTT3 informed HTT1 and AP2 of the information - they said they had visited that morning and the situation was the same when they were at the property.
- 4.13 In the early hours of 3 January, Mr A was referred to the Access Team and was assessed by AP3. It was noted that Mr A had taken a knife and had been threatening to harm himself, so the police had been called. Mr A had not been detained on Section 136 Mental Health Act and had attended A&E of his own volition. Mr A was tearful, but calm, responsive and well mannered. He was unable to say what had provoked him and voiced religious beliefs but no delusional thoughts. Mr A agreed to return home but actually asked if he could stay in hospital. AP3 said that hospital admission was not possible (she does not state why), but the home treatment team were due to see him later. Mr A was advised to go straight home to bed and leave any discussion with his partner until the morning. We do not know why hospital admission was not possible because the records do not provide this information.
- 4.14 At about 9:00 am it was noted that Mr A was still in police custody and may need an Appropriate Adult<sup>10</sup> for interview. Mr A had been arrested for having a knife and threatening to kill himself and partner. AP1 received a call from MHLT1 advising that Mr A was a significant risk to himself and others and that a Mental Health Act assessment had been arranged for 1:00pm. Attending the Mental Health Act assessment were CP1, AMHP2 (AMHP) and a student AMHP. The outcome was that detention under Section 2 Mental Health Act was recommended, and arrangements were made for another doctor (a Section 12 doctor) to attend later to complete the second recommendation. A student AMHP completed this entry. The focus during this assessment is on Mr A's risk, ignoring the degree of his illness, which was also omitted in the previous assessment.
- 4.15 On the Mental Health Act form completed by the AMHP it was noted that Mr A's Nearest Relative<sup>11</sup> was Ms L, despite the fact that both Mr A and Ms L had informed staff that they had split up.
- 4.16 CP1's medical recommendation for Mr A to be detained (Form A4) noted that he felt that Mr A's mental state may be influenced by cannabis, but did not consider this the sole reason for Mr A's behaviour. CP1 also noted he did not

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<sup>10</sup> An Appropriate Adult is someone who provides support to vulnerable adults if they are questioned by the police. Their role is to ensure that the police treat the person fairly and respect their rights, they will also ensure that the person understands what is happening at the police station.

<sup>11</sup> The Nearest Relative is a special term used in the Mental Health Act 1983. It gives one member of a person's family rights and responsibilities if a person is detained in hospital under Sections 2, 3, 4 or 37 of the Mental Health Act. A Nearest Relative is not the same as a person's next of kin. There is a list of who can be someone's Nearest Relative. The list is in strict order and the person who is highest on the list is the individual's Nearest Relative.

consider that Mr A had capacity to agree to admission and therefore recommended Mr A be detained because Mr A presented a “significant and unpredictable risk to himself”.

- 4.17 The second medical opinion was undertaken by S12D3, a Section 12 doctor. S12D3 considered Mr A to be acutely psychotic and a risk to his own and others' safety and that he could not be safely managed in the community.
- 4.18 Mr A was then conveyed to MHU1, a mental health inpatient unit run by the Trust.

#### **4 January 2017 – Admission to MHU1 on Section 2 Mental Health Act**

- 4.19 Mr A was admitted to MHU1, ward staff noted that Mr A was a detained inpatient on S2 of the Mental Health Act. There was evidence of significant risk behaviour and that people potentially at risk from his behaviour were his partner (Ms L) and his mother (Mrs E), and it was noted that a further risk assessment was required. Ward staff noted that it was unclear whether Mr A's behaviour was drug induced and that sometimes his delusions were contradictory. It was also noted that Mr A had been diagnosed with scabies, but he was receiving treatment.
- 4.20 Mr A had asked ward staff to send a letter to his partner (Ms L) and a different letter to his father. The content of the letter to Ms L indicated that Mr A was acutely unwell. Staff administered lorazepam 1mg (it is unclear if this was oral medication) at the instruction of on call doctor but noted that it appeared to have little effect on Mr A's presentation.
- 4.21 An admission care plan and infection control care plan were completed by STU1 (a student). It was noted that Mr A was convinced that STU1 was actually a senior member of staff and was pretending to be a student. Care plans were also completed for:
- history of harm to others and fire setting;
  - scabies.
- 4.22 Ward staff contacted the infection control team for advice. It was noted that a diagnosis of scabies had been confirmed but it was unclear whether Mr A had used the treatment prescribed by his GP. The advice from the infection control team was to keep Mr A segregated for 24 hours after starting treatment to avoid the risk of cross infection.
- 4.23 Mr A was discussed at the ward review meeting when it was recorded that the clinical impression was that Mr A had possibly suffered a psychotic episode and that he had underlying problems with attachment, personality traits (antisocial or emotionally unstable), and comorbid drug use. The plan was for:
- ward staff to contact Mr A's family regarding visiting him and to obtain a corroborative history;



- assess Mr A's mental state;
  - not prescribe any medication for 72 hours;
  - junior doctors to complete Mr A's physical examinations;
  - contact the police for Mr A's forensic history;
  - Mr A to be nursed on general observations unless his risks indicate differently (an inappropriate level of observation given his risks and lack of medication – care delivery problem 12);
  - conduct a urine drug screen.
- 4.24 That evening ward staff received a call from Ms L who provided some background information about Mr A. Ms L said that just prior to admission to hospital, Mr A had brandished a bread knife and said that he was going to kill himself or Ms L if she didn't ring somebody.
- 4.25 On 5 January Mr A's urine tested positive for benzodiazepines and negative for all other substances tested (the clinical entry notes that Mr A had been given lorazepam shortly before the test was done, despite the fact that at the ward review meeting the previous day it was planned for Mr A to have no medication for the first 72 hours – care delivery problem 14). Mr A told staff that he believed that the “intervention team” had given him some type of cocaine when in police cells.

## **6 January 2017 – transfer to MHU2 still on Section 2 Mental Health Act**

- 4.26 Mr A was transferred to MHU2 on 6 January. However, it is unclear to the Panel when he was actually transferred because there are no entries that refer to discussions about transferring Mr A to MHU2. There is an entry made by a junior doctor at MHU1 referring to a physical examination conducted shortly after 10:00am. However, the next entry is at 8:10pm completed by JD3 who was the on-call doctor for MHU2 that evening. In addition, there is no reference in Mr A's records to why he was being transferred. (We learned from staff that this was because he had initially been to MHU1 because there had been no bed capacity at MHU2 which was closer to Mr A's home.
- 4.27 JD3 summarised Mr A's previous assessment under the Mental Health Act and his presentation during the previous two days following admission to hospital at MHU1. JD3 noted that his impression was that it was difficult to establish whether Mr A had suffered a true acute psychotic episode, because of his use of substances or possibly an underlying personality or adjustment disorder. JD3 noted the plan was to continue with lorazepam and zopiclone 7.5mg daily, that Mr A's treatment for scabies should also continue and review by a senior doctor should be arranged along with an ECG. JD3 also noted that Mr A had a phobia of needles noted and that Mr A should be encouraged to agree to further blood tests. JD3 also noted that ward staff should

encourage good dental hygiene and that Mr A had a possible dental abscess. Mr A's phobia of needles was not reflected in the nursing care plan.

- 4.28 On 7 January Mr A went into another patient's bedroom to wake them to ask them to go to the shop for a paper. It was reported that the other patient was annoyed at being woken. Staff informed Mr A that he was not to enter other bedrooms. Despite this advice, Mr A entered a patient's bedroom again and staff told him to return the item he had removed and reminded him to stay out of other bedrooms. In the evening Mr A asked for some one-to-one time with RN2. Mr A was tearful and said he felt nobody was listening to him. He asked for a quieter room and said that he felt helpless and unable to protect his family but was unclear what they need protecting from. Mr A wanted the nurse to sit with him in his room but was told this was not possible because his plan included one-to-one time for 30 minutes per day. RN2 later noted that one-to-one time was to be given with two members of staff present due to Mr A's risk (but she was not clear about what risk specifically). Mr A asked again for time with RN2 and was told that he had "already spent 30 minutes with [RN2] and that he could speak on the ward in the main area with staff generally". Mr A had already told staff that he struggled in the noisy general space and staff encouraged him to return to his room if the ward became too loud for him. RN2 noted that "Firm boundaries [are] required as Mr A may take advantage of staffs time".
- 4.29 During the evening on 9 January one to one time was "conducted" whilst dispensing Mr A's medication. Mr A asked for some more one-to-one time with staff a couple of hours later, staff noted that Mr A had received one-to-one time earlier, so agreed to give him ten minutes. Mr A was initially tearful and said he was struggling with the environment on the ward. Mr A stated he felt he had been lied to and that he had received substandard care. Mr A was upset that he perceived other patients were getting more care than him. Mr A complained that he had not seen a doctor since admission. Staff informed Mr A of the date of his review with the doctor (the following day) and it was noted that he appeared happy with this.
- 4.30 On 10 January a retrospective entry was made for 8 January. Mr A had attended the office and handed in medication (zopiclone and promethazine) he had been administered from the previous evening (7 January), indicating that he had not swallowed the medication. There is no indication that staff adjusted Mr A's risk assessment or risk management plan, nor that they considered a room search, in addition the records indicate that promethazine was only added to Mr A's medications after the incident.
- 4.31 Later that day Mr A was discussed in the ward review meeting, when his diagnoses were recorded as adjustment disorder and mental and behavioural disorder due to cannabinoid use. Mr A said that he wanted some therapy for his anxiety, but staff advised Mr A that anxiety management therapy was delivered in the community (rather than inpatient services). Mr A's medication was permethrin 5% cream (for treatment of scabies), lorazepam 1-2mg on request, zopiclone 3.5mg on request, nicorette inhaler, and promethazine 25mg on request. (Although this information was recorded in Mr A's contemporaneous clinical records, the Panel has not been able to find a

corresponding Medication Administration Record (MAR). Given Mr A's history and events leading to his detention under the Mental Health Act it is difficult to understand how the diagnosis of adjustment disorder was formulated. It is possible that this diagnosis contributed to Mr A's care plan being inappropriate and not meeting his needs. Mr A was not asked about hallucinations and his care plan did not offer any regular treatment (medication or therapy) to address his presenting needs.

4.32 That evening RN4 noted that Mr A had approached staff numerous times making various requests. Mr A asked:

- for a different bedroom but gave no reason;
- to speak to the "highest solicitor in this place" and was advised that a solicitor would be provided in due course now that the appeal paperwork had been completed;
- to see his blood results sheets; the printed sheets were not yet available, so JD3 showed Mr A the results on the screen;
- to see "expert legal person" on Human Rights Act or that he was provided with a number to call one; he was advised that a solicitor would be in touch regarding the tribunal soon and that during the evening it would be unlikely that any expert would be available to talk to. RN4 offered to find some written information or leaflets which Mr A declined because he wanted to speak to a person.

4.33 A Section 17 leave form was completed that allowed Mr A to leave the ward accompanied by staff between 10:00am and 4:00pm for periods of up to two hours, and to stay in the local area. It was noted that Ms L had been informed of the arrangements by RN2.

4.34 In the early morning of 11 January, Mr A approached staff saying he felt unwell (he felt sick). Staff reassured him and advised him to have a drink. It was noted that Mr A remained on 15-minute observations. That evening Mr A approached RN5 (charge nurse) in the clinic room and brought out a pair of scissors. Mr A said that he had taken them from the clinic drawer the previous day when a staff member wasn't looking. Mr A was asked what he intended to do with the scissors, but he was either "unable or declined to answer". The severity of his actions was explained to him and Mr A was told that he was not to enter the clinic room again. An incident report was completed but there was no update to Mr A's risk assessment and management plan and no evidence that ward staff considered a room search at this point.

4.35 On 12 January Mr A was discussed in the ward review meeting again. Mr A was critical of his own behaviour and reported that he had damaged trust property (a mattress) and said he would pay for the damage he had caused using the scissors taken from the treatment room. Mr A said that he had not planned to use the scissors for this, he had planned to use them to take out his tooth (that was causing him pain). Mr A reported that he had cut himself with a razor whilst on the ward, he showed staff two cuts on his left posterior

distal forearm. The treatment plan was for Mr A to access occupational therapy. Medication was permethrin 5% cream (scabies treatment), lorazepam 1-2mg as required, zopiclone 3.5mg as required, nicorette inhaler, and promethazine as required. No update was made to Mr A's risk assessment and management plan to address his self-harm and damage to Trust property. RN6 referred Mr A to the integrated care team.

- 4.36 On 13 January ward staff noted that Mr A had been up numerous times during the night and appeared to be seeking attention from staff. He told staff that when he cut his mouth he was trying to remove his (wisdom) tooth that had been causing him pain, but he "refused to say what he used" to do this. Staff noted that Mr A had not appeared anxious or distressed and there had been no evidence of agitation. Staff noted that Mr A appeared "calculated in presentation". Mr A was later given 111 as an emergency dentist number. Ward staff observed him on the phone describing his pain and Mr A asked them to speak to the triage nurse on the phone who wanted to confirm Mr A's symptoms. OT1 (occupational therapist) advised the 111 nurse that staff could only repeat what Mr A was saying as "we do not deal with teeth in this setting". It was noted that a 111 nurse would call within two hours and that they would speak to a member of staff first, therefore the ward telephone number was provided.
- 4.37 Also on 13 January a retrospective entry was made indicating that Mr A was discussed at the ward review meeting on 9 January. A summary of Mr A's reason for admission was noted along with the fact that his Mental Health Review Tribunal meeting had been scheduled for the following week. No information was provided about his medication (the entry noted "see medication card") and no information was provided about Mr A's risk or his care plan. There was no reference to Mr A's views about his care and treatment and the next review was noted as 12 January.
- 4.38 That afternoon ward staff received a call from a 111 nurse who was calling to give advice about Mr A's gum wound "caused by self-harm". OT1 spoke to the 111 nurse who advised that Mr A take medication for the pain and suggested that ward doctors prescribe Corsadyl mouthwash. Staff were advised to monitor Mr A for infection, fever or facial swelling. OT1 updated Mr A who said he was told not to take Corsadyl. Mr A said he had harmed himself using his fingernail and some scissors two days previously.
- 4.39 JD4 examined Mr A's mouth and initially Mr A did not want to explain how he acquired his mouth injury, but eventually admitted he had damaged his gum with his fingers. JD4 encouraged Mr A to contact an emergency dentist for a check up. JD4 later noted that CP3 had contacted the ward to advise that Mr A could be prescribed paroxetine for his anxiety. JD4 therefore prescribed paroxetine 20mg and explained the medication to Mr A, noting that type of medication can sometimes cause an increase in suicidal thoughts. Mr A was reluctant to start the medication because "he would kill himself" but JD4 explained he might not develop side effects, and to approach staff if he did.

- 4.40 Nursing observations were completed every four hours due to the risk of infection in Mr A's mouth. Mr A was encouraged to talk to staff if he felt that he was getting worse physically.
- 4.41 CP3 completed a psychiatric report in preparation for the Mental Health Review Tribunal hearing CP3 noted that Mr A was intermittently emotional when talking about his father and that Mr A's recent social stressors were, bullying at work, the break-up of his relationship, and seeing his father for the first time in six years and then his father leaving again.
- 4.42 On 14 January RN4 noted that Mr A had been asking about the Mental Health Act during the previous evening and had wanted RN4 to provide physical proof that he was a patient by showing him his detention papers. RN4 advised that he could request copies of notes or paperwork by completing a form and other staff suggested that he look at his rights leaflet. Staff tried to administer antidepressant medication to Mr A but he told them he believed he was going to start antipsychotic medication. Reassurance was given but Mr A was reluctant to accept medication and said he wanted to try without medication. Mr A was advised staff would discuss the matter with the doctor "on Monday". Mr A received a visit from his former partner, staff noted that they sat in the dining room. There is no indication that staff considered the plan for Ms L's safety. This should have been put in place given that she had been identified as being at risk from Mr A.
- 4.43 On 15 January a Section 2 Mental Health Act patient information form was started but it is incomplete because there was no information about who the Trust understood to be Mr A's Nearest Relative.

## 16 January 2017 – Assault on Mr O

- 4.44 At approximately 2:00am on 16 January HCA2 was conducting patient observations and saw Mr A leave Mr O's bedroom. HCA2 went into Mr O's bedroom and saw that the mattress was on the floor, she requested support from other staff and all available staff who responded went into Mr O's bedroom.
- 4.45 Some of these staff then went to stay with Mr A and check on the welfare of other patients. All the other patients were safe and well. When RN8 and HCA3 entered Mr A's room they found him talking on phone to police. HCA3 asked what he had done to which Mr A responded "I have committed murder, I have killed somebody". RN8 asked why Mr A had been in Mr O's room, Mr A said "he was manipulating me, he was stealing from me, he was threatening me behind your backs". HCA3 advised Mr A not to say any more until the police had arrived. Staff stayed with Mr A until police arrived on the ward. When the police arrived, they handcuffed Mr A and took him into custody.
- 4.46 It appears that Mr A was prescribed four days' worth of medication to take with him to the police station: paroxetine 20mg once daily; promethazine 25mg as required, but maximum of twice daily; zopiclone 3.75mg as required, but maximum of once daily.

- 4.47 During the morning AND1, Associate Nurse Director contacted the custody sergeant to see if any of Mr A's family had been informed that he was in custody. Police advised that Mr A had asked for a named person (not his mother or his girlfriend) to be informed but this had not happened. The ward manager, WM1 was asked to contact Mr A's mother and his partner.
- 4.48 WM1 called Ms L to ask for contact details for Mr A's mother, as she was unable to find Mr A's mother's information on the system. Ms L was anxious and asked why the information was needed. WM1 offered assurance that Mr A was safe but there had been an incident and staff needed to contact his mother. WM1 suggested that Ms L contact Mr A's mother for more information. Ms L confirmed that Mr A had little contact with his father and provided WM1 with Mr A's mother's telephone number.
- 4.49 WM1 called Mr A's mother (Mrs E) and informed her that Mr A had been involved in an incident with another patient and he was in police custody. Mrs E was anxious and asked for more information but was advised that staff could only share limited information. Mrs E said that she had visited Mr A the previous day and had spoken about the recent contact with his father, and her view that this had been the trigger for Mr A's recent episode leading to admission to hospital. Mrs E was advised to contact the police for further information about Mr A, and she was also asked to contact Ms L to update her.
- 4.50 CP3 later assessed Mr A's fitness to be interviewed by police because Mr A's solicitor and mother had raised concerns the previous day. It was noted that Mr A had reported feeling confused about why he had harmed Mr O, he said that he felt scared and alone and scared he was not there for his family. Mr A said he felt Mr O was after him and that he was a leader of a cult. Mr A told CP3 that Mr O had taken Mr A's shirt and worn it, although Mr A later allowed Mr O to have it. Mr A said that he felt Mr O had been "after him" from the third day of being admitted to hospital but said that he didn't know what to believe at the time CP3 was interviewing him. Mr A said "I've messed up my life, my family and Mr O's family. There'll be many patients on the ward who'll be upset. Tell everyone I'm sorry". It was noted that Mr A had initially been reluctant to take paroxetine for anxiety because of the possible side effects (he felt it would make his mental health worse). Mr A also said that he didn't feel he could talk to staff, but he could talk to other patients. Mr A said that he had requested one-to-one sessions for his thoughts saying, "writing poems about how I feel has helped me keep a straight head". Mr A said that he felt suicidal because he had destroyed his and Mr O's family but he didn't know how to hurt himself. CP3 determined that Mr A had "mental capacity to consent to be interviewed by police".

## 5 Care and treatment of Mr O

### 2 January 2017 – Admission to mental health unit MHU2 on Section 2 Mental Health Act

- 5.1 On 2 January Mr O arrived at A&E accompanied by the police who reported that Mr O had been distressed whilst in a public place. (Mr C has told us that this report is incorrect, and that Mr O was actually upstairs at the home they shared when Mr C heard him talking on the phone. Mr C told us that shortly afterwards the police arrived and took Mr O outside, from where they took him to A&E.) HTT3 from the Access Team<sup>12</sup> tried to assess Mr O, but he presented as very confused, would not answer her questions and was unable to finish a sentence without changing the subject. Staff noted that the Trust had previous involvement with Mr O but that there had been no contact since 2005. Mr O told staff that he had reported his partner (Mr C) to the police for serious offences and accused his partner of a number of offences against him (Mr O). Staff noted that Mr O was inconsistent about some details about the allegations against Mr C. Staff were not clear whether Mr O's reports about Mr C were delusional, however HTT3 noted she would make safeguarding referral and the Panel can see that this was done later the same day.
- 5.2 S12D3, a Section 12 doctor assessed Mr O under the Mental Health Act and noted that Mr O remained severely confused and agitated. It was reported that Mr O's most recent contact with mental health services was ten years previously and that Mr O had difficulties with substance misuse and personality issues. S12D3 concluded that Mr O needed to be admitted to hospital under the Mental Health Act. This was supported by Ms Y, an AMHP, who made the application for Mr O to be detained on Section 2. Ms Y noted that staff were unclear whether Mr C was Mr O's formal live-out carer, a live-in carer or friend. Despite attempts to do so, AMHP3 was unable to gather any more information during the assessment to clarify Mr O's claims about Mr C. AMHP3 noted on the Mental Health Act form (Form 2) that she was unable to ascertain who Mr O's Nearest Relative was.
- 5.3 At Mr O's arrival on MHU2 a number of assessments were completed, most of which indicated low or no risk. The alcohol screening tool indicated that it was possible that Mr O was dependent and that referral to services was required.

### 3 January 2017 – Placed in seclusion

- 5.4 Mr O's case was discussed at the ward review meeting on 3 January. It was noted that Mr O's diagnosis had not been established but that he had a history of borderline personality disorder. Mr O's medications were paracetamol, promethazine 25mg (maximum of 100mg/24 hrs), and zopiclone 3.75mg once daily. No information was recorded in the safeguarding category. Staff noted that it was difficult to establish a sound history, and that Mr O had reported numerous hospital admissions in Belfast, Cheshire, Crewe,

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<sup>12</sup> The Access Team has a number of functions that include assessment, crisis intervention and resolution, home based treatment, hospital liaison services for older adults and care home liaison services for older adults.

and Lincoln "under false names...". Mr O repeated his earlier allegations about his partner Mr C. The impression was that Mr O had emotionally unstable personality disorder, dementia secondary to alcohol, and there was a question about Munchausen's syndrome, but staff felt they needed more time to observe him to be able to get clarity about this. The plan was for staff to contact mental health services where Mr O had lived previously, consider a CT scan and antipsychotic medication if Mr O's condition did not improve.

- 5.5 During the afternoon Mr O became unsettled, he was given promethazine 25mg and escorted to a low stimulus area. Mr O's behaviour escalated, and he was put into a passive restraint on the sofa, after which he appeared to calm down but then his behaviour escalated again, and he began to kick the door, shout and swear, and was more aggressive towards staff (so much so that staff noted they felt threatened by him). Mr O began to throw his head back and kick out at staff so a decision was made to seclude him. (IR1 form 88945 refers).
- 5.6 Mr O was reviewed by CP3 and CP1 during the evening when he again repeated the allegations about his partner. CP1 noted that staff had no evidence to support the allegations but that they needed to bear in mind there may be a psychotic explanation of an underlying safeguarding issue and that staff should explore this more when Mr O's mental state was more stable. CP1 noted that Mr O's history of alcohol abuse needed to be clarified and that a discussion in ward round was required in order to determine whether to administer prophylactic pabrinex<sup>13</sup>. CP1 recommended that Mr O remain in seclusion whilst his risk of violence was so unpredictable and indicated that further sedation was required. CP1 prescribed lorazepam 2mg to be administered immediately, and a further dose a few hours later if the first dose was not effective. It was noted that the next seclusion review was due first thing the following day, and an independent seclusion review was due between 9:00am and 5:00pm the following day. CP1 also noted that a multi-disciplinary team discussion about communicating with Mr O's partner was required. Mr O had said that he did not want staff to speak to his partner, and it was noted that the potential for safeguarding concerns was yet to be explored, however it was felt that Mr O's partner may have important information about Mr O's recent stressors and his alcohol pattern.
- 5.7 North Lincolnshire Council records indicate that on this date the safeguarding referral was picked up and an email sent back to the referrer to provide more details on the referral form and gain consent (from the person at risk, i.e. Mr O). There is no reference to this in the Trust documents and the local authority records note that no response was received. It is unclear from the information the Panel has seen, what information the council considered to be missing from the original safeguarding referral.

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<sup>13</sup> Pabrinex



## 4 January 2017 – Seclusion ended

- 5.8 Seclusion reviews were undertaken in a timely fashion and every two hours and at 3:20pm Mr O's mental health and behaviour were much calmer and more rational since the previous review. Seclusion was therefore terminated, and it was noted that Mr O had been secluded for 23 hours. There is no evidence that a proper physical assessment was undertaken at times when Mr O was asleep during seclusion reviews.
- 5.9 On leaving seclusion Mr O advised staff that he was lactose intolerant, so staff noted that they would make kitchen staff aware of this. Staff noted that Mr O had stated his son was his next of kin but that he had no contact details for him. When Mr O's partner tried to call him Mr O told staff that he did not want to talk to him and said that he did not want them to share any information with him. Staff noted that Mr O required a lot of reassurance following this call. Later Mr O told staff that his partner had his bank card and that he had access to the pin code because he had watched Mr O key it in. There is no evidence that this information was reflected in Mr O's care plan or risk management plan.

## 5 January 2017 – Ambulance requested

- 5.10 Mr O provided staff with information about his background and how he came to be supported by his partner. Mr O also talked about previous admissions to hospital elsewhere and said that he had recently received input from two support workers from mental health services where he had previously lived. He provided details of his registered GP practice but said that he had not registered with a local GP since his move. Mr O repeated his concerns about his bank card but also said that he had been mugged on New Year's Eve (Mr C has told us that Mr O's report about being mugged is untrue and that he and Mr O were at home together on New Year's Eve).
- 5.11 During the afternoon Mr O's confusion worsened significantly and he was complaining of abdominal pain. Staff noted that an urgent assessment was required at a general hospital to exclude Wernicke's Encephalopathy<sup>14</sup>. JD4 contacted the general hospital to speak to the medical registrar but received no response and the ambulance service was having difficulty responding to calls. JD4 noted that the single point of access team spoke to "the most senior doctor available" who did not believe that Mr O required admission, and also did not consider 999 was required. JD4 advised that her registrar wanted Mr O reviewed by A&E as there were no facilities to resuscitate patients at MHU2, nor to give intravenous therapy. JD4 discussed the matter with Dr S2 who also spoke to CP3. CP3 felt assessment at A&E was required due to Mr O's presentation and advised JD4 to call 999 without further discussion with general hospital senior medic. JD4 contacted the non-emergency ambulance who advised they would dispatch a vehicle and crew, and that staff were to call 999 if Mr O deteriorated in the meantime.

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<sup>14</sup> Wernicke's encephalopathy is a neurological emergency resulting from thiamine deficiency with varied neurocognitive manifestations, typically involving mental status changes and gait and oculomotor dysfunction. [bestpractice.bmj.com](http://bestpractice.bmj.com)

Paramedics did not arrive until after Mr O had gone to sleep but it is unclear to the Panel why paramedics had arrived at all as an earlier entry had indicated that the ambulance had been cancelled.

- 5.12 Ward staff requested both CAT<sup>15</sup> and MRI<sup>16</sup> scans for Mr O because of the sudden onset of confusion and disorientation. There is an undated letter, but the Panel believes it accompanied the request for scans and therefore was likely to have been written on 5 January. The letter provided all the information that we have already set out but added that Mr O was displaying ataxia<sup>17</sup> that was worse when he changed direction and that he had a raised level of c-reactive protein<sup>18</sup> in his blood on 2 January. Staff noted they were concerned that Mr O was deteriorating despite treatment for alcohol withdrawal, and that he was also complaining of abdominal pain.

## 6 to 9 January 2017

- 5.13 The following day Mr O's physical health improved and when staff assessed Mr O's alcohol withdrawal symptoms, they found no significant concerns.
- 5.14 On 8 January staff noted that Mr O had been generally settled during the day and that he had spent a lot of time with Mr A. In late afternoon Mr O was observed to be talking excessively much of which was aimed at his partner, who was not present.
- 5.15 On 9 January Mr O became animated and increasingly agitated, with his speech bizarre and incoherent. Mr O got close to another patient when talking incoherently which the other patient found difficult to tolerate. Staff administered lorazepam and were unable to offer an effective one-to-one session due to Mr O's rambling and incoherent speech. There is no evidence that Mr O's care plan or risk assessment were adjusted at this time, nor that his observations level was reviewed.

## 10 January 2017 – Incident with another patient

- 5.16 On 10 January Mr O was discussed in the ward review meeting when it was felt that Mr O was experiencing a manic episode. Medication was thiamine 100mg three times daily, Vit B co-strong<sup>19</sup>, and olanzapine 5mg once daily. The plan was to increase olanzapine 5mg to twice daily. There is no evidence that Mr O's observations level was reviewed. An incident report was

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<sup>15</sup> A computerised tomography scan (CT or CAT scan) uses x-rays and a computer to create detailed images of the inside of the body.

<sup>16</sup> Magnetic resonance imaging (MRI) is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.

<sup>17</sup> Ataxia is a term for a group of disorders that affect coordination, balance and speech.

<sup>18</sup> A high level of c-reactive protein is an indicator of inflammation. It can be caused by a wide variety of conditions, from infection to cancer. High c-reactive protein levels can also indicate inflammation in the arteries of the heart, which can mean a higher risk of heart attack.

<sup>19</sup> Vitamin B Compound Strong (Vit B co strong) is used to treat vitamin B deficiency. The effects of a vitamin B deficiency can include: swelling of the tongue, mouth or lips, swelling of nerves which can cause pain, tenderness or loss of function and the growth of new blood vessels in the eye which can affect vision.

completed that stated that another patient (not Mr A) had tried to remove Mr O's hat, causing Mr O to become agitated and run towards and push the other patient causing him to hit his head. Although the records are inconsistent about the nature of the incident as another entry notes that it was Mr O that fell and hit his head. Regardless of which patient was harmed, there is no evidence that Mr O's care plan was reviewed or that a safeguarding alert was made, although an incident report was made (IR number 89120.)

## **11 January 2017 – Placed on enhanced observations**

5.17 Staff noted that Mr O had been unsettled during the night, shouting and banging his bedroom door. When Mr O woke he had appeared confused, another patient (it is unclear whether it is the same patient involved in the altercation the previous night) had walked past Mr O and Mr O had tried to grab him resulting in staff intervention. Mr O was placed on level 2 observations (within eye sight) when in the day area. Mr O appeared to be responding to unknown stimuli during the day, waving his hands towards objects. An enhanced observations care plan noted that Mr O had been placed on one-to-one nursing observations at 9:20am that day.

## **12 January 2017 – Remained on enhanced observations**

5.18 The enhanced observations care plan indicated:

- midnight and 2:00am – observations completed;
- 02:00-06:00 – “remained in [his] bedroom”;
- 06:00-10:00 – no entries;
- 10:00 - 12:00 – observations completed;
- 12:00-14:00 – bed
- 14:00-15:00 - observations completed;
- 15:00-17:00 – bed;
- observations not completed after 17:00.

5.19 Night staff noted that Mr O had remained in his room during the evening, continuously talking to himself, increasingly agitated and shouting. Mr O had tipped up his bed when staff approached him and said that he had trashed his room. Staff noted that Mr O did not go to sleep until about 3:30am.

5.20 Later that morning Mr O was taken to the general hospital for a CT scan. Mr O spent the majority of the day in his room, still responding to unknown stimuli, and observations continued.

## 13 to 15 January 2017

- 5.21 On 13 January a ward review was recorded, noting that it took place on 9 January. The multi-disciplinary team had discussed diagnoses of alcohol dependence and personality disorder, noting that Mr O presented with bizarre speech content. There is no record of Mr O's views of the care plan, or Mr O's risks, or a review of the level of observations. Later an ECG<sup>20</sup> was performed which was normal, although an irregular baseline was noted it was not significant enough to require any follow up action.
- 5.22 On 15 January Mr O received a visit from his partner and staff noted that Mr O was delighted to see him. Mr O and his partner spent the afternoon on the ward together, it is unclear from the records whether this was in private (for example in Mr O's bedroom) or if their meeting took place in a general space (for example the day area). Mr C has told us that the meeting took place in Mr O's bedroom at Mr O's request.

## 16 January 2017 – Assault on, and subsequent death of, Mr O

- 5.23 At approximately 2:00am HCA2 was conducting patient observations and saw Mr A leave Mr O's bedroom. HCA2 went into Mr O's bedroom and saw that the mattress was on the floor, she requested support from other staff and all the staff who responded went into Mr O's bedroom.
- 5.24 When staff entered Mr O's bedroom his location was not immediately obvious, staff checked Mr O's bathroom before lifting the mattress under which they found Mr O lying on his back, with his head propped up against the radiator. Staff requested the assistance of the Nurse in Charge who attended, and another member of staff dialled 999. Staff pulled Mr O flat onto his back and the emergency grab-bag was collected.
- 5.25 AND1 contacted the A&E department at about 5:20am and was advised that Mr O was in resuscitation. The police contacted AND1 at about 6:30am and advised that Mr O was heavily sedated and intubated and would remain so for a while before general hospital staff attempted to withdraw sedation to establish if he could breathe independently. AND1 contacted the intensive care unit at about 8:00am and was advised that there had been no contact with Mr O's family or his partner regarding his current situation. WM1 was asked to contact Mr O's partner to obtain family contact numbers.
- 5.26 WM1 contacted Mr O's partner at about 9:30am. WM1 informed him that there had been an incident overnight, and that she could not provide any details other than to advise that Mr O was in the intensive care unit at the local general hospital. Mr O's partner said that he had visited Mr O the previous night and Mr O had reported trouble with a fellow patient, however the description that Mr O had given to his partner did not match Mr A's description. WM1 gave assurance given that the two incidents were not connected. Mr O's partner confirmed that Mr O had not had contact with his

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<sup>20</sup> An electrocardiogram (ECG) is a simple test that can be used to check the rhythm and electrical activity of a patient's heart.

family for some years. Mr O had tried to contact one of his sons via social media but had not been successful. Mr O's partner stated that he was the only family Mr O had. WM1 suggested that Mr O's partner made his way to the general hospital as soon as possible.

- 5.27 During the afternoon CP3 and MM1 visited Mr O in the intensive care unit and noted that Mr O's partner was also present. CP3 noted that Mr O's prognosis had been reported as poor and consequently CP3 rescinded Mr O's detention under the Mental Health Act because his main health needs were physical. CP3 confirmed that Mr O was from that moment an informal patient, she completed the necessary paperwork and informed the Mental Health Act office.
- 5.28 The local authority records for this date note that the safeguarding concern received on 2 January was closed by the social worker because no further information had been received from the Trust. In closing the referral, the following statement was made by the social worker:
- “This concern was of 2/1/2017 and the case was allocated to myself on 16/1/2017 following [Mr O's] death at [MHU2]. From the information in the concern, my initial concerns are that [Mr O] was and would be financially, emotionally and physically abused from the source of harm. However following [Mr O's] death at [MHU2] these risks no longer exist, there is no further action to take and this concern can be ended.”
- 5.29 At about 8:10pm WM1 received a call from the intensive care unit to advise that Mr O had passed away.
- 5.30 A safeguarding alert regarding the incident was completed and forwarded to the Adult Protection Team at North Lincolnshire Council. This was followed up by direct contact from the Trust Lead Professional Adult Safeguarding Adults to explain the situation.
- 5.31 The local authority records indicate that they received a safeguarding alert referring to the assault on Mr O by Mr A. The local authority noted that a Section 42 enquiry<sup>21</sup> and that the police were investigating the incident.
- 5.32 On 15 February a safeguarding social worker visited MHU2 to see the Modern Matron to discuss a ward safety plan. The social worker was advised that the Matron was on annual leave and an appointment was made for 20 February.
- 5.33 On 20 February the safeguarding social worker visited MHU2 again but was advised that the Matron was still on leave. The social worker advised that this was their second visit to read and obtain a copy of the ward safeguarding plan. The social worker was advised to put the request in an email and the Matron would action it on their return from leave.

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<sup>21</sup> The Care Act 2014 (Section 42) requires that each local authority must make enquiries or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect.

- 5.34 On 6 March the safeguarding social worker called MHU2 to speak to the Matron but was advised that they were not at work that day. The social worker asked that a message be left for the Matron to call them on return to the office.
- 5.35 The following day the safeguarding social worker called MHU2 to speak to the Matron but was advised that they were not in the office. The social worker asked that a message be left for the Matron to call them to discuss the safeguarding plan.
- 5.36 On 8 March the safeguarding social worker tried yet again and was advised that the Matron was in a meeting. The Matron returned the call later that day and advised that the safeguarding support plan would be ready for collection on 14 March. The social worker noted that they would collect it that day.
- 5.37 On 20 March the local authority noted that the safeguarding plan had been received and that the Section 42 enquiry was closed.

## 6 Duty of Candour

6.1 We have reviewed the Trust's recording of its actions under the Care Quality Commission Regulation 20: Duty of Candour. Regulation 20 was introduced in April 2015 and is also a contractual requirement in the NHS Standard Contract. In interpreting the regulation on the duty of candour, the Care Quality Commission uses the definitions of openness, transparency and candour used by Sir Robert Francis in his inquiry into the Mid Staffordshire NHS Foundation Trust. These definitions are:

- **“Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
- **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
- **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.”

6.2 To meet the requirements of Regulation 20, a registered provider has to:

- “Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity.
- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification.
- Provide an account of the incident which, to the best of the provider's knowledge, is true of all the facts the body knows about the incident as at the date of the notification.
- Advise the relevant person what further enquiries the provider believes are appropriate.
- Offer an apology.
- Follow up the apology by giving the same information in writing, and providing an update on the enquiries.
- Keep a written record of all communication with the relevant person.”

6.3 It is our view that the Trust did meet its requirements under Regulation 20 in relation to Mr O's family.

6.4 However, we consider that, whilst the Trust technically may have met its requirements under Regulation 20, the spirit of openness and transparency in relation to Mr A and his family, was not fulfilled. At the time of his offence,

Mr A was detained under the Mental Health Act because he was assessed as a danger to himself or others and was under the care (and detention) of mental health services. During this time Mr A was deemed mentally ill and was detained for the purposes of assessment. In our view Mr A therefore was a person using services (as defined in Regulation 20) and therefore classed as a relevant person.

- 6.5 Furthermore, point 7b) of the regulation states that moderate harm includes significant, but not permanent, harm; “**moderate increase in treatment**” means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care);
- 6.6 Mr A is now in a secure unit and will remain there for some considerable time. This suggests that Mr A sustained at least moderate harm as he will require prolonged hospital treatment as a result of this incident. In addition, there is a risk that Mr A suffers perpetrator trauma, requiring treatment, particularly if his mental illness resolves and he appreciates what he has done.
- 6.7 In our view Mr A and his next of kin, at least in the spirit of openness, should have been informed that Mr A had been involved in a notifiable patient safety incident, and provided with the same explanations as the victim and his family.

### **Communication with Mr A’s family**

- 6.8 The Trust telephoned Mr A’s mother (Mrs E) on 16 January 2017 to inform her that Mr A had been involved in an incident with another patient and he was in police custody. Staff advised Mrs E to contact the police for further information about Mr A. Staff also asked Mrs E to contact Ms L to update her.
- 6.9 The Trust wrote to Ms L on 7 July 2017. The letter informed Ms L that a serious incident investigation would be undertaken and invited her to contribute to the investigation if she wished. Ms L was also invited to extend the invitation to other members of Mr A’s family. We understand that Ms L did not contact the internal investigation team.
- 6.10 We can find no evidence that the Trust wrote to Mr A’s mother, Mrs E. She was not directly invited to contribute to the internal investigation.
- 6.11 We understand that Mrs E did speak to someone from the Trust shortly after the internal investigation report had been completed. At that time Mrs E had indicated that she did not want to see the internal report. Mrs E later changed her mind about wanting to see the internal report but was not clear about who she should approach.
- 6.12 When we met with Mrs E in May 2018 we discussed access to the internal investigation report with her and we then asked the Trust to make contact with Mrs E to progress this. We provided the Trust with information about how best to make contact with Mrs E and the most suitable time of day for her. Following a change in personnel at the Trust, this information was provided



again in August 2018 because Mrs E still had not received any contact from the Trust.

- 6.13 We can see that in September 2018 Mrs E received communication from the Trust regarding a meeting to discuss the internal report. Mrs E told us in November 2018 that she had not yet responded to the Trust because she had been focussing on her daughter's recent wedding.

### **Communication with Mr O's family**

- 6.14 The Trust made telephone contact with Mr O's partner, Mr C on 16 January 2017. This was followed up by a letter of condolence from the ward manager, sent on 27 January 2017 and a further letter of condolence from the Associate Nurse Director on 30 January 2017.
- 6.15 Mr C contacted the Trust Chief Executive's office on 16 May 2017 to express concerns that:
- the investigation into his partner's death was not being progressed in a timely manner;
  - he felt he was being provided with conflicting information.
- 6.16 The Interim Director of Nursing and Quality responded to Mr C's call because the Chief Executive was not on site that day. The Director of Nursing and Quality explained that the Trust had developed draft terms of reference that had to be agreed by the police, because of the ongoing police investigation.
- 6.17 Throughout May and June the Director of Nursing and Quality liaised with Mr C and a representative from the charity Hundred Families regarding the terms of reference for the internal investigation and ensuring that Mr C had the right support from the Trust.
- 6.18 We have been provided with copies of the text messages sent between the Interim Director of Nursing and Quality and Mr C. We can see that there have been in excess of 75 texts between November 2017 and March 2018. The majority of these messages are in relation to providing support to Mr C, liaison whilst waiting for the internal investigation report, and arranging a memorial service on the ward for Mr O on the anniversary of his death.

### **Analysis of Trust communication**

- 6.19 It is our view that the apology and ongoing support provided to Mr C was very good. The Trust kept detailed records and generally followed up actions agreed in a timely fashion. The level of support provided to Mr C around the anniversary of Mr O's death was in our view very good.
- 6.20 Mr C was provided with a draft copy of the internal investigation report and given opportunity to comment upon it.

6.21 However, this is in stark contrast to the position with Mr A's family. Mrs E did not receive any formal correspondence following the incident nor a direct invitation to be involved in the internal investigation. The letter inviting 'family' input to the investigation was only sent to Ms L. We consider this to have been inappropriate because:

- the Trust was aware that Mr A and Ms L had separated prior to his admission to hospital in January 2017;
- the Trust did not know what the relationship between Ms L and Mrs E was like and therefore the Trust could not have been assured that Ms L would extend the invitation to Mr A's direct family.

6.22 More than 18 months after the incident, Mrs E had still not seen a copy of the final report. We also consider this to be inappropriate, particularly as we had passed on a specific request from Mrs E in May 2018 for a meeting with the Trust so that Mrs E could see the report and have the findings explained to her.

6.23 See our Recommendation 1.

## 7 Internal investigation and action plan

- 7.1 The incident occurred on a ward and therefore the Trust was aware of the incident almost immediately. The police, ambulance service and on-call manager were notified.
- 7.2 We understand that the on-call manager did not ask for any details of the incident when the nurse in charge of the night shift called her to inform her of what had happened. The on-call manager then called the on-call director but was unable to provide any information, other than that there had been an incident on the ward. The on-call manager did not attend the unit and did not offer any support to ward staff. In our view this was an inadequate response to an emergency situation – we discuss this further in Section 8.
- 7.3 The internal investigation commenced in May 2017 and concluded in August 2017, however the final report was not signed off by the Trust Board until January 2018.
- 7.4 There was a delay in starting the investigation because the police investigation had not concluded. In our experience this is common as internal investigations are often delayed when there is a live police investigation because of the risk of contamination of evidence.
- 7.5 We understand that the reason for the delay in the Trust Board signing off the report was partially because of needing to wait for the conclusion of the criminal justice proceedings and partially because the report had to be amended.
- 7.6 The internal investigation team comprised:
- Legal Director from Capsticks;
  - Associate Medical Director, Doncaster Care Group
  - Modern Matron, Adult Inpatient Service, Rotherham
- 7.7 The investigation team first made contact with Mr A's partner and Mr O's partner on 7 July 2017 inviting them both to contribute to the investigation.
- 7.8 The report is a single narrative report covering the care and treatment provided to both Mr A and Mr O.
- 7.9 The internal investigation team interviewed 21 members of staff and Mr O's partner, Mr C. Summary notes were retained from these interviews and we have had access to these.
- 7.10 The investigation team did not interview any of Mr A's family or carers. The investigation team was only provided with Ms L's contact details and she did not respond to the letter sent on behalf of the internal investigation team. No contact was made with Mr A's mother, Mrs E.

- 7.11 The internal investigation report stated that the internal investigation team had identified two issues within Mr O's records:
- lack of appropriate documentation;
  - observations;
- 7.12 There is not the same clarity within the narrative about Mr A's records. Within the conclusion section the report refers to concerns that "neither the risk assessment nor supporting care plans were being regularly updated and in some instances proper incident forms completed".
- 7.13 The recommendations deal with issues identified in the care and treatment of both Mr A and Mr O (referred to as Mr Y and Mr X respectively in the internal report). The recommendations are themed and cover the following issues:
- multi-disciplinary team functioning;
  - involvement of families/friends;
  - observations;
  - safeguarding processes;
  - safe staffing (nursing and medical).

## Recommendations

- 7.14 The internal investigation team made 26 recommendations, eight of which were considered to be directly relevant to the incident and 18 of which were considered to be specific to the clinical care provided to Mr A and Mr O:

### Relevant to the incident

- R1 As part of the review of the observation policy, the Trust should ensure processes around 15-minute observations are reviewed to determine whether they should be staggered.
- R2 The Trust should review the existing safeguarding referral and follow up processes within [MHU2].
- R3 The Trust should put in place a local protocol for visitors informed by the existing Trust policy, following a consultation on whether it is appropriate for visitors to come directly onto [MHU2] and if so, to visit patients in their bedrooms.
- R4 The Trust should consider whether a formal policy, or other form of process, is needed to monitor patients visiting the rooms of other patients at [MHU2].
- R5 The Trust should review whether all options have been explored in recruiting an experienced consultant psychiatrist to [MHU2].

- R6 The Trust should ensure that the nurse staffing is continuously reviewed and that the role is one where staff can develop their careers through proper support, supervision and clinical guidance.
- R7 The Trust should carry out a review of the appropriateness of MHU2 Plus as part of [MHU2].
- R8 The Trust should review the number of commissioned beds and the current arrangements for the use of [a specific] Ward for MHU2.

### **Specific to the clinical care provided to Mr A and Mr O**

- R9 The Trust should engage in a consultation process with medical consultant staff who work in acute adult inpatient wards about 'best practice' for multi-disciplinary team functioning and alongside available national guidance review current Trust wide practice against available standards and guidance.
- R10 The Trust should review how it approaches, engages and communicates with family and carers when caring for inpatients with particular emphasis on guidance for more complicated scenarios such as where there is a safeguarding alert relating to the patient's family member, friend or carer.
- R11 The Trust should ensure that all staff are fully aware of the observation policy and have a comprehensive understanding of when observation levels can be changed and audited.
- R12 The Trust should ensure that all staff at MHU2 are reminded of the importance of appraising themselves of what is known about patients by reading what is documented in the notes.
- R13 The Trust should ensure that all staff at MHU2 are fully trained and follow the admission process fully when a new patient comes on to the ward.
- R14 The Trust should ensure that both the frequency and quality of medical admission clerking at MHU2, and the nursing admission process, are regularly audited.
- R15 The Trust should ensure that all staff at MHU2 are aware of their responsibilities for assessing the mental capacity of patients to give informed consent for relevant decisions. Further, medical staff must ensure that patients' capacity to give informed consent to their medication is both recorded in the clinical record and that the appropriate capacity documentation is completed.
- R16 The Trust should ensure that essential equipment such as an ECG machine is functional and that clear contingency plans are in place to deal with faulty equipment.

- R17 The Trust should ensure that MHU2 staff are appropriately trained to ensure that they are fully aware of their responsibilities when reviewing patients who have been secluded.
  - R18 The Trust should ensure that both the frequency and quality of medical entries when patients are secluded is regularly audited within MHU2.
  - R19 The Trust should review the training matrix for all MHU2 staff to ensure that staff are up to date with their Risk Assessment updates.
  - R20 The Trust needs to assure itself that when patients transfer from one hospital to another within the Trust, there is clarity about the expectation of the admission process involved for the receiving hospital.
  - R21 The Trust needs to assure itself that all staff at MHU2 understand the importance of reporting incidents and how this contributes to clinical governance processes.
  - R22 The management team at MHU2 should review the rationale for the use of the MHU2 multi-disciplinary team template and why it is used regularly to make retrospective entries in Silverlink and the appropriateness of this.
  - R23 The Trust should assure itself that MHU2 staff understand the clinical assessments and judgements involved in decisions relating to granting Section 17 leave.
  - R24 The management team at MHU2 should review the processes involved in moving patients between bedrooms. All such decisions should ideally be agreed at multi-disciplinary team meetings so that potential risks involved can be reviewed.
  - R25 The Trust should consider implementing a contingency plan to deal with exceptional events of determining who the appropriate person would be to undertake a 'fitness to be interviewed' assessment of a Trust patient. This is to prevent against the patient's own consultant being required to attend.
  - R26 The Trust should consider running regular update training sessions for all relevant staff on 'assessing psychopathology: dilemmas and pitfalls'.
- 7.15 Whilst we do not necessarily disagree with the recommendations made by the internal investigation team, it is our view that they fail to properly consider and address the underlying issues present in the unit.

### **Analysis of Trust action plan**

- 7.16 The Trust action plan is structured in a way that is not easy to identify which recommendations have been addressed. We have indicated below which

recommendations we believe relate to each area of improvement identified in the action plan as follows:

- To reduce instances of moderate or greater harm being caused to patients (R1, R2, R6, R11, R16, R21).
- To promote a learning culture (R21).
- That the ward has clear systems and processes for organising, managing and recording patient care delivery that is in line with the PIPA model and Trust policy/best practice (R9, R12, R13, R22).
- That the admission process on the ward is based on best practice guidance and that staff are clear on their roles and the expectations placed upon them (R14).
- That the provision of care on the ward provides continuity and recovery focussed interventions in line with best practice (R10, R15, R17, R18).
- That the processes of leave and discharge from the ward are safe and effective and that staff are clear about the expectations that are placed upon them (R14, R23).
- To promote a positive culture on the ward where patients feel safe and listened to and where staff are happy to work (R3, R4, R6, R19, R24).
- To provide a care pathway across the acute care pathway that is safe, effective and evidence based (R7, R8, R20, R24).

7.17 We have seen and heard evidence that the environment and culture on the ward has vastly improved since January 2017. The audit processes that have been implemented indicate that progress has been made across training, observations, visiting arrangements and engagement with families and carers, supervision, and nursing and medical staffing.

7.18 We are unable to identify that the action plan has addressed two recommendations: R5 (recruitment of an experienced consultant psychiatrist) and R25 (addressing the issue of determining fitness to interview).

7.19 R25: We have not seen evidence that the Trust has provided guidance regarding the assessment of patients with regards to fitness to interview. This was raised by the internal investigation team because they felt that it was inappropriate for CP3 to have been required to undertake Mr A's fitness to be interviewed assessment, given she had just been involved in a traumatic event concerning her patients. The internal investigation team noted that their view was that an independent consultant should have been found to conduct the assessment. It is reasonable to assume that the Trust accepted this recommendation, given its inclusion in the final version of the internal investigation report. Therefore, we would expect to see the recommendation represented in the action plan.

- 7.20 R5: However, we know that the Trust continued to work on recruiting a substantive consultant psychiatrist and was successful in appointing someone in the summer of 2018.
- 7.21 The action plan provides a deadline for each identified action, an associated lead, and the evidence source indicating completion.

## Conclusions of review of internal investigation and action plan

- 7.22 This was a Level 2 investigation carried out by a solicitor from Capstick's supported by the Associate Medical Director for Doncaster services and Modern Matron for Rotherham services from within the Trust. We reviewed the report against our standards and determined that whilst several recommendations were made, the investigation report itself did not follow root cause analysis principles recommended by NHS England, NHS improvement and the National Patient Safety Agency.
- 7.23 A formal root cause analysis process had not been followed, although the investigation team confirmed that root cause analysis principles were applied. As a result, there was no formal application of root cause analysis tools such as a 'five why's analysis', time person grid, a flowchart or error chain. In addition, whilst the investigation team were mindful of human factors, they did not apply a formal human factors approach or analysis. Furthermore, an exploration of their understanding of root cause determined that they did not fully understand this terminology.
- 7.24 We found that the internal investigation did not adequately explore the safeguarding of Mr O. The report only focused on the fact that Mr O had made a safeguarding allegation against his partner at home, and that this had not been responded to appropriately. In our view Mr O was displaying behaviour in the days before the incident that put him at risk from other patients which was not addressed adequately by ward staff or identified in the internal report. The internal report notes:
- "Although [Mr O] was monitored by 1:1 observations for 24 hours, there is no evidence of a risk assessment being conducted or a safeguarding plan being developed to respond if [Mr O's] behaviour continued or deteriorated."**
- 7.25 The internal investigation was asked to consider previous safety concerns regarding MHU2, and whilst the report discusses progress made since concerns were historically identified, it does not draw any correlations between what was said in previous reports and what happened in this case. Despite many attempts being made to address previous safety concerns it is apparent that staffing levels, clinical leadership, record keeping, and risk assessment remained problems on the ward in 2017. The report does not make this clear.
- 7.26 Our review of the report indicates that there was no comment on how the unit complied with national statutory obligations, guidelines or policies and procedures, although the report does have some references to internal protocols not being followed. There is no mention of whether Mental Health



Act paperwork was correctly applied or updated, no consideration of either patients' treatment compared with Care Quality Commission regulations (for example regarding seclusion records or safeguarding practice), National Institute of Health and Clinical Excellence guidelines, British National Formulary prescribing guidance, Royal College of Psychiatrists, Royal College of Nursing recommendations or otherwise.

- 7.27 Because of these omissions, the investigation report does not make clear what went wrong, what happened that should not have happened and what did not happen that should have happened in chronological order. The investigation report does not clearly identify issues as care or service delivery problems and does not draw out issues specifically as contributory factors.
- 7.28 There is a statement that there was nothing that the staff did not do that could have prevented the incident (paragraph 15.5 page 70). We disagree with this statement in that if staff had not been congregating in the communal area, one member of staff may have been patrolling the bedroom areas which may have meant that Mr A may have been seen entering Mr O's room. In addition, if observation practice had been less routine and predictable to Mr A he may not have taken the risk of entering Mr O's room at that time. In essence both those points are possibilities, rather than certainties, however this does not make either situation unlikely.
- 7.29 Predictability and preventability are subjective judgements, often applied in a legal sense associated with accountability and blame. In cases where it has been made clear that a death was preventable there are often legal repercussions. The purpose of root cause analysis is to examine systems so that the circumstances that allow a serious incident to arise are less likely to happen.
- 7.30 The internal investigation report made recommendations that may improve practice in the future. However, the report states that (page 60 paragraph 12.59) the investigation team could not identify any material contributory issue or root cause in Mr A's clinical management and care which could have prevented the incident.
- 7.31 Because of this the report does not make clear the linkages and consequences of each of the issues identified. The report also does not identify which of the recommendations are the most significant or most important to address.
- 7.32 The lack of focus on what went wrong and why, and the lack of risk assessment of each of the recommended actions, means that in practice the gravity of not meeting the recommendations is not made clear.
- 7.33 The action plan lacked clarity about which recommendation was being addressed in each section. We do not consider it to be wrong to group or theme recommendations but there must be a clear line of sight of recommendations made in internal investigation reports and where they are subsequently addressed in an action plan.

- 7.34 The Trust must ensure that serious incident investigation reports make clear the links between the issues identified and the recommendation being made, ensuring that the most important or significant recommendations are identified. See our Recommendation 2.

### **Clinical Commissioning Group monitoring of action plan**

- 7.35 NHS North Lincolnshire Clinical Commissioning Group was responsible for approving the internal investigation report and action plan, and monitoring progress of Trust actions.
- 7.36 The Clinical Commissioning Group policy in place at the time (Serious Incidents, Incidents and Concerns Policy July 2015) sets out the process that the Clinical Commissioning Group followed, and expected its commissioned service providers to follow. Included within this was:

All SI investigation reports are reviewed and discussed at the SI panel. The SI panel is a collaborative group drawn from NHS NL CCG and NHS NEL CCG. The SI panel will:

- Receive, critique and provide feedback on the SI report
  - Maintain a transparent and open system to assure quality of Root Cause Analysis, and to receive assurance that action plans resulting from SI reports have been followed up and adequately completed within the timescales indicated in the SI report
  - Review implementation of action plans and assurance on SI reports received
  - Identify learning points and be assured of sharing of learning
  - Monitor the implementation of this policy, including reporting timescales, quality of reporting, feedback to providers, performance management responsibilities, dissemination of lessons learned and assurance on actions taken
  - Ensure SIs are closed on STEIS when it is satisfied the investigation and action plans are completed
  - Work in conjunction with the CCG Communications service where a media response is required
  - Ensure actions are adequate or when it has sufficient assurance that actions have been completed
- 7.37 The Clinical Commissioning Group holds regular monthly meetings with the Trust to discuss individual serious incidents, progress with investigations and action plans, and the dissemination of learning from these. However the Clinical Commissioning Group has advised that there does not appear to have

been discussion at that meeting about this specific serious incident, other than to acknowledge that it was subject to an independent investigation commissioned by NHS England. The Clinical Commissioning Group has confirmed that this forum would have been the appropriate place for discussions regarding monitoring and assurance.

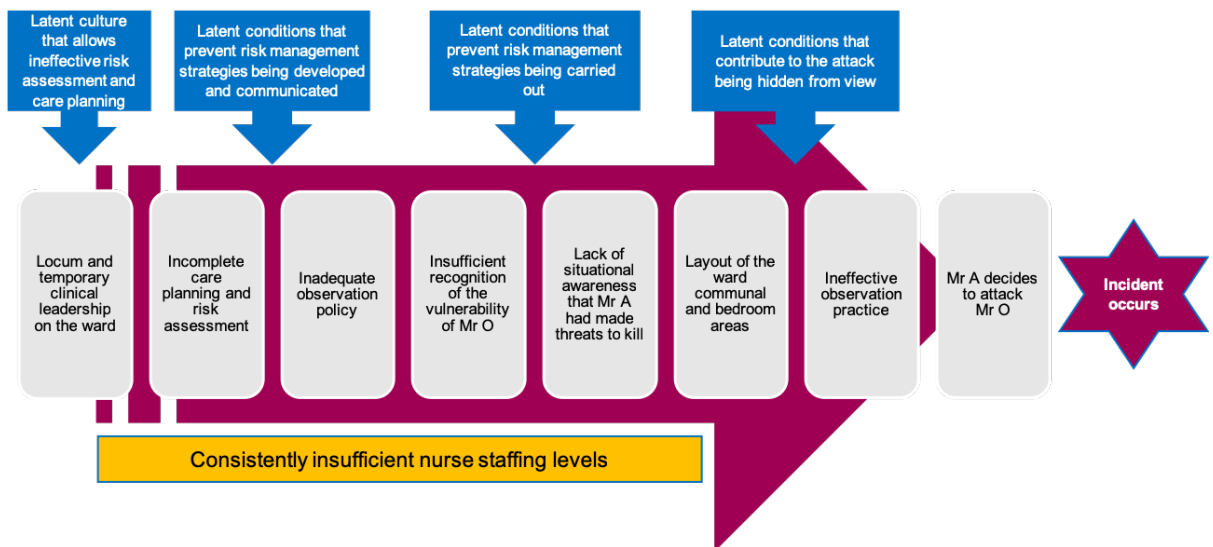
- 7.38 The Clinical Commissioning Group has not been able to identify that any specific meetings took place with the Trust to discuss the incident report and associated action plan. The Clinical Commissioning Group did participate in Incident Co-ordination meetings for which minutes were taken, the last of which was held in May 2017. We have seen an extract of those minutes.
- 7.39 On 11 December 2017 the Clinical Commissioning Group Head of Safeguarding advised the start up meeting for this independent investigation that the Clinical Commissioning Group had received assurance regarding the internal governance and scrutiny of the investigation and that the Clinical Commissioning Group had received a copy of the action plan.
- 7.40 The Clinical Commissioning Group has subsequently clarified that they have not been able to identify evidence that the final internal investigation report was received by the Clinical Commissioning Group, nor can they identify any written records relating to the assurance referred to in paragraph 7.38.
- 7.41 Finally, the Clinical Commissioning Group has not been able to identify any formal correspondence between the organisation and the Trust regarding the incident and associated action plan.
- 7.42 It is therefore clear that the Clinical Commissioning Group did not fulfil its responsibilities set out in its own policy in place at the time of the incident.
- 7.43 The Clinical Commissioning Group has revised the serious incident policy since January 2017. We have received and reviewed the new policy and we understand from the Clinical Commissioning Group Director of Nursing and Quality that there is an intention to further review this policy.
- 7.44 In September 2018 the Clinical Commissioning Group appointed a new Director of Nursing and Quality. Since taking up post she has started to strengthen the governance arrangements relating to serious incidents. The Director of Nursing and Quality has stated that detail information and assurance, including tracking of individual serious incidents is more robust and the Clinical Commissioning Group Head of Nursing now chairs the serious incident meeting with providers, and reviews progress against individual serious incidents on a weekly basis.
- 7.45 The Clinical Commissioning Group Director of Nursing and Quality was sufficiently concerned at her findings of the Clinical Commissioning Group oversight and monitoring of this serious incident, that she has commissioned an internal investigation within the Clinical Commissioning Group.

7.46 We share the concerns expressed by the Clinical Commissioning Group Director of Nursing and support the review that has been commissioned. It is our view that when the serious incident policy is revised the Clinical Commissioning Group must be clear about the assurance and monitoring processes and how these are to be evidenced. See our Recommendation 7.

## 8 Discussion and analysis of Mr A's and Mr O's care and treatment

- 8.1 Through our investigation we have established that there were 34 care delivery problems and four service delivery problems with the care and treatment provided to both patients whilst on MHU2. We have provided a list of these at Appendix F.
- 8.2 Not all of these problems impacted on the incident itself. However, there were several that if the correct process of care had been implemented may have led to a different outcome. For example, if the community staff had provided more accurate assessment of Mr A's mental state and risks, this would have in turn been able to be used by ward staff to create a better understanding of the risks posed to and by Mr A on the ward. If the ward staff had been updating and re-assessing risk on a regular basis they may have been aware of the risks posed to Mr O and other patients by Mr A.
- 8.3 In order to prevent errors from occurring organisations have safety systems in place, usually in the form of policies, procedures and protocols. In any organisation human factors such as the cultural attitude to safety and the quality of support provided to employees contribute to underlying conditions arising that improve or reduce the effectiveness of the safety system referred to above. In addition, individuals make mistakes that can lead to active errors. In most cases each one of these problems do not cause a serious incident to occur, however occasionally a momentary alignment of all of the problems allows a catastrophic incident to occur.
- 8.4 In the case of Mr A's assault on Mr O that resulted in Mr O's death, there were a number of underlying conditions in place that created the circumstances to allow active errors to have a significant impact. To illustrate the importance and impact of these we have applied the principle of an error chain (or Swiss cheese model as described by James Reason).

Figure 1: Error chain



- 8.5 Initially there were underlying conditions in place that eroded the application of some processes aimed at effectively treating and caring for both Mr A and Mr O.
- 8.6 The poor application of care planning, risk assessment and risk management processes was exacerbated by insufficient clinical leadership on site. The locum consultant leadership on the ward created a changing environment where staff were uncertain or unclear about how to carry out care. This was further exacerbated by the attitude of the whole care team (including non-ward-based staff) that tolerated incomplete or out of date risk assessment and care plans.
- 8.7 Contributing to these underlying conditions was a consistent problem with inadequate staffing levels or inappropriate skill mix. In addition, the Trust observation policy indicated rigid routines for observations that patients could circumvent and that did not convey to staff the need to randomise observations and make them part of the caring process. Finally, the ward layout meant that parts of the ward were not in view of the staff when based in the ward office.
- 8.8 These conditions meant that staff were inconsistent in their approach to caring for both patients and were not sufficiently cognisant of the risks that Mr A had made threats to kill and that Mr O was a vulnerable person. In practice it meant that, due to inappropriate skill mix and the lack of situational awareness of the risks, staff on duty were not worried about leaving Mr A and Mr O unobserved for a short period of time.
- 8.9 Breaking this down further, the contributory factors were:
- inconsistent staffing levels;
  - inappropriate skill mix;
  - inconsistent clinical leadership;

- cultural tolerance of incomplete risk assessment and care planning;
- inadequate observation policy and guidance.

## Nursing issues

8.10 We asked the Trust to provide us with information about staffing levels at the time of the incident and as at February 2018. We have also been provided with the duty roster for the four-week period from Monday 26 December 2016. Both sets of information provide us with a headcount, not whole-time equivalents, however there is a variance in some of the details:

Table 1 Mulberry Ward staffing complement 2017 and 2018

	Duty roster	Trust summary Jan 2017	Trust summary Feb 2018
Consultant		1	1
Modern matron		1	1
Ward manager/Band 7	1	1	2
Band 6 registered mental health nurses	2	2	3
Discharge coordinator		1	1
Psychology			1
In reach nurse			1
Band 5 registered mental health nurses	6	7	8
Pharmacy technician			1
Band 3 nursing assistants			3
Band 3 activities coordinator			1
Band 2 nursing assistants	26	24	18
Allied health professionals		2	2
Total staff on the unit	35	39	43

- 8.11 We heard from staff that it was considered a “full complement” if there were two registered nurses and four nursing assistants on duty for a night shift, covering 19 patients. We also heard that a day shift would often run with one registered nurse and four or five nursing assistants. If the low stimulus area needed to be used this would remove two nursing assistants from the ward complement, meaning that one registered nurse and two nursing assistants would be responsible for the remaining patients on the ward.
- 8.12 We were told that the perspective of staff was that the ward was poorly staffed, often unable to secure a satisfactory mix of registered nurses and nursing assistants, and that the nurses were at “burnout point”.

- 8.13 One nurse told us that she was concerned that a very newly qualified preceptorship nurse was due to have been the only registered nurse on duty at one point because another registered nurse could not be found to cover an afternoon shift. The nurse told us that she was so concerned about this that she worked a double shift so that the preceptorship nurse would not be left solely responsible for the ward. The Safer Staffing reports identify MHU2 as one of the wards where there were concerns about staffing levels. This evidence supports the information we received from staff.
- 8.14 Staff told us that at the time of the incident there was a core group of about five registered nurses that supported each other:
- one newly qualified registered mental health nurse;
  - two registered mental health nurses in their second year, post qualification;
  - one registered mental health nurse who had been qualified for three years;
  - one registered learning disability nurse who had been qualified for six years.
- 8.15 We heard that staff had no capacity to be involved in quality or patient safety activities beyond day-to-day basic interventions with patients.
- 8.16 One consequence of nursing staff levels being low is that patients have insufficient one-to-one time with their named nurse. The records indicate that Mr A had asked for additional time with staff, but this was refused on the grounds that Mr A had already received his allocated one-to-one time on a given day. We explored this issue during interviews with senior staff when it was acknowledged that this was poor practice and that the one-to-one time that was care planned for patients was intended to be a minimum time, rather than a maximum.
- 8.17 The Trust told us that they had significant issues with recruitment of nursing staff at the time of this incident. However, following the review of the staffing mix the Trust has increased the number of senior nurses, psychology and occupational therapy input (as can be seen previously in Table 1)
- 8.18 We can see that there has been an increase in the number of disciplines and experience of staff on the in the last eighteen months. The Trust's Safer Staffing Handbook – Essential Staffing Documents dated March 2018 refers to the commitment by the Trust Board to safe staffing levels across its services. The document sets out the minimum staffing levels for all wards across the Trust. For MHU2 it shows:
- early shift – 2 registered nurses, two nursing assistants;
  - late shift – 2 registered nurses, two nursing assistants;



- night shift – 2 registered nurses, two nursing assistants.
- 8.19 The National Quality Board<sup>22</sup> guidance summarises what has been available to mental health units over the past few years and reiterates the point that staffing levels need to be adjusted regularly to meet the needs of the patient group at the time. It is clear that the Trust places an expectation on ward managers and modern matrons to review staffing levels in a dynamic and ongoing way, and to support this the Trust has provided an escalation flowchart to guide staff in identifying, managing and escalating staff shortages that we understand is used by ward managers.
- 8.20 The Trust has implemented a weekly governance meeting for each care group that each week covers one of four themes on a rotating basis. A summary of those meetings is fed into the weekly operational management meeting and the weekly executive management team meeting. Individual teams are represented at the governance meeting by the relevant modern matron and the Trust expects the modern matrons to be the conduit for information between the governance meetings and the teams.
- 8.21 The skill mix of staff on shift is 50:50 registered nurses to healthcare assistants. We heard from the Interim Director of Nursing that the safer staffing review is undertaken annually and that the isolation of the unit is considered, for example where another similarly sized ward is on a larger campus the other ward has fewer registered nurses on shift. We were also told that the ward manager has responsibility for assessing the safety of shifts, an escalation process is in place if there are concerns that need to be raised.
- 8.22 From our experience we would suggest that suitable staffing should see a minimum standard of one registered nurse to seven beds. Therefore, for MHU2 this would mean three registered nurses and three healthcare assistants on shift. In our opinion the lower number of two registered nurses on shift could compromise safety if there are no other allied health professionals on duty.
- 8.23 As discussed above, from triangulating our interviews with staff with the Trusts safer staffing reports, we established that there were times when nurse staffing levels were probably not satisfactory. This is an acknowledged problem nationally. Whilst nurse staffing levels were in line with the agreed skill mix and numbers from the trust safer staffing review, due to fluctuating patient acuity pressures on the ward there were times when staffing was not sufficient. In addition, it was noted that there had been recruitment challenges in the area that had an impact on the continuity of staff on the ward.
- 8.24 We know, from our experience, that even slightly lower staffing levels may create a gradual erosion of care standards over time. If the skill mix, or the numbers of the staffing on the ward is not sufficient it is likely the right care would not be undertaken at the right time. As described above, we

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<sup>22</sup> National Quality Board (2018) *Safe, sustainable and productive staffing - An improvement resource for mental health* Edition 1 January 2018

established that care standards were not always adhered to on MHU2. This manifested itself in the following care delivery problems:

- inadequate care planning;
- inadequate assessment;
- inadequate risk management.

## Medical issues

- 8.25 Medical leadership on the ward had been inconsistent with the consultant post being filled by locum staff for some time. The consultant for MHU2 was responsible only for patients on the ward.
- 8.26 The consultant did not have an office base within the ward and whilst we acknowledge that consultant staff often have an office base away from the ward, we heard from staff that the consultant was not a strong presence on the ward and often did not attend the daily handover meetings. Sometimes there would be no medical presence and at other times the consultant would send a junior doctor.
- 8.27 We were told that the ward staff used a RAG rating to determine the level of risk for each patient and that in order to reduce a patient's risk level a discussion with the doctor should take place. RAG (Red/Amber/Green) rating is a system by which patients are categorised in accordance with the level of risk. Red is the highest level of risk, green is the lowest. The policy in the Trust is that all patients newly admitted to a ward will be RAG rated as red for the first 72 hours, or the first multi-disciplinary review.
- 8.28 The acute care pathway in place at the time refers to the RAG rating system, noting that the degree of complexity and risk in across different services would lead to a different rating. For example a patient who might be rated as red whilst in community mental health services, would likely be rated as amber if admitted to an inpatient unit.
- 8.29 The acute care pathway clarifies the criteria by which patients should be identified as red, amber or green across different services and states that in an inpatient setting a patient who is rated as red should be seen by the consultant on a daily basis at either the:
- daily review and mental state examination;
  - nursing assessment review;
  - FACE assessment review
- 8.30 We have seen and heard that this did not always take place. Lack of medical leadership on a ward can result in diagnostic and treatment delays and this can be compounded if registered nurse staffing levels are low. Despite being on the ward for two weeks Mr A was still not receiving any treatment (except

for as required medication). We acknowledge that he had been offered and had rejected medication, but we have found no evidence of any active interventions aimed at improving Mr A's mental state.

- 8.31 We are aware that the consultant post has now been filled on a substantive basis and that the medical leadership on the ward has improved significantly as a result.
- 8.32 The Trust has introduced the Purposeful Inpatient Admissions (PIPA) model. PIPA meetings are held daily with the focus being on ensuring that each patient has a meaningful day with planned activities and interventions. Senior staff attend these meetings on an ad hoc basis to gain assurance that the discussions are meaningful and effective.

### **Cultural tolerance of incomplete risk assessment and care planning**

- 8.33 The internal investigation team noted concerns of incomplete risk assessments, care plans and incident forms and made an associated recommendation.
- 8.34 As we have indicated previously, it is our view that the internal investigation failed to properly understand why this was the case.
- 8.35 Staff told us that the ward was so pressured that if a patient transferred to MHU2 from another mental health inpatient unit in the Trust, staff did not “redo the full admission” to MHU2.
- 8.36 Staff did not involve Mr A's mother, Mrs E, in his care planning and although staff in the community involved Mr A's girlfriend, Ms L, this diminished considerably once he was detained and it became clear that the relationship had ended.
- 8.37 Mr O's partner, Mr C, was not invited to be involved in Mr O's care planning at all. This was a significant missed opportunity to gain more information about Mr O's background and to triangulate information that Mr O had given to staff.
- 8.38 The Trust has focussed on risk assessment and care planning in the action plan developed in response to the internal investigation. We have already commented on the completion of the action plan and therefore we will not make any further recommendation here. However, it is essential that the Trust and commissioners ensure that there are sufficient staff to undertake timely and robust risk assessment and care planning throughout both inpatient and community services.

### **Out of hours management support**

- 8.39 Out of hours management support is covered by the Trust's Managers On-Call Policy. This policy describes the behaviours and actions expected from managers and directors whilst they are on call.

- 8.40 The on-call manager who received the call from the nurse in charge of the shift, advising that Mr A had assaulted Mr O, did not:
- offer advice or support to the nurse;
  - seek to understand the details of incident;
  - provide a detailed and informed report to the director on call.
- 8.41 It is of concern to us that the nurse in charge of the shift received no support from the on-call manager. Although in saying this, we do acknowledge that through other means, other senior staff were informed of the incident and subsequently attended the unit to provide both practical and professional support to the staff.
- 8.42 Every manager that we spoke to indicated that this individual manager's response was out of step with expected practice. Although the policy stops short of stating when a manager would be expected to attend in person, it does indicate that if a scenario requires an on-call member of staff to attend in person "they will agree to do so, or ensure a fully briefed deputy of equal authority can attend". It is our view that the manager on call should have sought more information from the ward and attended the unit.
- 8.43 The lack of support from the on-call manager resulted in the nurse in charge of the shift having to negotiate with police officers regarding the issue of moving patients elsewhere to free up the crime scene area. As it was it seems that the nurse in charge of the shift gave a sound argument for not moving patients (a decision we and the Trust support). However, this could have resulted in a very different outcome. Front line staff must feel that they have the support of managers both in hours and out of hours, when dealing with serious incidents.
- 8.44 See our Recommendation 3.

## Safeguarding

- 8.45 Although staff did report concerns about Mr O's potential vulnerability to his carer, these were not properly followed up when the local authority asked for more information. When we interviewed senior staff for our investigation we were told that the local authority had not followed up on the initial safeguarding alert. This indicates to us there is a need for a robust process for escalation, oversight and follow up both immediately and in the longer term, for organisations that are members of the Local Safeguarding Adult Board to ensure that learning from such events is fully captured and shared.
- 8.46 Ward staff did not put in place a protective plan for when Mr O's partner visited the ward. Given the information that Mr O had disclosed (whether or not the allegations were true) ward staff should have developed and implemented a protection plan for Mr O, that all members of the multi-disciplinary team had knowledge of and understood. However, this was not

done and Mr O was allowed to be alone with his partner when he visited Mr O on the ward.

- 8.47 Ward staff reported an altercation between Mr O and another patient that resulted in a minor injury. Staff did report this as an incident but did not report this as a safeguarding concern and did not review or adjust nursing plans in order to keep both patients involved safe.
- 8.48 See our Recommendations 5a and 5b.

### **Observation policy and guidance**

- 8.49 The Trust has implemented a new observation policy that requires staff to ensure that when patients are on 15-minute observations there are no set times for patients to be formally observed and that the definition of 15 minutes is that it should be a maximum of 15 minutes between observations. This means that patients are not able to predict when staff are next going to observe them or other patients.
- 8.50 We are concerned that the recording of observations does not form a core component of a patient's electronic record. We had to request the observation records for Mr A and Mr O separately because we did not receive them when the Trust sent us copies of their clinical records. We heard that staff continue to complete observation records separately on paper and that unless the patient has enhanced observations the records do not form part of the electronic records.
- 8.51 It was not always clear to us when decisions were made to change observation levels for Mr O. There is an indication that he was on enhanced one-to-one observations on 12 January, but we have not been able identify at what point (if at all) these were formally reviewed. Staff statements given to the internal investigation indicate that Mr O was on 15-minute observations and Mr A was on two hourly observations.
- 8.52 See our Recommendation 6.

### **Access to physical health care**

- 8.53 Mr A complained of notable dental pain that resulted in him damaging his gum with his fingers and removing a pair of scissors from the clinic room in order to try to relieve the pain.
- 8.54 Staff had completed a dental assessment that indicated Mr A believed he had an abscess and they knew that he was not registered with a dentist. Staff were also aware that Mr A had called the NHS 111 service to seek advice on how to deal with his dental pain, and ward staff had received advice from the NHS 111 service on how to manage Mr A's pain.
- 8.55 Mr A was a detained patient and was not able to leave the ward to be able to deal with the problem himself. At no point did staff consider that Mr A needed to have access to a dentist. We acknowledge that ward staff were stretched

during this time, but the Trust has told us that there is a long-standing arrangement with the community dental service to provide dental care to detained patients.

- 8.56 Although the internal investigation team referred to Mr A's dental pain and the lack of access to appropriate treatment, there was no associated recommendation. We are not aware that the Trust has undertaken any work since this incident to raise awareness of the arrangement with the community dental service to ward staff. If this is the case, then we would recommend that the Trust addresses this. See our Recommendation 4.
- 8.57 Ward staff were sufficiently concerned about Mr O's physical health that they contacted the local general hospital for medical advice. The consultant psychiatrist was unhappy with the response from physical healthcare staff and instructed the junior doctor to try to resolve it with a counterpart from the general hospital. This was unsuccessful and ward staff ended up calling an emergency ambulance.
- 8.58 The emergency ambulance was not able to attend for more than four hours for clinical reasons and it appeared that although ward staff had believed that the ambulance had been stood down, paramedics arrived whilst Mr O was asleep.
- 8.59 Trust staff were unable to access the appropriate physical healthcare and treatment in a timely fashion at a time when they were very concerned about Mr O's physical health. Trust staff could have escalated the issue to the on-call manager for support in securing access to the right clinical assessment for Mr O, but they did not do so. Ultimately, Mr O's physical health stabilised and after a few hours staff were no longer as concerned about him.
- 8.60 We are concerned about the ability of MHU2 to manage minor physical healthcare issues of patients, such as dentistry and alcohol detoxification, the latter being something that should be routine in a mental healthcare inpatient setting.
- 8.61 If however Mr O's physical healthcare state was urgent Trust clinical staff were left in a position where they felt that their patient was not getting the right care and treatment and they did not have the skills and knowledge to be able to provide it. See our Recommendation 4.

## 9 Conclusions and recommendations

- 9.1 It is our view that the staffing levels and skill mix on the ward had a significant impact on the conditions in place at the time of the incident. However, the most significant was the observation policy. If the observations had been carried out differently it would have reduced the likelihood that Mr A would have been able to go into Mr O's room and be undisturbed for 15 minutes.
- 9.2 A different application of observations may have meant that staff were looking for Mr A and Mr O on a more random and unpredictable basis. Mr A may not have attempted to do anything if he knew that staff may look for him at any moment. However, the observation policy was prescriptive and it was applied inflexibly. Observations were undertaken at planned intervals that would have been apparent to all patients. Staff could have used their professional judgement to apply a different approach within the guidelines given. Professional judgement requires experience, clinical expertise, confidence in themselves and confidence that they will be supported by the organisation. In addition, staff need time to be able to consider and reflect on situations, so that they can exercise situational awareness.
- 9.3 Staff were not sited in the long patient corridor overnight and there was no CCTV. Either of these factors would have reduced the risk of the incident taking place.
- 9.4 We heard that staff had been anxious about risk assessment and risk levels within the unit. There were examples of:
- patients being brought to the unit without adequate consideration of their motivations for admission or previous criminal activity;
  - staff raising concerns that one part of the ward was not safely staffed;
  - differences in how risk assessments and risk ratings were applied.
- 9.5 This in practice meant that risks were not adequately controlled and caused staff to be anxious about their own and patients' safety. Staff reported that they did not feel safe, particularly on nights and on the enhanced care part of the ward.
- 9.6 Feeling safe is one of the most basic human rights and when feeling unsafe, this causes anxiety. Anxiety affects an individual's perception of risk and situational awareness, and continued state of anxiety can lead to stress which in turn can affect an individual's cognitive processing. We heard that staff raised concerns about safety and felt that they were not listened to, at times feeling undermined because they said they were worried. This tolerance of inadequate staffing and uncontrolled risks created the circumstances for a serious incident to occur.
- 9.7 Staff on the ward seemed to have followed procedures in a transactional, task focused manner dealing with immediate and obvious issues and not responding to less obvious requirements such as proactive risk management.

The fact that ward staff did not recognise ward responsibilities to Mr O whilst he was an inpatient, when there was an allegation by him against his carer, is an example. Ward staff were concerned that the local authority had not progressed the investigation, although we have heard that the local authority asked for more information but did not receive it. Regardless of this ward staff did not consider what they should be doing to protect Mr O whilst he was in their care, because the risk had not arisen. However, they did place Mr O on one-to-one observations when his behaviour caused an altercation between himself and another patient. This was because the risk then was immediate and obvious. The one-to-one observations were then stopped without any risk assessment or agreed plan. A more proactive approach would have addressed potential risks that were yet to emerge, based on previous occurrences.

- 9.8 Looking at it the other way round: an intolerance of uncontrolled risk would have meant that staff had support to proactively manage emerging risks, such as Mr A's previous threats to kill, and Mr O's vulnerability. This may have meant more frequent random checks for both patients.
- 9.9 In our view the most significant contributory factor is the culture of safety on the ward. The tolerance of uncontrolled risk meant that staff did not have the resources or plans in place to manage risks effectively. We cannot say that Mr A would not have subsequently killed someone but we can say that promoting a culture that is less tolerant of risk will reduce the likelihood of patient harm in the future.
- 9.10 As part of our terms of reference we have been asked to consider whether this incident could have been predictable or preventable.

## Predictability and preventability

- 9.11 Predictability is “the quality of being regarded as likely to happen, as behaviour or an event”.<sup>23</sup> An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.<sup>24</sup>
- 9.12 Prevention<sup>25</sup> means to “stop or hinder something from happening, especially by advance planning or action” and implies “anticipatory counteraction”; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

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<sup>23</sup> <http://dictionary.reference.com/browse/predictability>

<sup>24</sup> Munro E, Runggay J, Role of risk assessment in reducing homicides by people with mental illness. *The British Journal of Psychiatry* (2000)176: 116-120

<sup>25</sup> <http://www.thefreedictionary.com/prevent>



- 9.13 It is our view that the Trust could not have predicted that Mr A would assault Mr O or that the assault would result in Mr O's death. Neither do we consider that the Trust could have prevented Mr O's death.
- 9.14 However, as we have indicated elsewhere we do consider that there were actions that the Trust should have taken that would have resulted in better quality care and treatment being provided to both Mr A and Mr O.

## Recommendations

- 9.15 This independent investigation has made seven recommendations to improve practice, five of which relate to the incident and the subsequent management of it, and the two remaining recommendations are findings that were incidental to the event that would improve the provision of health care and treatment.

### Recommendations related to the incident and subsequent management

#### Recommendation 6

The Trust must ensure that observations form part of a patient's electronic record.

#### Recommendation 3

The Trust must assure itself and its commissioners that front line staff receive appropriate support from managers both in hours and out of hours, when dealing with serious incidents.

#### Recommendation 1

NHS England must clarify the responsibilities of a Trust in relation to Duty of Candour and Being Open when the incident relates to a criminal offence.

#### Recommendation 2

The Trust and their commissioners must ensure that serious incident investigation reports make clear the links between the issues identified and the recommendations being made.

#### Recommendation 7

The Clinical Commissioning Group must ensure that the revised serious incident management policy provides clarity about the assurance and monitoring processes and how these are to be evidenced.

## Recommendations relating to incidental findings

### Recommendation 4

The Trust must ensure that clinical staff have the skills and knowledge to be able to provide appropriate physical healthcare (in particular acute alcohol withdrawal), or be able to access appropriate physical healthcare from other organisations (in particular community dental services) in a timely fashion.

### Recommendation 5a

The Trust must ensure that staff are fully aware of and execute their responsibilities for safeguarding when there are concerns about the vulnerability of patients.

### Recommendation 5b

The Trust and the Clinical Commissioning Group must work with the Local Adult Safeguarding Board and its members to develop a robust process for escalation, oversight and follow up both immediately and after a serious incident (where Safeguarding concerns are identified), and in the longer term, to ensure that learning from such events is fully captured and shared.

## Good practice

- 9.16 When Mr A was assessed in police custody on 3 January the liaison nurse was extremely concerned about his mental state. So much so that she made two follow up telephone calls to the access team to ensure that Trust services remained engaged in Mr A's care and treatment. It is our view that this was the first time that any clinician involved in Mr A's care and treatment responded appropriately in effectively managing his risks.
- 9.17 When Mr A was admitted to MHU1 on 4 January 2017 staff received and filed a copy of Mr A's Person Escort Record (PER). This had been completed by the police for the journey via ambulance from police custody to hospital. We rarely see this information recorded in clinical records.

## Appendix A - Terms of reference for independent investigation

These individual Terms of Reference for Independent Investigation 2017/1375 have been drafted by NHS England North in consultation and with the agreement of North Lincolnshire Safeguarding Adults Board.

- These Terms of Reference will be developed further in collaboration with the offender and affected family members. However the following will apply in the first instance.
- The investigation should seek to identify and promote effective learning and improvement action to prevent future deaths or the recurrence of serious harm.
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, Police and other support organisations.
- Review the Provider's internal investigation/ chronology of events and assess the adequacy of its findings, recommendations and resultant action plan.
- Review the progress that the Trust has made in implementing the action plan associated with their external investigation.
- Review the care, treatment and services provided by, the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of their offence.
- Review the appropriateness of the treatment of both service users (victim and perpetrator) in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments, risk management and appropriate escalation.
- Consider the examination of the assessed needs of both service users' care plans with the involvement of the service users.
- Examine the effectiveness of the service users' care plans including the involvement of the service user and the family.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Explore whether any aspects of workplace culture potentially impacted on the incident.
- Review the effectiveness of governance and quality systems within the organisation, including whether arrangements for identifying and escalating risks, concerns and opportunities for improving quality of the service, were appropriate and embedded in practice.
- Consider the impact of commissioning and accountability arrangements in relation to effective quality monitoring, information sharing and safeguarding.

- Examine intelligence and any previous concerns about the quality of care or safeguarding and review the appropriateness of responses with reference to local policies, national guidance and statutory obligations.
- Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing detailed rationale for the judgement
- Provide a written report to NHS England which includes measurable and sustainable recommendations.
- Deliver a learning event for the Trust and other key stakeholders to share the report's findings and to provide an opportunity to explore and fully understand the intention behind all recommendations.
- Assist/support the Provider in developing a robust, measurable outcome based implementation plan.
- Assist NHS England North in undertaking a brief post investigation evaluation.

### **Supplemental to Terms of Reference**

- Support the Commissioners where requested to develop a structured plan for review of implementation of recommendations. This should be a proposal for measurable change and be comprehensible to service users, carers, and others with a legitimate interest.

## Appendix B – Documents reviewed

### Rotherham Doncaster and South Humber NHS Foundation Trust documents

- Clinical records for Mr A
- Clinical records for Mr O
- Serious incident investigation report
- Action plan
- Terms of reference for internal investigation
- Serious incident policy v14.1
- Notes from internal investigation interviews
- Safeguarding referrals made in respect of Mr O
- Transition thresholds and RAG System V2
- Adult mental health admission SOP CEG March 2015 v1
- Local working instructions acute care pathway
- Supportive observations policy v4.7
- Supportive observations policy v4.8
- Supportive observations policy v5
- Seclusion policy v10.1
- Seclusion policy v11.1
- Incident forms completed in respect of Mr A
- Incident forms completed in respect of Mr O
- Care programme approach policy v9
- Care programme approach policy v10
- Access team – local working instructions v1.1
- Access team – local working instructions v2
- Medical devices policy v8
- Lifecycle of clinical and corporate records policy v4
- Searching of a person policy v6.2
- Granting Section 17 leave policy v11
- Competency profiles for staff
- Clinical supervision staff policy v7.1
- Staffing establishment – MHU2 January 2017
- Staffing establishment – MHU2 February 2018

- Safer staffing handbook
- Inpatient staff acuity and dependency profiles v3
- Staffing performance reports
- MHU2 team structure April 2018
- Clinical audit reports
- Overview of access to dental services for detained patients
- Physical health policy v3
- Problematic alcohol consumption policy v2
- Problematic alcohol consumption policy v3
- Alcohol rehabilitation policy v2
- Floor plan – MHU2
- Care group risk register February 2018
- Incident statistics
- Domestic abuse policy v3
- Domestic abuse policy v4
- Learning lessons briefings
- Safer staffing review and declaration
- Letters, summary of telephone calls and text messages to Mr O's family
- Letter to Mr A's family

### **Other documents**

- North Lincolnshire Council social care documents for Mr A
- North Lincolnshire Council social care documents for Mr O
- GP records for Mr A

## Appendix C – Professionals involved

Pseudonym	Role and organisation
AMHP1	Approved mental health practitioner, team not known
AMHP2	Approved mental health practitioner, team not known
AMHP3	Approved mental health practitioner, team not known
AND1	Associate nurse director
AP1	Access practitioner, Access Team
AP2	STR Worker, Access Team
AP3	Mental health nurse, Home Based Treatment Team Role unclear, Access Team
CP1	Consultant psychiatrist, Home Based Treatment Team
CP2	Consultant psychiatrist, MHU1
CP3	Consultant psychiatrist, MHU2
CP4	Consultant psychiatrist, team not known
DC1	Discharge coordinator, MHU2
HCA1	Healthcare assistant, MHU2
HCA2	Healthcare assistant, MHU2
HCA3	Healthcare assistant, MHU2
HCA4	Healthcare assistant, MHU2
HCA5	Healthcare assistant, MHU2
HTT1	Mental health practitioner, Home Based Treatment Team
HTT2	Mental health practitioner, Home Based Treatment Team
HTT3	Mental health practitioner, Home Based Treatment Team
HTT4	Mental health practitioner, Home Based Treatment Team
JD1	Junior doctor – second year, MHU1
JD2	Junior doctor – first year, MHU1
JD3	Junior doctor – second year, MHU2
JD4	Junior doctor – first year, MHU2
MHLT1	Liaison diversion mental health nurse, Mental Health Liaison Team
MM1	Modern matron, MHU2
OT1	Occupational therapist, MHU2
OTA1	Occupational therapy assistant, MHU2
PC1	Police constable
RN1	Registered nurse, MHU1
RN2	Registered nurse, MHU2
RN3	Registered Charge nurse, MHU2

Pseudonym	Role and organisation
RN4	Registered nurse, MHU2
RN5	Registered Charge nurse, MHU2
RN6	Registered nurse, MHU2
RN7	Registered nurse, MHU2
RN8	Agency registered nurse, MHU2
RN9	Registered nurse, MHU2
S12D1	Section 12 doctor, team not known
S12D2	Section 12 doctor, team not known
S12D3	Section 12 doctor, team not known
STU1	Student, but unclear what discipline, MHU1
WM1	Ward manager, MHU2



## Appendix D – Chronology of Mr A’s care and treatment

Date	Information
<b>20 to 31 December 2016 – First contact with Trust services</b>	
20/12/2016	<p>Mr A attended the A&amp;E department at a General Hospital. He was complaining of abdominal and chest pain, he felt weak, nauseous and feverish and told staff that he took cannabis to manage his pain. Mr A reported that he suffered from anxiety and depression, that he had been hearing voices and staff noted he appeared delirious, pale and he was tachycardic. Staff noted that Mr A was a "very troubled young man but receptive to help". Mr A’s diagnosis was recorded as a drug overdose and he was referred to the Trust’s crisis team shortly after 11:00pm.</p> <p>Mr A was assessed by the crisis team. Crisis team staff noted that Mr A had no significant risk history, but that he was at high risk of relapse and that his presentation at that time may indicate an early phase of a serious mental illness. It was felt that Mr A would benefit from treatment and further assessment at home. No appropriate plan was completed at this time (inadequate care plan – care delivery problem 1).</p>
21/12/2016	<p>Mr A was visited at home by two staff from the home treatment team. They noted that Mr A was friendly and welcoming, but that he appeared unkempt and was wearing a dressing gown over his clothes. Mr A reported that he had experienced “mental health issues” for a large proportion of his life and had led a transient lifestyle due to his parents being in the military, their later separation and subsequent lack of contact with his father. Mr A said that he had started self-harming at the age of 14 years because he was bullied at school and he later turned to cannabis, cocaine and alcohol to manage his feelings. Staff noted that Mr A spoke articulately and confidently about himself, but most of the content was contradictory and histrionic at times. Staff noted that an “atmosphere of unpredictability” was present during the meeting. Screening questionnaires were completed that indicated that Mr A was severely depressed and anxious. Staff agreed to visit again three days later to obtain more information. It was noted that visits should be undertaken by two members of staff and that Mr A may be more settled around males "especially as he cited [a] strong but dysfunctional attachment to [his] father". The panel found that this response could have been more robust, given the air of unpredictability and the need for two members of staff. A physical health check form is present in Mr A’s records, but it has not been completed. The panel found that although this was not Mr A’s highest priority at the time, the fact that it wasn’t completed is contrary to the Trust policy and national guidance (inadequate assessment – care delivery problem 2).</p>
23/12/2016	<p>Mr A called the home treatment team and reported feeling “emotionally unstable”. Staff noted that he sounded very quiet at first, but his speech became clearer during conversation. A discussion took place about Mr A’s plans for the weekend, the following week. Mr A spoke of a positive relationship with father and that this was the only positive relationship he had. He asked if staff would visit over Christmas, and he was advised that he would be telephoned the following day to arrange a visit.</p>
24/12/2016	<p>AP1 (access practitioner) and AP2 (STR worker for the access team) visited Mr A at home. Mr A presented as well kempt and engaging, said he had been “fantastic” and did not mention the call the previous day. Mr A</p>

Date	Information
	<p>said that he felt euphoric, that he had been to his mothers and told her he had been touched by god. Staff recorded that Mr A was “now in full control of himself” and had good mental agility and full understanding of his psychosis. He told staff that he felt at peace and that he could escape his psychotic thoughts because of a gland in his head and his different brain, but still wanted help from the home treatment team. Mr A said that he had not had cannabis for more than a week. AP1 asked if Mr A’s girlfriend, Ms L, could join them to which Mr A agreed. Ms L did not say anything and seemed guarded but did nod agreement when AP1 told Mr A that the team would be involved and would help him. Mr A was given assessment paperwork to complete for the next visit. The plan was for the home treatment team to call Mr A on 26 December and visit again on 27 December to collect the assessment paperwork and assess his mental state. Staff would also discuss Mr A’s case with medical team and arrange a medical review. We found that staff did not undertake a full assessment (care delivery problem 3) whilst they were at Mr A’s home. We also consider that it was inappropriate to wait for three days for any further follow up, given the presentation of Mr A and the guarded nature of his partner (care delivery problem 4). Our opinion is that a phone call to check on Mr A’s mental state later that day or follow up visit for the next day would have been more appropriate. There was no exploration of why Mr A’s partner was feeling guarded and worried (staff should have tried to speak with Mr A’s partner on her own) and it is our view that this was a missed opportunity to understand more about Mr A’s mental state.</p> <p>We can find no evidence that staff attempted to contact Mr A on 26 December, as planned - failure to deliver planned service (service delivery problem 1).</p>
27/12/2016	<p>HTT1 (mental health nurse) and HTT2 (mental health nurse) from the Home Based Treatment Team visited Mr A at home. They were greeted by Mr A’s partner, Ms L, who asked to speak to them before they saw Mr A. Ms L informed them that she was concerned about Mr A’s declining mental health, as he believed that he was Jesus and that judgement day will occur on 17 February 2017. He had told Ms L that he would go to the Vatican to see the Pope who would then tell the world. Ms L said that Mr A had thrown all of the toothpaste out of the house the previous day because of the fluoride, saying he didn’t want the government to control him. Ms L said that Mr A had not taken any illicit substances since being seen at A&amp;E. Home treatment team staff then saw Mr A who said he was feeling content, happy and elated and that he had found God. He said that he believed that all his sins had left him, but that it was human nature to be bad. Mr A had not completed any of the documents staff had left with him previously and said that God did not want him to do so. Staff attempted to explain to Mr A that it would be helpful for him to continue to engage with mental health services and to see the doctor. It was noted that Mr A appeared to lack insight into his mental health and that staff would call him in a few days. We found that the plan to leave Mr A for a few days was inadequate, given the presenting behaviour of Mr A and his partner’s concerns (care delivery problem 5).</p> <p>Around lunchtime a member of staff from the home treatment team received a telephone call from Ms L who expressed concern that Mr A had said he didn’t want medical intervention and he was told by the staff that visited that morning that this would not be forced on him. Ms L said that Mr A did not know she was calling and asked if Mr A could be given medication</p>

Date	Information
	<p>covertly, however it was explained that all patients with capacity must consent to treatment. Ms L said she was concerned that Mr A was unwell but that he couldn't see it and said that he had been hearing voices the previous night. It was noted that AP1 and AP2 would be informed of Ms L's call.</p> <p>Staff contacted Ms L on return to the office to reassure her that they had not discharged Mr A and would continue to engage with him. It was noted that the plan was to:</p> <ul style="list-style-type: none"> <li>• discuss Mr A's case in a clinical review meeting;</li> <li>• arrange an appointment for medical review;</li> <li>• discuss his engagement with the service;</li> <li>• encourage him to accept home visits;</li> <li>• call him on 30 December.</li> </ul> <p>A screening tool was completed but it is unclear who completed the form because it was not signed. The form contains hand written, disjointed notes that include a reference to a relative of Mr A's with schizophrenia, and another relative with query autistic spectrum disorder. We found that this was an inadequate quality of assessment at this time (care delivery problem 6).</p>
28/12/2016	<p>At about 8:30am Ms L called the home treatment team to say that Mr A had been up and down all night, and that he had told her he was moving away as he needed to see the Pope in Rome. Ms L said that Mr A had said God was talking to him and she was concerned he might act on ideas in relation to hurting himself. AP1 who took the call noted that he would discuss this information with the team and asked Ms L to keep an eye on Mr A (who was asleep in bed at that time) and call again if she needed any further support.</p> <p>Later that morning CP1 (consultant psychiatrist), HTT2 (home based treatment team) and HTT3 (home treatment team) discussed Mr A's case in the clinical review meeting. It was noted that it was "unclear what was happening in this case", there were possible attachment issues from childhood, especially in relation to his father. Mr A appeared to be displaying grandiose and religious psychotic symptoms which, from Ms L's reports, appear to be escalating. Mr A had refused to consider medication and had said that he did not require mental health services because he had found God. Staff had noted inconsistencies in his story and the apparent insight into the fact that he is psychotic seemed not to fit with his other remarks. Staff noted a marked change from his initial presentation and Ms L had reported that Mr A's sleep pattern had deteriorated. Staff noted "we should bear in mind the possibility of an emerging episode of hypomania/mania". The plan was for HTT3 to speak to Ms L to arrange for CP1 and a nurse from the home treatment team to visit Mr A at home the following day at 10:00am. There was a query about whether Mr A needed to have an assessment under the Mental Health Act and it was noted that if anything more acute happened in the meantime, a more immediate response should be considered.</p> <p>Shortly after this discussion HTT3 attempted to contact Ms L, but she was unable to speak to Ms L or leave a message. It was noted that HTT3 would try again later.</p>

Date	Information
	<p>At about 12:45 pm Ms L contacted the Home Treatment Team because she was increasingly concerned about Mr A's behaviour. Ms L reported that Mr A had started cutting up his clothes that morning saying, "God has told me I don't need them". Ms L said she had been trying to contact the team all morning and that she had been out and about, staff interpreted this as being because Ms L was afraid of Mr A's behaviour. AP3 (mental health nurse, home based treatment team) asked about her safety, Ms L said Mr A had said "he will not kill her as god has not told him to". It seemed that Mr A doubted whether God would tell him to harm Ms L and he did not know what he would do if God did tell him. AP3 acknowledged the concerns for Ms L's safety and advised that home treatment team staff were out of office at that time, but AP3 would discuss the matter on their return. We found that there was a lack of professional curiosity that led to a poor response to Mr A and his partner, given the risks to which Mr A's partner was exposed (care delivery problem 7).</p> <p>Shortly before 3:00pm HTT3 called Ms L, who repeated the earlier information. HTT3 advised that Mr A had been discussed in the clinical review meeting and that the plan was to make a home visit the following day. Ms L was unsure whether this was satisfactory and expressed concerns that Mr A had become aggressive towards her saying she "had the devil in her". Mr A had eaten little over recent days and not had much sleep. Ms L asked about a Mental Health Act assessment, she was aware of her entitlement to request one but was not sure what it meant. HTT3 explained, and therefore Ms L formally requested that an assessment was done. HTT3 noted that Ms L was aware that her request would be passed to the on-call AMHP<sup>26</sup> who would make contact later. Ms L was advised to contact the home treatment team if anything else arose in the meantime. It is unclear as to what additional support the home treatment team could have offered at this time. It may have been more appropriate to recommend that Ms L contacted the police if anything more arose.</p>
	<p>At about 7:30pm an entry was made into Mr A's GP records that noted Mr A had attended an appointment with a GP and reported that he was suffering from an itchy rash affecting his fingers, torso, legs and feet. The GP noted it was "highly suggestive" of scabies and prescribed permethrin<sup>27</sup> 5% cream and advised Mr A to obtain over the counter antihistamine. It is unclear what time Mr A actually attended the appointment.</p>
	<p>At about 7:50pm a Mental Health Act assessment was completed by S12D1 (Section 12 doctor), S12D2 (Section 12 doctor) and AMHP1 (approved mental health practitioner). Mr A had been sitting at the side of the fire smiling during the assessment. He had spoken of emotional trauma from the age of four years, when his parents had separated. He had remembered his sibling being spat at in the face and that he felt unable to cope "because of the bullies". Mr A had believed that he had cancer because of the pain he had in his back, but he believed at the time of the assessment that this pain was actually extreme anxiety. Mr A spoke about "bi-neural sounds, astral projection, being Jesus Christ, judgement day</p>

<sup>26</sup> Approved Mental Health Practitioner (AMHP) is a mental health professional who has been approved by a local social services authority to carry out specific duties under the Mental Health Act. They are responsible for coordinating assessments, and admissions to hospital.

<sup>27</sup> Permethrin cream is used to treat scabies in children and adults.

Date	Information
	<p>coming and belief in bible prophecies". Ms L told the assessing team that until two or three days previously Mr A had never spoken about religion. It was noted that Mr A's father had visited him that afternoon, and this was the first time Mr A had seen him in six years. Ms L said she felt worried and nervous, but not scared that he would do anything, however she was worried his behaviour would escalate. The assessing team found no evidence of mental disorder that required admission that night. It was acknowledged that Mr A may become ill again but that he had agreed to accept help from the home treatment team. The plan was for the home treatment team staff to visit the following day to assess the situation. Mr A had completed the questionnaire staff had left with him previously and therefore he handed it over.</p>
29/12/2016	<p>Mr A's GP completed a fit note at Mr A's request. The GP noted that Mr A had been under the care of mental health services since his attendance at A&amp;E on 20 December but so far, the GP had only received a notification from A&amp;E and had received no information from mental health services. We found that this was a delay in transfer of information, that could have caused difficulties in continuing care for Mr A. It does not appear to have any direct impact on this case.</p> <p>HTT2 discussed Mr A's case with CP1. It was agreed that HTT1 would contact Mr A to suggest he attend an appointment with CP1 the following day. At about 9:40am HTT2 called Mr A who agreed to attend the appointment. HTT2 advised that the home treatment team would not visit that day, but if Mr A had any concerns he should call the access team. A member of staff from the home treatment team noted that Mr A's RAG rating had been reduced from red to amber. It is unclear as to why the agreed plan was changed at this point. We could find no reason to reduce the risk rating from red to amber, there was no record that Mr A's presentation during the telephone call indicated a change (care delivery problem 8).</p>
30/12/2016	<p>Mr A was seen by CP1 and HTT4 (home treatment team). CP1 noted that Mr A presented as complex with several co-existing conditions, a recent psychotic episode that sounded "affective, marked by grandiose delusions and agitated behaviour". Mr A was seen with his mum (Mrs E) and his partner (Ms L) both of whom reported that over the previous 48 hours Mr A had settled back almost to normal. He no longer believed that he was Jesus and he was not receiving "felt" instructions from God. Both Mrs E and Ms L were concerned Mr A would have another episode. CP1 noted that Mr A continued to express delusional sounding beliefs about travelling to an astral plain and using bi-neural sounds via his pineal gland. Mr A displayed no hostility or agitation and recognised that he had some form of mental disorder. CP1 noted background issues that "raised the possibility of an [autistic spectrum condition]". Mr A reported anti-social behaviour as a teenager and responded in a concrete/literal way to some of CP1's questions. CP1 noted that his impression was that Mr A had experienced an acute psychotic episode that had multiple triggers, but the episode appeared to be resolving. Mr A had reported possible lower level auditory hallucinations over the previous five to six months and CP1 noted some personality and neurodevelopmental issues. Mr A's RAG rating was noted</p>

Date	Information
	<p>as amber. The plan was for a home visit on 1 January, zopiclone<sup>28</sup> to be tried for three nights in view of Mr A' recent poor sleep pattern, and a referral to the early intervention team to be made after the weekend. CP1 noted there was "no rush to start antipsychotic meds", but that Mr A's experiences should continue to be monitored because he was at high risk of further episodes of psychosis.</p>
31/12/2016	<p>Home treatment team staff sought background information about Mr A from the police and were informed that the police held no information about him. Shortly after 10:00am on 31 December AP1 responded to a message to call Ms L. Ms L reported that Mr A had been missing for three hours. Ms L was advised to call the police because Mr A was known to mental health services. Ms L said that she had tried to contact Mr A, but his phone had been switched off. AP1 then received a call from the police asking if mental health services had been in contact with Mr A that day. The police were advised that Mr A had been seen the previous day and was due to be seen the following day. At around 4:00pm AP1 received a voicemail from Ms L advising that Mr A had been found, but no other information left on message.</p>
1/1/2017	<p>During the morning (but not recorded until after 4:30pm) HTT1 received a call from the police (PC1) enquiring about the visit to Mr A that morning. PC1 advised that the police were planning to offer a debrief (it is unclear to whom) and to obtain more information about previous day's events. PC1 informed HTT1 that Ms L had found a note that Mr A had written the previous day, on one side "Remember my love", the other "I fall from Grace because I have sinned, love you down star I still look up". (Mr A's mother has told us that this will actually have said "Dawn Star") It transpired that "Dawn Star" was Mr A's pet name for Ms L. Mr A had set out framed quotes in front of the fireplace that included pictures with reference to the devil and a Toy Story figure that Ms L had bought him. Ms L said that Mr A had not taken a key with him when he left the house. PC1 said that the police had spoken to some of Mr A's friends who had reported that Mr A had lost most of his friends because they thought his behaviour was purely seeking attention.</p> <p>HTT2 later visited Mr A at home, accompanied by AP2 and PC1. They were greeted by Ms L who reported that Mr A had slept in the spare room the previous night and when she had checked on him that morning she could see that he had drawn all over his face. Ms L said that following his appointment with CP1, Mr A had become bizarre stating he was God and that he was deceiving everyone. Ms L said she felt responsible for Mr A and had taken time off work to try to look after him. During the previous two weeks she had found it difficult to talk to him, he had made threats to her but had said if God told him to kill her he was not sure what he would do. When Mr A joined them, he reported that he knew he had been talking rubbish and said he did not believe he was Jesus. Mr A said that he had been really upset the previous morning following an argument with Ms L, he was angry with his dad, and fed up of people telling him what to do and people not listening to him. Mr A reported that he had gone to the church and climbed on the roof, he had experienced fleeting thoughts of self-harm, had thought about jumping off the church roof but realised he was "acting</p>

<sup>28</sup> Zopiclone is a medicine used for short periods of time to treat insomnia

Date	Information
	<p><b>crazy</b>” so climbed down. He had walked to friend's house, had a bath (he was dirty because he had fallen over), and his friend had given him a meal before Ms L had collected him. Mr A said that he had not been sleeping, and that he had tried zopiclone, he had taken half a tablet, but it had no effect, so he took another and another and eventually had taken all three tablets. Mr A became tearful at times, and asked for admission to hospital to get away from Ms L. It was noted that Mr A had smashed his mobile <b>“in temper”</b> the previous day so all contact to be via Ms L. A referral to the early intervention team was discussed, but there is no indication of the outcome of that discussion. HTT2 noted that there was no evidence of mental disorder or risk to self or others to require admission to hospital. The plan was to provide Ms L with information about carer support, call Ms L to arrange a home visit on 3 January, refer Mr A to the early intervention team and arrange joint visit with them. We found that there was a lack of professional curiosity in exploring why Mr A had behaved the way he did the previous day and night (care delivery problem 9).</p> <p>Shortly after 2:30pm Mr A called HTT3. Mr A was tearful because he said that he and Ms L had split up and that she had thrown him out. Mr A said he had nowhere to stay. Ms L came on the line to speak to HTT3, Ms L said that Mr A had not been thrown out of the house, but they had indeed split up. HTT3 explained to Mr A that it was normal to be upset in the circumstances but that he was able to stay at the property. HTT3 suggested that Mr A might find it helpful to stay somewhere else, Mr A said he would ask his mother. HTT3 informed HTT1 and AP2 of the information - they said they had visited that morning and the situation was the same when they were at the property.</p>
3/1/2017	<p>Mr A's GP surgery received a report from A&amp;E. Mr A had attended A&amp;E at 12:36am, accompanied by the police. Mr A had said he believed he was influenced by God and asked to be seen by the crisis team. The report noted <b>“No investigations required, referral needed, no treatment required, no safeguarding concerns, home, no follow up”</b>. We established that this report was incorrect as Mr A was seen and was in need of intervention – see below (care delivery problem 10).</p> <p>Mr A was referred to the Access Team and was assessed by AP3 at about 3:00am. It was noted that Mr A had taken a knife and had been threatening to harm himself, so the police had been called. Mr A had not been detained on Section 136 Mental Health Act and had attended A&amp;E of his own volition. Mr A was tearful, but calm, responsive and well mannered. He was unable to say what had provoked him and voiced religious beliefs but no delusional thoughts. Mr A said that he was <b>“not a risk to anyone”</b>, Mr A had a toy character from a child's film and kept trying to give the character's hat away but was good natured when this was refused by staff. Mr A agreed to return home but actually asked if he could stay in hospital. AP3 said that hospital admission was not possible (she does not state why), but the home treatment team were due to see him later. Mr A was advised to go straight home to bed and leave any discussion with his partner until the morning. We do not know why hospital admission was not possible because the records do not provide this information.</p> <p>Shortly after 9:00 am HTT3 received a telephone call from MHLT1 (liaison diversion mental health nurse) to advise that she had assessed Mr A overnight in police custody and found him to be <b>“quite delusional”</b>. MHLT1 wanted to know if the access team were remaining involved in Mr A's care</p>

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	<p>and treatment. HTT3 confirmed they were, and that Mr A was receiving ongoing assessment and his presentation changeable. It was noted that Mr A was still in police custody and may need an Appropriate Adult<sup>29</sup> for interview. Mr A had been arrested for having a knife and threatening to kill himself and partner.</p> <p>At about 11:00 am AP1 received a call from MHLT1 advising that Mr A was a significant risk to himself and others and that a Mental Health Act assessment had been arranged for 1:00pm. Attending the Mental Health Act assessment were CP1, AMHP2 (AMHP) and a student AMHP. The outcome was that detention under Section 2 Mental Health Act was recommended, and arrangements were made for another doctor (a Section 12 doctor) to attend later to complete the second recommendation. A student AMHP completed this entry. The focus during this assessment is on Mr A's risk, ignoring the degree of his illness, which was also omitted in the previous assessment (care delivery problem 11).</p> <p>CP1 completed his entry shortly before 5:00pm when he noted that he had hoped to manage Mr A in the community but in view of the further escalation and risks, the unpredictable risk of attempting suicide, and Mr A's reluctance to consider medication, CP1 felt Mr A needed to be admitted for a period of assessment. CP1 recommended that:</p> <ul style="list-style-type: none"> <li>• a urine drugs screen was carried out;</li> <li>• Mr A be assessed for the need for anti-psychotic medication;</li> <li>• the query about scabies to be clarified;</li> <li>• the use of drawing pictures to be considered to conduct mental state examinations, because he felt that Mr A may have some processing issues that would benefit from exploring;</li> <li>• a referral to North Lincolnshire early intervention team to be completed early in Mr A's admission.</li> </ul> <p>On the Mental Health Act form completed by the AMHP it was noted that Mr A's Nearest Relative<sup>30</sup> was Ms L.</p> <p>It was noted on Mr A's conditional police bail form (a copy of which was in Mr A's medical records) that Mr A was required to contact Humberside police within one hour of being released from mental health service detention.</p> <p>CP1's medical recommendation for Mr A to be detained (Form A4) noted that Mr A had said he anticipated the end of the world which he believed would occur before his 27th birthday, describing this as "The Rapture". CP1 felt that Mr A's mental state may be influenced by cannabis, but CP1 did not consider this the sole reason for Mr A's behaviour. CP1 noted it was clear that Mr A saw his suicide as a resolution to the global "tectonic crisis relating to gamma radiation bursts". Mr A said he felt he should be detained so that he could be "judged". CP1 noted he did not consider that Mr A had capacity to agree to admission and therefore recommended Mr A be</p>

<sup>29</sup> An Appropriate Adult is someone who provides support to vulnerable adults if they are questioned by the police. Their role is to ensure that the police treat the person fairly and respect their rights, they will also ensure that the person understands what is happening at the police station.

<sup>30</sup> The Nearest Relative is a special term used in the Mental Health Act 1983. It gives one member of a person's family rights and responsibilities if a person is detained in hospital under Sections 2, 3, 4 or 37 of the Mental Health Act. A Nearest Relative is not the same as a person's next of kin. There is a list of who can be someone's Nearest Relative. The list is in strict order and the person who is highest on the list is the individual's Nearest Relative.



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	<p>detained because Mr A presented a “significant and unpredictable risk to himself”.</p> <p>The second medical opinion was undertaken by S12D3, a Section 12 doctor. S12D3 noted that Mr A had not been known to mental health services previously, but that he was presenting at that time as very confused and bewildered in thoughts and beliefs regarding his safety. Mr A appeared to believe that he would die on 7 January 2017 and he was seen writing this date on the wall of his cell. Mr A described his mind as a kaleidoscope, and that he was getting rapid, confusing thoughts. S12D3 recorded that Mr A was unable to stay on any particular topic and didn't appear to have the capacity to consent to admission or treatment. S12D3 considered Mr A to be acutely psychotic and a risk to his own and others' safety and that he could not be safely managed in the community.</p> <p>Mr A was then conveyed to MHU1, a mental health inpatient unit run by the Trust.</p>
<p><b>4 January 2017 – Admission to mental health inpatient unit MHU1 on Section 2 Mental Health Act</b></p>	
<p>4/1/2017</p>	<p>A Person Escort Record (PER) form was completed for the ambulance journey from police custody to hospital. The form noted that Mr A had been detained under the Mental Health Act whilst in custody. His health issues were noted as an abscess, heart palpitations, depression, anxiety, bipolar disorder, and schizophrenia.</p> <p>At about 4:45am Mr A was admitted to MHU1. Ward staff noted that Mr A was a detained inpatient on S2 of the Mental Health Act. There was evidence of significant risk behaviour and that people potentially at risk from his behaviour were his partner (Ms L) and his mother (Mrs E), and it was noted that a further risk assessment was required. Ward staff noted that it was unclear whether Mr A's behaviour was drug induced and that sometimes his delusions were contradictory. It was also noted that Mr A had been diagnosed with scabies, but he was receiving treatment.</p> <p>At about 6:45am it was noted that Mr A had asked ward staff to send a letter to his partner (Ms L) that read:</p> <p>"Hiya love, this is [Mr A]. You do not know of what I am capable and never have, but I will show you a life without pain and sorrow. You have never been afraid of pain but my love I will show you the greatest night display. On the 17/2/17 when I die do not look down but look up as I am always looking up."</p> <p>Mr A also asked staff to send a letter to his father that read simply: "Told you so". Staff administered lorazepam 1mg (it is unclear if this was oral medication) at the instruction of on call doctor but noted that it appeared to have little effect on Mr A's presentation.</p> <p>During the morning ward staff received a telephone call from Ms L asking how Mr A was. Ms L asked to speak to Mr A but was advised that staff would pass on a message as they were talking on the office phone. Ms L expressed concern about Mr A's food intake and was advised that staff would encourage him to eat.</p> <p>Ms L was noted as Mr A's next of kin.</p> <p>An admission care plan and infection control care plan were completed by STU1 (a student). It was noted that Mr A was convinced that STU1 was actually a senior member of staff and was pretending to be a student.</p>

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	<p>Care plans were also completed for:</p> <ul style="list-style-type: none"> <li>• history of harm to others and fire setting;</li> <li>• scabies.</li> </ul> <p>It was noted that Mr A did not consider that harm to others or fire setting would be an issue whilst on the ward. Mr A's fire setting risks would be managed by him not having a lighter (and staff would remove it if they found one in his possession). It was noted that de-escalation would be used as first line response, and that restraint or seclusion would only be used if Mr A or others remain at risk after de-escalation. Ward staff later noted that more information was needed from Mr A's family and the police about Mr A's risks to others and fire setting.</p> <p>Mr A told ward staff that he did not feel his GP was confident in her diagnosis of scabies and therefore Mr A had not administered the treatment prescribed by his GP. Clinical staff to: administer treatment as prescribed by the medical team, Mr A to be encouraged to spend time in his bed space to avoid risk of infection to others, staff to follow infection control processes (apron/gloves etc/bed linen). Ward staff contacted the infection control team for advice. It was noted that a diagnosis of scabies had been confirmed but it was unclear whether Mr A had used the treatment prescribed by his GP. The advice from the infection control team was to keep Mr A segregated for 24 hours after starting treatment to avoid the risk of cross infection.</p> <p>A ward review was held, present were CP2 (consultant psychiatrist), RN1 (staff nurse), JD1 (junior doctor – second year), JD2 (junior doctor – first year). The record of the discussion was made by CP2. It was noted that Mr A was upset at the pain and stress he had caused to Ms L, and it was apparent he was struggling with the breakdown of his relationship. Mr A described hearing voices the previous night after being detained by the police and said that it had been a traumatic experience. He also said he felt that Ms L had dismissed his feelings. The clinical impression was that Mr A had possibly suffered a psychotic episode and that he had underlying problems with attachment, personality traits (antisocial or emotionally unstable), and comorbid drug use. The plan was for:</p> <ul style="list-style-type: none"> <li>• ward staff to contact Mr A's family regarding visiting him and to obtain a corroborative history;</li> <li>• assess Mr A's mental state;</li> <li>• not prescribe any medication for 72 hours;</li> <li>• junior doctors complete Mr A's physical examinations;</li> <li>• contact the police for Mr A's forensic history;</li> <li>• Mr A to be nursed on general observations unless his risks indicate differently (an inappropriate level of observation given his risks and lack of medication – care delivery problem 12);</li> <li>• conduct a urine drug screen.</li> </ul> <p>That afternoon Mr A's mother (Mrs E) called to ask how he was. Staff gave her an update and Mrs E said that although the ward was a long way from her home she would visit Mr A that day. Ward staff advised that there was a plan to return Mr A to Scunthorpe as soon as a bed was available.</p> <p>Ward staff later raised concerns about Mr A's risks, because he had disclosed a history of fire setting and assaults. It was noted that more information was needed from Mr A's family and the police.</p>

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	<p>That evening ward staff received a call from Ms L who provided some background information about Mr A. Ms L said that just prior to admission to hospital, Mr A had brandished a bread knife and said that he was going to kill himself or Ms L if she didn't ring somebody. Ms L said: "he's a nice guy, I don't want to villainise him, yes I was scared but more worried he would hurt himself rather than me". Ms L said that the only involvement Mr A had with the police that she knew about that was he had stolen a car when he was younger.</p> <p>A letter was sent to Mr A's GP providing details of his admission to hospital. A second letter was also sent on 4 January from S12D1 to Mr A's GP providing information about Mr A following a Mental Health Act assessment, but the letter does not make the date of the assessment clear and because of this the GP would not have known how recent or out of date the information was. In addition, we have only had sight of this letter because we have reviewed Mr A's GP records; it was not contained within the information we received from the Trust. We believe this letter provides information about Mr A from when he was assessed on 28 December because it refers to him not having been detained and that ongoing support would be provided by the crisis team. This represents a delay in communication to primary care and we consider this was service delivery problem 2.</p>
5/1/2017	<p>A FACE<sup>31</sup> risk profile was completed that provided the same information as the risk profile completed the previous day. This should have been updated in light of new information (care delivery problem 13).</p> <p>A physical health check was completed that noted all of Mr A's physical observations as being within normal limits. It appears to us that this was completed by ward staff at MHU1.</p> <p>Mr A reported to staff that he felt an impending sense of doom, staff noted slight motor agitation and prolonged eye contact. Mr A was reluctant to accompany staff to a quiet room and stated that he had planned his escape route. Staff explained he had been detained on Section 2 of the Mental Health Act, so he was not able to leave the ward. Mr A asked for something to calm his mind and said the scabies cream he had applied might cause him to have an anaphylactic reaction. Mr A said that he had seen "some Islamic people" on the ward and had assumed there must be a bomb somewhere, making him feel the need to leave. Mr A then talked about his father, stating he had given birth to Mr A so that they could "work together to understand how nuclear bombs work. There are two types, fusion and fission. I am very scientifically minded". Mr A's urine drug screen results were positive for benzodiazepines and negative for all other substances tested (the clinical entry notes that Mr A had been given lorazepam shortly before the test was done, despite the fact that at the ward review meeting the previous day it was planned for Mr A to have no medication for the first 72 hours – care delivery problem 14). Mr A told staff that he believed that the "intervention team" had given him some type of cocaine when in police cells.</p>

<sup>31</sup> FACE (Functional Analysis of Care Environments) is ACE is a portfolio of assessment tools designed for adult and older people's mental health settings. It includes both screening and in-depth levels of assessment and includes specialist forms applicable to areas such as substance use, mental capacity, perinatal services and forensic services.

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<b>6 January 2017 – transfer to mental health inpatient unit MHU2</b>	
6/1/2017	<p>An oral health assessment was completed by staff on MHU2 (the document does not indicate which member of staff completed it) but there was no mention of Mr A's dental abscess, despite JD3 identifying the issue in his admission assessment when Mr A arrived at MHU2. It was however noted that he was not registered with a dentist and that he had not had a dental check in at least the last year (care delivery problem 15).</p>
	<p>A healthcare acquired infection assessment was completed that noted that Mr A did not present an infection risk and had not been exposed to others with infection. This is incorrect as Mr A was being treated for scabies (care delivery problem 16).</p> <p>We believe that both the assessments referenced above were undertaken by junior doctors at MHU1, prior to Mr A's transfer to MHU2.</p> <p>Mr A was transferred to MHU2 on 6 January. However, it is unclear to us when he was actually transferred because there are no entries that refer to discussions about transferring Mr A to MHU2. There is an entry made by a junior doctor at MHU1 referring to a physical examination conducted shortly after 10:00am. However, the next entry is at 8:10pm completed by JD3 who was the on-call doctor for MHU2 that evening. We found several examples of poor record-keeping like this (care delivery problem 17).</p> <p>JD3 summarised Mr A's previous assessment under the Mental Health Act and his presentation during the previous two days following admission to hospital at MHU1. JD3 noted that his impression was that it was difficult to establish whether Mr A had suffered a true acute psychotic episode, because of his use of substances or possibly an underlying personality or adjustment disorder. JD3 noted the plan was to continue with lorazepam and zopiclone 7.5mg daily. Mr A's treatment for scabies should also continue and review by a senior doctor should be arranged along with an ECG. JD3 also noted that Mr A had a phobia of needles noted and that Mr A should be encouraged to agree to further blood tests. JD3 also noted that ward staff should encourage good dental hygiene and that Mr A had a possible dental abscess. Mr A's phobia of needles was not reflected in the nursing care plan (care delivery problem 18).</p>
<b>7 to 15 January 2017 – inpatient treatment at MHU2</b>	
7/1/2017	<p>It was reported 05:18 Mr A had been up and awake "most of the night", and that he had not settled until 2:00am.</p> <p>At around lunchtime it was recorded that Mr A had gone into another patient's bedroom to wake them to ask them to go to the shop for a paper. It was reported that the other patient was annoyed at being woken. Staff informed Mr A that he was not to enter other bedrooms. Despite this advice, Mr A entered a patient's bedroom again when he took a clock and left £5 under the pillow. Staff told Mr A that the clock was not his to take and to return it; he was again reminded to stay out of other bedrooms. Mr A returned the clock. Mr A had also lent a pair of shoes to another patient whose own shoes had broken. Staff had advised Mr A not to do so, but he had not heeded their advice.</p> <p>At around 6:00pm Mr A asked for some one-to-one time with RN2. Mr A was tearful and said he felt nobody was listening to him. He asked for a quieter room because he felt everything was loud and he was over sensitive to this. Mr A said that he felt helpless and unable to protect his</p>

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	<p>family but was unclear what they need protecting from. Mr A asked for RN2 to sit with him in his room but was told this was not possible because his plan included one-to-one time for 30 minutes per day. RN2 later noted that one -to-one time was to be given with two members of staff present due to Mr A's risk (but she was not clear about what risk specifically). Mr A asked again for time with RN2 and was told that he had "already spent 30 minutes with [RN2] and that he could speak on the ward in the main area with staff generally". Mr A had already told staff that he struggled in the noisy general space and staff encouraged him to return to his room if the ward became too loud for him. RN2 noted that "Firm boundaries [are] required as Mr A may take advantage of staffs time". We found that this was inappropriate given that Mr A had only just been admitted to an inpatient environment and should have been given time with his primary nurse. Good practice indicates that such decisions should be taken by multi-disciplinary team but we found no evidence of this and neither did it form part of Mr A's nursing plan (a service delivery problem (3) due to lack of staff and a care delivery problem (19) due to an inappropriate plan by one nurse.)</p> <p>At about 7:15pm Mr A's mother (Mrs E) called for an update on Mr A. Information from discussions with Mr A that day was given, and Mrs E stated she would not visit yet as unsure what benefit it would be, but asked staff to pass on her love. Mrs E asked to speak to Mr A but he was tearful and declined to talk to her.</p>
8/1/2017	<p>Shortly before 5:00am it was noted that Mr A had struggled to sleep and had been constantly wandering on the ward. Mr A had requested and was administered zopiclone but reported that it had no effect as he was still unable to sleep.</p> <p>During the evening Mr A was visited by his family and his "partner" (Ms L) who reported to staff that they felt Mr A was doing well. Mr A was later read his rights under Section 2 Mental Health Act and stated that he understood them.</p>
9/1/2017	<p>Shortly after 5:00am it was recorded that Mr A had been chatty with other patients during evening, but as they went to bed he had become subdued. At around 11:45pm he told staff that he couldn't sleep and therefore he would stay with staff at the table. Mr A was advised to try to sleep to promote good sleep hygiene. Staff offered zopiclone which Mr A accepted, and it was reported that he slept from about 1:00am.</p> <p>Ward staff spoke with infection prevention and control staff regarding the management of Mr A's scabies. It was noted that Mr A required a further application of medical cream and that it needed to be applied one week after the first application.</p> <p>At around 7:00pm one to one time was "conducted" whilst dispensing Mr A's medication. Mr A stated that "a number of mishaps" had caused him to be on the ward but did not elaborate further.</p> <p>At around 9:30pm Mr A asked for some more one-to-one time with staff. It was noted that Mr A had received one-to-one time earlier, so staff agreed to give him ten minutes. Mr A was initially tearful and said he was struggling with the environment on the ward. Mr A stated he felt he had been lied to and that he had received substandard care. Staff advised Mr A of the complaints process, but Mr A said that the unit would be shut down if he did that, so he decided not to. Mr A was upset that he perceived other patients were getting more care than him. Staff explained that care was</p>

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	<p>personalised, so it might appear others were receiving more care than him. Mr A did not accept this and said he felt ignored and the place was making him ill. He was contradictory at times but ignored staff when this was pointed out. Mr A complained that he had not seen a doctor since admission. Staff informed Mr A of the date of his review with the doctor (the following day) and it was noted that he appeared happy with this. We consider the lack of one-to-one time for Mr A to be a service delivery problem (4).</p>
10/1/2017	<p>A retrospective entry was made for 8 January. Mr A had attended the office and handed in medication (zopiclone and promethazine) he had been administered from the previous evening (7 January), indicating that he had not swallowed the medication. There is no indication that staff adjusted Mr A's risk assessment or risk management plan, nor that they considered a room search, in addition the records indicate that promethazine was only added to Mr A's medications after the incident. (Care delivery problem 20).</p> <p>Mr A was discussed in the ward review meeting. Present for the discussion were CP3 (consultant psychiatrist), JD3 (junior doctor) and RN3 (charge nurse). Mr A's diagnoses were noted as adjustment disorder and mental and behavioural disorder due to cannabinoid use. Events leading to Mr A's admission were discussed and Mr A reported that he felt much better having had time to think. Mr A reported working with someone who had kept calling him names and that they had fallen out. Mr A said that he felt unable to work with this person after the insults and name calling worsened that resulted in his depression and anxiety getting worse. Mr A said he had "lost his rag" and had given up. Mr A said that he wanted some therapy for his anxiety. Mr A said that he had been beaten up a lot and bullied at school, he had "sparred" with a friend who was into boxing, but the friend wouldn't stop hitting him and other friends didn't stop it. Mr A was tearful when discussing this. Staff advised Mr A that anxiety management therapy was delivered in the community (rather than inpatient services). Mr A's medication was permethrin 5% cream (for treatment of scabies), lorazepam 1-2mg on request, zopiclone 3.5mg on request, nicorette inhaler, and promethazine 25mg on request. (Although this information was recorded in Mr A's contemporaneous clinical records, we cannot find a corresponding Medication Administration Record (MAR) chart (care Delivery problem 21).</p> <p>The plan was to invite Mrs E to visit Mr A, for Mr A to have one to two hours escorted leave at the discretion of nursing staff, obtain a programme from the recovery college, stop lorazepam, access anxiety management, encourage Mr A to write a life story, access occupational therapy, and encourage Mr A to seek new job on discharge from inpatient care. Given Mr A's history and events leading to his detention under the Mental Health Act it is difficult to understand how the diagnosis of adjustment disorder was formulated. Additionally, there was no documented evidence that Mr A was not asked about hallucinations and his care plan did not offer any regular treatment (medication or therapy) to address his presenting needs. (Care delivery problem 22.)</p> <p>Mr A received help to appeal his detention under Section 2 Mental Health Act. It was noted that Mr A had been settled during the day and had talked about the ward review. Mr A said that he wanted to enrol at the recovery college for anxiety management. Reassurance was given, and an offer made of further discussion which Mr A declined as everything had been</p>

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	<p>discussed in the review meeting and with the advocate whom he had seen that day.</p> <p>At around 7:00pm RN4 noted that Mr A had approached staff numerous times making various requests. Mr A asked:</p> <ul style="list-style-type: none"> <li>• for a different bedroom but gave no reason;</li> <li>• to speak to the "highest solicitor in this place" and was advised that a solicitor would be provided in due course now that the appeal paperwork had been completed;</li> <li>• to see his blood results sheets; the printed sheets were not yet available, so JD3 showed Mr A the results on the screen;</li> <li>• to see "expert legal person" on Human Rights Act or that he was provided with a number to call one; he was advised that a solicitor would be in touch regarding the tribunal soon and that during the evening it would be unlikely that any expert would be available to talk to. RN4 offered to find some written information or leaflets which Mr A declined because he wanted to speak to a person.</li> </ul> <p>A Section 17 leave form was completed that allowed Mr A to leave the ward accompanied by staff between 10:00am and 4:00pm for periods of up to two hours, and to stay in the local area. It was noted that Ms L had been informed of the arrangements by RN2.</p>
11/1/2017	<p>Shortly before 6:00am Mr A approached staff saying he felt unwell (he felt sick). Mr A was advised to have a glass of water, get some fresh air or lie down. Mr A asked staff if an ambulance would be available if it was needed. Staff reassured him and again advised him to have a drink. Mr A left the ward office and walked around the ward talking to his peers. Mr A again reported that he was feeling sick and was told by staff he had not followed earlier advice. Mr A asked if he could help staff with cleaning and appeared to forget he was feeling sick. He helped staff clean the sofas, staff thanked him and he went to bed. It was noted that Mr A remained on 15-minute observations.</p> <p>At about 6:00pm Mr A approached RN5 (charge nurse) in the clinic room and brought out a pair of scissors. Mr A said that he had taken them from the clinic drawer the previous day when a staff member wasn't looking. Mr A was asked what he intended to do with the scissors, but he was either "unable or declined to answer". The severity of his actions was explained to him and Mr A was told that he was not to enter the clinic room again. Mr A asked if the incident could just be kept to themselves, and he was told that this was not possible. An incident report was completed. There was no update to Mr A's risk assessment and management plan and no evidence that ward staff considered a room search at this point (care delivery problem 23).</p>
12/1/2017	<p>Night staff noted that Mr A had been chatting to his peers at the start of the night shift. He then asked staff to escort him round the unit, when staff asked him why he said he "just wanted to". Staff refused to do so, and Mr A went to talk to another patient. Mr A requested zopiclone but continued to walk around the communal area after it was administered. It was noted that the medication appeared to take effect after about 20 minutes.</p> <p>Mr A was discussed in the ward review meeting again. Present were CP3 (consultant psychiatrist), JD4 (junior doctor – first year), and RN6. Mr A's diagnoses remained as adjustment disorder and mental and behavioural</p>

Date	Information
	<p>disorder due to cannabinoid use. Mr A described his behaviour on the ward as a "brat" and reported that he had damaged trust property (a mattress) and said he would pay for the damage he had caused using the scissors taken from the treatment room. Mr A said that he had not planned to use the scissors for this, he had planned to use them to take out his tooth (that was causing him pain). Mr A said that he had threatened his girlfriend so that he would get help. Staff asked who they could speak to get some collateral history, Mr A asked them to speak to a close friend rather than his family. Mr A reported that he had cut himself with a razor whilst on the ward, he showed staff two cuts on his left posterior distal forearm. The plan was to continue working to the tribunal date, for Mr A to access occupational therapy, and for staff to encourage him to seek a new job on discharge from inpatient care. Medication was permethrin 5% cream (scabies treatment), lorazepam 1-2mg as required, zopiclone 3.5mg as required, nicorette inhaler, and promethazine as required. No update was made to Mr A's risk assessment and management plan to address his self-harm and damage to Trust property (care delivery problem 24).</p> <p>During the early evening staff noted that Mr A had been less demanding of their time that day and that he had been interacting more with his peers. RN6 referred Mr A to the integrated care team.</p>
13/1/2017	<p>During the course of the night shift, RN7 also referred Mr A to the integrated care team.</p> <p>It was noted that Mr A had been up numerous times during the night and appeared to be seeking attention from staff. He told staff that when he cut his mouth he was trying to remove his (wisdom) tooth that had been causing him pain, but he "refused to say what he used" to do this. Staff noted that Mr A had not appeared anxious or distressed and there had been no evidence of agitation. Staff noted that Mr A appeared "calculated in presentation" and that he had not slept much despite staff prompts to try to rest.</p> <p>During the morning Mr A was given 111 as an emergency dentist number. Ward staff observed him on the phone describing his pain and Mr A asked them to speak to the triage nurse on the phone who wanted to confirm Mr A's symptoms. OT1 (occupational therapist) advised the 111 nurse that staff could only repeat what Mr A was saying as "we do not deal with teeth in this setting". It was noted that a 111 nurse would call within two hours and that they would speak to a member of staff first, therefore the ward telephone number was provided.</p> <p>A retrospective entry was made indicating that Mr A was discussed at the ward review meeting on 9 January. Present were CP3 (consultant psychiatrist), MM1 (modern matron), WM1 (ward manager), RN5 (charge nurse), DC1 (discharge coordinator), OT1, CP1 (consultant psychiatrist), JD4 (junior doctor – first year), OTA1 (occupational therapy assistant). A summary of Mr A's reason for admission was noted along with the fact that his Mental Health Review Tribunal meeting had been scheduled for the following week. No information was provided about his medication (the entry noted "see medication card") and no information was provided about Mr A's risk or his care plan (inadequate care planning - care delivery problem 25). There was no reference to Mr A's views about his care and treatment and the next review was noted as 12 January.</p>



Date	Information
	<p>Shortly after midday ward staff received a call from a 111 nurse who was calling to give advice about Mr A's gum wound "caused by self-harm". OT1 spoke to the 111 nurse who advised that Mr A take medication for the pain and suggested that ward doctors prescribe Corsadyl mouthwash. Staff were advised to monitor Mr A for infection, fever or facial swelling. OT1 updated Mr A who said he was told not to take Corsadyl. Mr A said he had harmed himself using his fingernail and some scissors two days previously. Mr A asked to speak to his solicitor and OT1 gave him the details.</p> <p>During the afternoon a discussion took place between ward staff and the infection prevention and control team. It was noted that the second treatment for scabies had been due the previous day. Ward staff were advised to check this had been completed and were also informed that itching can continue for two to three weeks after treatment.</p> <p>JD4 examined Mr A's mouth and initially Mr A did not want to explain how he acquired his mouth injury, but eventually admitted he had damaged his gum with his fingers. Mr A described that he had previously wanted to pull out his wisdom tooth himself, and believed he had an abscess but did not seek medical or dental advice at that time. Mr A said he had not seen a dentist since childhood. JD4 noted that Mr A had poor dental hygiene but there was no evidence of a laceration or bleeding, although the area was red, swollen and painful. JD4 encouraged Mr A to contact an emergency dentist for a check up. JD4 later noted that CP3 had contacted the ward to advise that Mr A could be prescribed paroxetine for his anxiety. JD4 therefore prescribed paroxetine 20mg and explained the medication to Mr A, noting that type of medication can sometimes cause an increase in suicidal thoughts. Mr A was reluctant to start the medication because "he would kill himself" but JD4 explained he might not develop side effects, and to approach staff if he did. Mr A was concerned that the medication would increase his heart rate and in turn make his gum wound bleed.</p> <p>That evening HCA5 noted that Mr A had kept a low profile on the ward that day, spending a lot of time in his room. Mr A had complained about feeling unwell, and nursing observations had been completed every four hours due to the risk of infection in Mr A's mouth. Mr A was encouraged to talk to staff if he felt that he was getting worse physically.</p> <p>CP3 completed a psychiatric report in preparation for the Mental Health Review Tribunal hearing. CP3 noted that Mr A had reported that there was a family history (maternal and paternal) of schizophrenia and bipolar affective disorder. Mr A reported that he had stolen some silver spoons from his grandmother and that he had been trouble with police at the age of 14, when he was close to being charged with grievous bodily harm, stating "it was a lad who pushed my button and when I get angry it can be very severe". Mr A said that he was involved in a number of minor incidents during his teenage years and that he had been involved in two incidents of arson, saying "it was actually me who led the team of friends", but equally Mr A repeatedly reported that he was easily influenced by others. Mr A said that he and his friends had set some hay bales on fire that were close to residential properties and that he had admitted the offence to police after being seen by an acquaintance.</p> <p>Mr A told CP3 that he had "always had issues with authority and I think I am the most superior, my mind is vast and free, I can flick in and out of my entirety just like that and I can see the visions of future... My mind is like a kaleidoscope it is everywhere, maybe I am neurologically different my</p>

Date	Information
	<p><b>synapses fire differently... I realised it when I was a kid and when I was going through emotional pain".</b> Mr A explained that these views stemmed from the separation of his parents when he was three or four years old. CP3 noted that Mr A was intermittently emotional when talking about his father and that Mr A's recent social stressors were, bullying at work, the break-up of his relationship, and seeing his father for the first time in six years and then his father leaving again.</p> <p>We can see from Mr A's GP records that the NHS 111 service correctly sent the GP a record of the interaction with Mr A.</p>
14/1/2017	<p>RN4 noted that Mr A had been asking about the Mental Health Act during the previous evening and had wanted RN4 to provide physical proof that he was a patient by showing him his detention papers. RN4 advised that he could request copies of notes or paperwork by completing a form and other staff suggested that he look at his rights leaflet. Mr A spent time sitting on the floor near main ward doors looking at his phone. Mr A was given zopiclone on request at about 1:40 am and staff noted that it appeared to have good effect.</p> <p>During the morning staff tried to administer antidepressant medication to Mr A but he told them he believed he was going to start antipsychotic medication. Reassurance was given that medication was prescribed for anxiety but they had other benefits too. Mr A was reluctant to accept medication and said he wanted to try without medication. Mr A was advised staff would discuss the matter with the doctor <b>"on Monday"</b>. Mr A asked about leave off the ward, he said he wanted to walk around the town centre, and then he said he wanted to go to his brother's house. Staff explained that they would not enter the home of someone not known to them. Mr A was initially unable to understand this and said other patients did the same whilst on leave but said he did understand after staff explained the rationale. Mr A received a visit from his former partner, staff noted that they sat in the dining room. There is no indication that staff considered the plan for Ms L's safety. This should have been put in place given that she had been identified as being at risk from Mr A (care delivery problem 26).</p>
15/1/2017	<p>Night staff noted that Mr A had spent time during the previous evening engaging appropriately with peers in the communal areas of the ward and that he had gone to bed at a reasonable time without issue. Night time checks indicate he appears to have slept well.</p> <p>In the afternoon ward staff escorted Mr A on a walk and chatted about what had brought him into hospital. Mr A talked about his <b>"loving partner... supportive family... good job"</b> and that low points in his life were linked to taking drugs. Mr A said he wanted to further his education to get a better job and thanked HCA1 for her help and agreed to continue conversation at a later time.</p> <p>A Section 2 Mental Health Act patient information form was started but it is incomplete because there was no information about who the Trust understood to be Mr A's Nearest Relative.</p>
<b>16 January 2017 – Assault on Mr O</b>	
16/1/2017	<p>At approximately 2:00am HCA2 was conducting patient observations and saw Mr A leave Mr O's bedroom. HCA2 went into Mr O's bedroom and saw that the mattress was on the floor, she requested support from other staff and all available staff who responded went into Mr O's bedroom.</p>

Date	Information
	<p>Some of these staff then went to stay with Mr A and check on the welfare of other patients. All the other patients were safe and well. When RN8 and HCA3 entered Mr A's room they found him talking on phone to police. HCA3 asked what he had done to which Mr A responded "I have committed murder, I have killed somebody". RN8 asked why Mr A had been in Mr O's room, Mr A said "he was manipulating me, he was stealing from me, he was threatening me behind your backs". HCA3 advised Mr A not to say any more until the police had arrived. Staff stayed with Mr A until police arrived on the ward. When the police arrived, they handcuffed Mr A and took him into custody.</p> <p>It appears that Mr A was prescribed four days' worth of medication to take with him to the police station: paroxetine 20mg once daily; promethazine 25mg as required, but maximum of twice daily; zopiclone 3.75mg as required, but maximum of once daily.</p> <p>During the morning AND1, Associate Nurse Director contacted the custody sergeant to see if any of Mr A's family had been informed that he was in custody. Police advised that Mr A had asked for a named person (not his mother or his girlfriend) to be informed but this had not happened. The ward manager, WM1 was asked to contact Mr A's mother and his partner.</p> <p>WM1 called Ms L at to ask for contact details for Mr A's mother, as she was unable to find Mr A's mother's information on the system. Ms L was anxious and asked why the information was needed. WM1 offered assurance that Mr A was safe but there had been an incident and staff needed to contact his mother. WM1 suggested that Ms L contact Mr A's mother for more information. Ms L confirmed that Mr A had little contact with his father and provided WM1 with Mr A's mother's telephone number.</p> <p>WM1 called Mr A's mother (Mrs E) and informed her that Mr A had been involved in an incident with another patient and he was in police custody. Mrs E was anxious and asked for more information but was advised that staff could only share limited information. Mrs E said that she had visited Mr A the previous day and had spoken about the recent contact with his father, and her view that this had been the trigger for Mr A's recent episode leading to admission to hospital. (Mrs E has confirmed to us that she provided all this information to a member of ward staff immediately prior to her visit to Mr A the previous day. Mrs E was concerned to learn that no record of this information was made at the time.) Mrs E was advised to contact the police for further information about Mr A, and she was also asked to contact Ms L to update her.</p> <p>CP3 later assessed Mr A's fitness to be interviewed by police because Mr A's solicitor and mother had raised concerns the previous day. It was noted that Mr A had reported feeling confused about why he had harmed Mr O, he said that he felt scared and alone and scared he was not there for his family. Mr A said he felt Mr O was after him and that he was a leader of a cult. Mr A told CP3 that Mr O had taken Mr A's shirt and worn it, although Mr A later allowed Mr O to have it. Mr A said that he felt Mr O had been "after him" from the third day of being admitted to hospital but said that he didn't know what to believe at the time CP3 was interviewing him. Mr A said "I've messed up my life, my family and Mr O's family. There'll be many patients on the ward who'll be upset. Tell everyone I'm sorry". It was noted that Mr A had initially been reluctant to take paroxetine for anxiety because of the possible side effects (he felt it would make his mental health worse). Mr A also said that he didn't feel he could talk to staff, but he could talk to</p>

Date	Information
	other patients. Mr A said that he had requested one-to-one sessions for his thoughts saying, "writing poems about how I feel has helped me keep a straight head". Mr A said that he felt suicidal because he had destroyed his and Mr O's family but he didn't know how to hurt himself. CP3 determined that Mr A had "mental capacity to consent to be interviewed by police".

## Appendix E – Chronology of Mr O’s care and treatment

Date	Information
<b>2 January 2017 – Admission to mental health inpatient unit MHU2</b>	
2/1/2017	<p>Mr O arrived at A&amp;E accompanied by the police who reported that Mr O had been distressed whilst in a public place. HTT3 from the Access Team<sup>32</sup> tried to assess Mr O, but he presented as very confused, would not answer her questions and was unable to finish a sentence without changing the subject. Mr O told HTT3 that he left the house to "eradicate demons" from his head from when he was mugged in 1997 and later said that he had a plan with police because of allegations against his carer. Mr O also reported that he had attended A&amp;E for police to trick him (Mr O). HTT3 noted that Mr O had a history of alcohol dependence, but that it was reported that he had taken no alcohol for the previous 24 hours, this was supported by a breathalyser test when the reading was 0.17mg/l. Mr O denied any drug use, and no evidence of alcohol withdrawal symptoms were noted. Staff noted that the Trust had previous involvement with Mr O but that there had been no contact since 2005. Mr O had significant scarring on his arms that appeared to be old self harm scars.</p> <p>Mr O told staff that he had reported his carer to the police for serious offences and accused his carer of a number of offences against him (Mr O). Staff noted that Mr O was inconsistent about some details about the allegations against his carer. Staff noted that Mr O’s carer had brought some of Mr O’s belongings to A&amp;E that morning but that some items that Mr O had mentioned were not present. Staff were not clear whether Mr O’s reports about his carer were delusional, however HTT3 noted she would make safeguarding referral and we can see that this was done later the same day.</p> <p>Mr O said he was Irish, Scottish and a gypsy, and that he had mental health problems for years but couldn't remember what they were. Mr O also said that he was talking in code to HTT3 and that the name he was using was not his real name, his real name was a secret.</p> <p>Mr O said that he had moved towns but he didn't know when he had moved. Staff noted that it was possible that Mr O had been under the care of mental health services when he was at his previous address but when staff asked Mr O about this he talked about his carer and sexual relationships with women.</p> <p>HTT3 noted that further assessment was required, and although Mr O had not expressed any risks to her, he had told A&amp;E staff if he were to leave he would end his life. This was reported differently in another clinical entry when it was noted that Mr O had said that his carer would kill him if Mr O left hospital.</p> <p>At about 3:00pm Mr O’s carer called A&amp;E to find out how Mr O was. Staff advised him that Mr O would be at A&amp;E for a while and it seems that Mr O’s carer then put the phone down.</p> <p>S12D3, a Section 12 doctor assessed Mr O under the Mental Health Act and noted that Mr O remained severely confused and agitated. It was reported that Mr O’s most recent contact with mental health services was</p>

<sup>32</sup> The Access Team has a number of functions that include assessment, crisis intervention and resolution, home based treatment, hospital liaison services for older adults and care home liaison services for older adults.

	<p>ten years previously and that Mr O had difficulties with substance misuse and personality issues. S12D3 concluded that Mr O needed to be admitted to hospital under the Mental Health Act.</p> <p>Shortly after 10:00pm Ms Y, an AMHP assessed Mr O and made the application for him to be detained on Section 2. Mr O refused to go into ambulance for transfer to MHU2, and therefore staff administered lorazepam. Ms Y noted that staff were unclear whether his carer was a live-in carer or friend. Despite attempts to do so, AMHP3 was unable to gather any more information during the assessment to clarify Mr O's claims about his carer. AMHP3 noted on the Mental Health Act form (Form 2) that she was unable to ascertain who Mr O's Nearest Relative was.</p> <p>At Mr O's arrival on MHU2 staff noted that he appeared very confused, with disjointed and rambling speech. Staff attempted to read Mr O his rights under the Mental Health Act but Mr O did not have the capacity to engage and showed little understanding of what was being said. Mr O was placed on 15-minute observations.</p> <p>Staff completed a number of assessments, most of which indicated low or no risk. The alcohol screening tool indicated that it was possible that Mr O was dependent and that referral to services was required.</p>
<p><b>3 January 2017 – Placed in seclusion</b></p>	
<p>3/1/2017</p>	<p>At about 3:00am RN R2 completed Mr O's admission entries, FACE assessment, and care plans. She recorded that Mr O had presented with a psychotic crisis, in the absence of any other information about him. RN4 also noted that Mr O's GP should be contacted later that day to request further information and details of Mr O's medication.</p> <p>Mr O was discussed in the ward review meeting later that morning. Present were JD3, CP3, and RN6. It was noted that Mr O's diagnosis had not been established but that he had a history of borderline personality disorder. Mr O's medications were paracetamol, promethazine 25mg (maximum of 100mg/24 hrs), and zopiclone 3.75mg once daily. No information was recorded in the safeguarding category. Staff noted that it was difficult to establish a sound history, and that Mr O had reported numerous hospital admissions in Belfast, Cheshire, Crewe, and Lincoln under different names because of a previous conviction in the 1970s. Staff also noted that Mr O had said he had previously been in the Royal Air Force, that he had been born in Gainsborough in February 1956, and that his surname was not his real surname. Mr O had a history of anxiety and depression, with borderline personality disorder, and amnesia. Mr O mentioned various people and carers under different names. He repeatedly described the person staff believed was his carer at that time as his previous carer saying he was "shifty", and "he's done it". Mr O repeated some earlier allegations about his carer and said that he (Mr O) had moved to Scunthorpe recently. The impression was that Mr O had emotionally unstable personality disorder, dementia secondary to alcohol, and there was a question about Munchausen's syndrome, but staff felt they needed more time to observe him to be able to get clarity about this. The plan was for staff to contact mental health services where Mr O had lived previously, consider a CT scan and antipsychotic medication if Mr O's condition did not improve.</p> <p>Shortly after 3:30pm Mr O's carer contacted the Access Team and gave his contact number, he stated that he was Mr O's carer.</p> <p>During the afternoon he became unsettled and was shouting and confrontational towards staff. Mr O was given promethazine 25mg at</p>

3:40pm and escorted to a low stimulus area. Mr O's behaviour escalated, and he was put into a passive restraint on the sofa, after which he appeared to calm down but then his behaviour escalated again, and he began to kick the door, shout and swear, and was more aggressive towards staff (so much so that staff noted they felt threatened by him). Mr O began to throw his head back and kick out at staff so a decision was made to seclude him. Seclusion started at 4:20pm, the consultant was contacted at 4:25pm, and the consultant reviewed Mr O at 5:00pm. (IR1 form 88945 refers).

At about 5.25pm CP3 noted that she had reviewed Mr O and had noted manic symptoms, pressurised speech, and that he had been both verbally and physically aggressive that had resulted in the decision to place Mr O in seclusion. A secondary review was conducted by CP1 that evening, when olanzapine 5mg was prescribed.

At about 11:30pm CP1 reviewed Mr O. CP1 noted that there appeared to be some confusion by staff with regards to the policy for secluded patients because CP3 had conducted an internal multi-disciplinary team review at 5:00pm so there was no requirement for a further review that evening. However, CP3 had documented her review in a different part of the form that had led to the confusion. CP1 did review Mr O in person because of concerns about acute alcohol withdrawal and the need to decide whether change to the treatment plan required. CP1 noted no current features of alcohol withdrawal, but that staff should continue to monitor for these. CP1 also noted that there were no features of mania present, other than "overtalkativeness", and some motor restlessness but he considered this to be psychologically rather than physically driven. Mr O was also displaying sexual disinhibition, grandiose delusions, and challenging behaviour. It appeared that Mr O's agitation had increased because of his beliefs that his carer was controlling other people around him, including staff, and Mr O implied that a particular member of staff was working under his carer's control. Mr O repeatedly asked "are you still with me?" during his meeting with CP1, CP1 noted that Mr O appeared to be suspicious that CP1 was communicating with Mr O's carer via "mind control". CP1 noted that Mr O had gross thought disorder with a Knight's move<sup>33</sup> quality. Mr O did not consider that he was acutely ill, and that he had no need to be in hospital. Mr O told CP1 that he felt that his carer was "gaslighting"<sup>34</sup> with the intention of Mr O being killed off. Mr O believed that his carer was a psychopathic serial killer and made numerous accusations about his carer abusing him. CP1 noted that staff had no evidence to support the allegations but that they needed to bear in mind there may be a psychotic explanation of an underlying safeguarding issue and that staff should explore this more when Mr O's mental state was more stable. CP1 noted that Mr O's history of alcohol abuse needed to be clarified and that a discussion in ward round was required in order to determine whether to administer prophylactic pabrinex<sup>35</sup>. CP1 recommended that Mr O remain in seclusion whilst his risk of violence was so unpredictable and indicated that further sedation was required. CP1 prescribed lorazepam 2mg to be administered immediately, and a further dose a few hours later if the first

<sup>33</sup> Knight's move thinking is a form of formal thought disorder, common in psychosis, in which connections between sentence or parts of sentences are without a coherent train of thought. [oxfordreference.com](http://oxfordreference.com)

<sup>34</sup> Gaslighting is the manipulation of someone by psychological means into doubting their own sanity.

<sup>35</sup> Pabrinex

	<p>dose was not effective. It was noted that the next seclusion review was due first thing the following day, and an independent seclusion review was due between 9:00am and 5:00pm the following day. CP1 also noted that a multi-disciplinary team discussion about communicating with Mr O's carer was required. Mr O had said that he did not want staff to speak to his carer, and it was noted that the potential for safeguarding concerns was yet to be explored, however it was felt that Mr O's carer may have important information about Mr O's recent stressors and his alcohol pattern.</p> <p>A prescription card was completed covering the period 3 January to 15 January. Prescribed medications were olanzapine, pabrinex, chlordiazepoxide, thiamine, and Vitamin B co-strong.</p> <p>North Lincolnshire Council records indicate that on this date the safeguarding referral was picked up and an email sent back to the referrer to provide more details on the referral form and gain consent (from the person at risk, i.e. Mr O). There is no reference to this in the Trust documents and the local authority records note that no response was received. It is unclear from the information we have seen what information the council considered to be missing from the original safeguarding referral. Inadequate safeguarding practice (care delivery problem 27).</p>
<p><b>4 January 2017 – Seclusion ended</b></p>	
<p>4/1/2017</p>	<p>SN K2 undertook nursing seclusion reviews at 7:20am, 9:20am, and 11:20am. Each time she noted that Mr O was sleeping at the time of review, so she was unable to assess his mental state, and therefore seclusion was to continue.</p> <p>At about 11:45am an independent seclusion review was completed by CP4, RN2, and HCA4. Mr O was settled but remained fixed on the idea that his carer was telepathically sending him messages and telling him to do things, including being aggressive. Mr O stated that his carer was sleeping and whispering to them. Staff noted that Mr O had limited insight, but knew where he was.</p> <p>RN2 undertook a further seclusion nursing review at 1:20pm when again Mr O was sleeping so she was unable to assess his mental state. RN2 attempted to wake Mr O without success, so RN2 asked staff to inform her when Mr O woke up. There is no evidence that a proper physical assessment was undertaken at this time (care delivery problem 28).</p> <p>At 3:20pm a RN2 and RN9 undertook a seclusion nursing review and this time Mr O was awake. It was noted that Mr O's mental health and behaviour were much calmer and more rational since the previous review. Seclusion was therefore terminated, and it was noted that Mr O had been secluded for 23 hours.</p> <p>At about 6:00pm Mr O left seclusion and apologised to staff stating he would not behave that way again and that it was not like him nor how he liked to be. Staff helped Mr O to shave and provided a clean change of clothing. Mr O advised staff that he was lactose intolerant and that this was why he had not eaten his sandwich whilst he had been in seclusion. Staff noted that they would make kitchen staff aware of this. Staff noted that Mr O had stated his son was his next of kin but that he had no contact details for him.</p> <p>During the evening staff and Mr O completed an alcohol assessment. Mr O stated he had been drinking spirits, whisky and cider every day for the previous few months, and he was upset that he had been drinking again. During this time Mr O's phone rang and he told staff it was his carer and</p>



	<p>that he didn't want to talk to him. Mr O asked staff to answer the phone and tell his carer this information. Staff did answer the phone and asked who was calling, they noted the response as "It's his best mate, [carer], I need to talk to him". Mr O refused to speak to the caller. The caller asked staff to tell him what was happening, but Mr O did not consent for them to share any information. The caller asked staff to say "You can come home as soon as you can, your home is always here for you." Staff did not pass this message on to Mr O because they noted he presented as quite nervous and stated, "He can't get to me can he?". Mr O required a lot of reassurance from staff following this call. Later Mr O told staff that his carer had his bank card and that he had access to the pin code because he had watched Mr O key it in. There is no evidence that this information was reflected in Mr O's care plan or risk management plan (care delivery problem 29).</p>
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### 5 January 2017 – Ambulance requested

5/1/2017

During the night Mr O was administered with lorazepam 1mg because he was displaying agitated behaviour. Staff had observed Mr O's legs twitching and tensing, and elevated breathing, however Mr O appeared coherent. Staff also covered him with more blankets in case he was cold.

During the afternoon Mr O had one-to-one time with OTA1, an occupational therapy assistant. Mr O stated he wanted to be called Rob or Ozzy and that he wanted to see Ozzy Osbourne. Mr O started talking about another person, called him "he" while extending and flexing his arms in explicit manner. He told OTA1 that "he" was his carer. Mr O gave his own date of birth and home address and said that he had lived at the address since 30 December 2016, but that he wasn't sure why he was in hospital. Mr O talked about his previous home address that had been a flat in Immingham. He said he had to move because the flats were being demolished. Mr O said that he had lived alone for a while, then Mr C had moved in with him as his carer but Mr O was unable to say why Mr C was his carer. Mr O talked about benefits and said that he was in receipt of disability living allowance and that the rate had been increased after he had appealed with his carer's help. Mr O talked about a previous marriage in April 1988 and said they had divorced in 2003. Mr O said he believed that his ex-wife and their son who was born in 1988 still lived in the former family home in Lincoln. Mr O said that he had another son who had been born in 1989 who was living in Grimsby. Mr O said that he had been in prison in 1981 for stealing and that he had previously been admitted to a mental health inpatient unit in Lincoln. He also said that he had previously cut his own arm because he felt he needed an operation but was vague about the details. He had recently received input from two support workers from mental health services elsewhere and had been registered at with a GP practice in his previous town but had not registered with a local GP since moving. Mr O was concerned that his carer had his Lloyds bank card, bus pass and money and stated that all of his belongings were in the property that he and his carer occupied. Mr O stated that he had been mugged on New Year's Eve near some public toilets but could not provide any further details.

Later Mr O had some further one-to-one time with RN2 who noted that he appeared settled with elements of lucid conversation. Mr O accepted pabrinex and chlordizepoxide and RN2 noted that kitchen staff had been advised of Mr O's lactose intolerance. RN2 noted that there were concerns about Mr O's physical health and that staff were waiting for an ambulance to arrive.

A retrospective entry made later by JD4 noted that staff had reported to him that Mr O was increasingly confused and was scoring highly on the alcohol screening tool. Staff had been unable to establish a definitive alcohol history, but Mr O had reported that he drank heavily over the new year and, more recently, daily. Mr O said that he wanted to cut down and denied having had alcohol withdrawal symptoms in the past. JD4 noted that Mr O had a fine tremor and Mr O said it had been present for a while, but Mr O appeared sweaty, and had a dark purple v-shaped bruise on his left anterior forearm but was unable to explain how he got it. JD4 had discussed his findings with CP3 at 10:00am who had advised prescribing pabrinex and chlordiazepoxide. Mr O had been reviewed by Dr S2, staff grade doctor, in the afternoon when it was noted that Mr O's confusion had increased further since the morning and he was no longer able to answer questions appropriately. Mr O was not orientated to time or place and was complaining of abdominal pain. Staff noted that an urgent assessment was required at the local general hospital to exclude Wernicke's Encephalopathy<sup>36</sup>. JD4 contacted the general hospital to speak to the medical registrar but received no response and the ambulance service was having difficulty responding to calls. JD4 noted that the single point of access team spoke to "the most senior doctor available" who did not believe that Mr O required admission, and also did not consider 999 was required. JD4 advised that her registrar wanted Mr O reviewed by A&E as there were no facilities to resuscitate patients at MHU2, nor to give intravenous therapy. JD4 discussed the matter with Dr S2 who also spoke to CP3. CP3 felt assessment at A&E was required due to Mr O's presentation and advised JD4 to call 999 without further discussion with general hospital senior medic. JD4 contacted the non-emergency ambulance who advised they would dispatch a vehicle and crew within four hours, and that staff were to call 999 if Mr O deteriorated in the meantime. A section 17 leave form was completed granting leave from 4:00pm on 5 January to 5:00pm on 9 January in preparation for Mr O's transfer to general hospital.

RN9 received a call from the ambulance service at 9:45pm and provided an update on Mr O's condition which appeared to have improved since staff initially contacted the ambulance service. Staff were advised that the ambulance had been cancelled but mental health staff were to call 999 if Mr O deteriorated again. Staff noted that 15 minutes observations were to remain in place to monitor Mr O's physical health.

Staff requested both CAT<sup>37</sup> and MRI<sup>38</sup> scans for Mr O because of the sudden onset of confusion and disorientation. Mr O was showing signs of psychosis (delusional beliefs and thought disorder) and had a history of excess alcohol use. There is an undated letter, but we believe it accompanied the request for scans and therefore was likely to have been written on 5 January. The letter provided all the information that we have

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<sup>36</sup> Wernicke's encephalopathy is a neurological emergency resulting from thiamine deficiency with varied neurocognitive manifestations, typically involving mental status changes and gait and oculomotor dysfunction. [bestpractice.bmj.com](https://bestpractice.bmj.com)

<sup>37</sup> A computerised tomography scan (CT or CAT scan) uses x-rays and a computer to create detailed images of the inside of the body.

<sup>38</sup> Magnetic resonance imaging (MRI) is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.

	<p>already set out but added that Mr O was displaying ataxia<sup>39</sup> that was worse when he changed direction and that he had a raised level of c-reactive protein<sup>40</sup> in his blood on 2 January. Staff noted they were concerned that Mr O was deteriorating despite treatment for alcohol withdrawal, and that he was also complaining of abdominal pain.</p>
6/1/2017	<p>Night staff reported that paramedics had not arrived until after Mr O had gone to sleep. It is unclear why paramedics had arrived as an earlier entry had indicated that the ambulance had been cancelled. Mr O had asked staff for a pen and paper to write to somebody to whom he owed money to assure them he was going to pay them back.</p> <p>During the evening Mr O had some one-to-one time with staff who noted that he was hard to understand but that he appeared more settled. It was noted that Mr O had become more “overtalkative” during the day and interrupting other patients. Mr O’s alcohol withdrawal score was at the low end of very mild withdrawal problems.</p> <p>JD4 completed a retrospective entry noting Mr O’s blood results, all of which were normal except for creatine kinase<sup>41</sup> which was 428 (range 40-320). JD4 noted that blood tests should be repeated the following day, and that if the creatine kinase levels increased again the medical registrar should be contacted for advice.</p> <p>Staff assessed Mr O’s alcohol withdrawal symptoms and found no significant concerns.</p>
7/1/2017	<p>Shortly before midday RN6 read Mr O his rights under the Mental Health Act but Mr O showed no understanding. Mr O referred to a fellow patient on the ward as his protector and stated he was expecting more protectors to arrive.</p> <p>The on-call doctor repeated Mr O’s blood tests and noted that the creatine kinase level remained unchanged, but that no action would be taken at that time. We have not seen any evidence to indicate that staff continued to monitor the increased levels of creatine kinase.</p> <p>Staff assessed Mr O’s alcohol withdrawal symptoms and found no significant concerns with the exception of agitation.</p>
8/1/2017	<p>Staff noted that Mr O had been generally settled during the day and that he had spent a lot of time with Mr A. In late afternoon Mr O was observed to be talking excessively much of which was aimed at his carer, who was not present.</p>
9/1/2017	<p>Mr O had been talking to a fellow patient at the start of the night shift and although he went to his bedroom he returned to the ward where he sat in the dark. Staff encouraged him to go to bed, but he said he was already in bed. Staff encouraged him to go to his room and noted that Mr O was using “bizarre speech” saying “I have a guardian now, a permanent one and I am actually an angel”.</p>

<sup>39</sup> Ataxia is a term for a group of disorders that affect coordination, balance and speech.

<sup>40</sup> A high level of c-reactive protein is an indicator of inflammation. It can be caused by a wide variety of conditions, from infection to cancer. High c-reactive protein levels can also indicate inflammation in the arteries of the heart, which can mean a higher risk of heart attack.

<sup>41</sup> Creatine kinase is an enzyme found in the heart, brain, skeletal muscle and other tissues. Increased amounts are released into the bloodstream when there is muscle damage.

	<p>In the afternoon Mr O became animated and increasingly agitated, with his speech bizarre and incoherent. Mr O got close to another patient when talking incoherently which the other patient found difficult to tolerate. Staff administered lorazepam and were unable to offer an effective one-to-one session due to Mr O's rambling and incoherent speech. There is no evidence that Mr O's care plan or risk assessment were adjusted at this time, nor that his observations level was reviewed (care delivery problem 30).</p> <p>JD4 chased the scans requested on 6 January but was advised that no referral had been received, so asked staff to fax the referral again. JD4 noted that she would chase the referral again the following day.</p>
<p><b>10 January 2017 – Incident with another patient</b></p>	
<p>10/1/2017</p>	<p>Mr O had an unsettled night and had talked continuously at two other patients until after midnight. Staff administered zopiclone with no effect. Mr O's speech was bizarre, and he was in and out of his room every 15 mins between 2:00am and 4:00am.</p> <p>During the morning a ward review took place, present were CP3, JD3, and RN3. Staff noted that the impression was very much that Mr O was experiencing a manic episode, he was unable to remain silent for more than five minutes, constantly had thoughts running around his head, and would quickly lose track when answering questions, clear pressured speech. Medication was thiamine 100mg three times daily, vit b co-strong, and olanzapine 5mg once daily. The plan was to increase olanzapine 5mg to twice daily. There is no evidence that Mr O's observations level was reviewed (care delivery problem 31).</p> <p>An incident report was completed that stated that another patient (not Mr A) had tried to remove Mr O's hat, causing Mr O to become agitated and run towards the patient. Mr O pushed the patient, and staff told him to stop, Mr O pushed the patient again and the patient fell, hitting his head then falling to the floor. Mr O was told to go to his room. Staff spoke to Mr O and advised him to speak to staff if he was feeling agitated, Mr O accepted on request medication. There is no evidence that Mr O's care plan was reviewed (care delivery problem 32) or that a safeguarding alert was made (care delivery problem 33).</p>
<p><b>11 January 2017 – Placed on enhanced observations</b></p>	
<p>11/1/2017</p>	<p>A progress note entry referring to the incident referred to above stated that Mr O approached the other patient and tried to remove his hat and that Mr O fell and hit his head, not the other patient. (IR number 89120.)</p> <p>Staff noted that Mr O had been unsettled during the night until about 3:30am. He had been shouting and banging his bedroom door. Staff had repeatedly asked him to go to his room and be quiet. If Mr O saw staff coming towards him he would run into his room and slam the door. Mr O had been on neurological observations until 4:30am all of which had been within the normal range although at times Mr O had complained of a sore neck.</p> <p>When Mr O woke he had appeared confused, another patient (it is unclear whether it is the same patient involved in the altercation the previous night) had walked past Mr O and Mr O had tried to grab him resulting in staff intervention. Mr O was placed on level 2 observations (within eye sight) when in the day area. Mr O appeared to be responding to unknown stimuli during the day, waving his hands towards objects. An enhanced</p>

	observations care plan noted that Mr O had been placed on one-to-one nursing observations at 9:20am that day.
12/1/2017	<p>The enhanced observations care plan indicated:</p> <ul style="list-style-type: none"> <li>• midnight and 2:00am – observations completed;</li> <li>• 02:00-06:00 – “remained in [his] bedroom”;</li> <li>• 06:00-10:00 – no entries;</li> <li>• 10:00 - 12:00 – observations completed;</li> <li>• 12:00-14:00 – bed</li> <li>• 14:00-15:00 - observations completed;</li> <li>• 15:00-17:00 – bed;</li> <li>• observations not completed after 17:00.</li> </ul> <p>Night staff noted that Mr O had remained in his room during the evening, continuously talking to himself, increasingly agitated and shouting. Mr O had tipped up his bed when staff approached him and said that he had trashed his room. Staff noted that Mr O did not go to sleep until about 3:30am.</p> <p>Later that morning Mr O was taken to the local general hospital for a CT scan. Mr O spent the majority of the day in his room, still responding to unknown stimuli, and observations continued.</p>
13/1/2017	<p>Night staff noted that Mr O had spent time in communal areas of the ward during the evening, and that he appeared calmer and his speech appeared to have slowed. Mr O told staff that he felt he had a long way to go until he was better. Mr O was nursed on 15-minute observations during the night.</p> <p>A ward review was recorded, noting that it took place on 9 January. Present had been CP3, MM1, WM13, RN5, DC1, and RN1 (see other entry). The multi-disciplinary team discussed diagnoses of alcohol dependence and personality disorder, noting that Mr O presented with bizarre speech content. There is no record of Mr O’s views of the care plan, or Mr O’s risks, or a review of the level of observations. (Care delivery problem 34.)</p> <p>Day staff noted that Mr O had spent the day in communal areas of ward, and that he continued to speak in riddles with bizarre content. An ECG<sup>42</sup> was performed which was normal, although an irregular baseline was noted.</p>
14/1/2017	<p>Night staff noted that Mr O had spent the evening in communal areas of the ward and that he remained calmer in presentation and with slower speech. Mr O had repeated to staff that he had a long way to go before better, 15-minute observations remained.</p>
15/1/2017	<p>Night staff noted that Mr O “continued to babble” when talking and would give a commentary on actions being carried out. Mr O complained that the toilet was not flushing, staff noted the flush was broken and arranged for it to be repaired. All patients were provided with bottled water due to water supply issue on the ward.</p> <p>Later staff noted a slight improvement in Mr O’s ability to converse. Staff also noted that Mr O was visited by a friend (his carer) and that Mr O was delighted to see him. Mr O and his carer spent the afternoon on the ward together, it is unclear whether this was in private (for example in Mr O’s</p>

<sup>42</sup> An electrocardiogram (ECG) is a simple test that can be used to check the rhythm and electrical activity of a patient’s heart.

	<p>bedroom) or if their meeting took place in a general space (for example the day area).</p> <p>Staff explained Mr O's legal rights under the Mental Health Act but again he showed no understanding.</p>
<p><b>16 January 2017 – Assault on, and subsequent death of, Mr O</b></p>	
<p>16/1/2017</p>	<p>At approximately 2:00am HCA2 was conducting patient observations and saw Mr A leave Mr O's bedroom. HCA2 went into Mr O's bedroom and saw that the mattress was on the floor, she requested support from other staff and all the staff who responded went into Mr O's bedroom.</p> <p>When staff entered Mr O's bedroom his location was not immediately obvious, staff checked Mr O's bathroom before lifting the mattress under which they found Mr O lying on his back, with his head propped up against the radiator. Staff requested the assistance of the Nurse in Charge who attended, and another member of staff dialled 999. Staff pulled Mr O flat onto his back and the emergency grab-bag was collected.</p> <p>AND1 contacted the A&amp;E department at about 5:20am and was advised that Mr O was in resuscitation. The police contacted AND1 at about 6:30am and advised that Mr O was heavily sedated and intubated and would remain so for a while before general hospital staff attempted to withdraw sedation to establish if he could breathe independently. AND1 contacted the intensive care unit at about 8:00am and was advised that there had been no contact with Mr O's family or his carer regarding his current situation. WM1 was asked to contact Mr O's carer to obtain family contact numbers.</p> <p>WM1 contacted Mr O's carer at about 9:30am. WM1 informed him that there had been an incident overnight, and that she could not provide any details other than to advise that Mr O was in the intensive care unit at the local general hospital. Mr O's carer said that he had visited Mr O the previous night and Mr O had reported trouble with a fellow patient, however the description that Mr O had given to his carer did not match Mr A's description. WM1 gave assurance given that the two incidents were not connected. Mr O's carer confirmed that Mr O had not had contact with his family for some years. Mr O had tried to contact one of his sons via social media but had not been successful. Mr O's carer stated that he was the only family Mr O had. WM1 suggested that Mr O's carer made his way to the general hospital as soon as possible.</p> <p>During the afternoon CP3 and MM1 visited Mr O in the intensive care unit and noted that Mr O's carer was also present. CP3 noted that Mr O's prognosis had been reported as poor and consequently CP3 rescinded Mr O's detention under the Mental Health Act because his main health needs were physical. CP3 confirmed that Mr O was from that moment an informal patient, she completed the necessary paperwork and informed the Mental Health Act office.</p> <p>The local authority records for this date note that the safeguarding concern received on 2 January was closed by the social worker because no further information had been received from the Trust. In closing the referral, the following statement was made by the social worker:</p> <p><b>“This concern was of 2/1/2017 and the case was allocated to myself on 16/1/2017 following [Mr O's] death at [MHU2]. From the information in the concern, my initial concerns are that [Mr O] was and would be financially, emotionally and physically abused from the source of harm. However</b></p>

	<p>following [Mr O's] death at [MHU2] these risks no longer exist, there is no further action to take and this concern can be ended.”</p> <p>At about 8:10pm WM1 received a call from the intensive care unit to advise that Mr O had passed away.</p> <p>A safeguarding alert regarding the incident was completed and forwarded to the Adult Protection Team at North Lincolnshire Council. This was followed up by direct contact from the Trust Lead Professional Adult Safeguarding Adults to explain the situation.</p> <p>The local authority records indicate that they received a safeguarding alert referring to the assault on Mr O by Mr A. The local authority noted that a Section 42 enquiry<sup>43</sup> and that the police were investigating the incident.</p>
15/2/2017	A safeguarding social worker visited MHU2 to see the Modern Matron to discuss a ward safety plan. The social worker was advised that the Matron was on annual leave and an appointment was made for 20 February.
20/2/2017	The safeguarding social worker visited MHU2 again but was advised that the Matron was still on leave. The social worker advised that this was their second visit to read and obtain a copy of the ward safeguarding plan. The social worker was advised to put the request in an email and the Matron would action it on their return from leave.
6/3/2017	The safeguarding social worker called MHU2 to speak to the Matron but was advised that they were not at work that day. The social worker asked that a message be left for the Matron to call them on return to the office.
7/3/2017	The safeguarding social worker called MHU2 to speak to the Matron but was advised that they were not in the office. The social worker asked that a message be left for the Matron to call them to discuss the safeguarding plan.
8/3/2017	The safeguarding social worker tried yet again and was advised that the Matron was in a meeting. The Matron returned the call later that day and advised that the safeguarding support plan would be ready for collection on 14 March. The social worker noted that they would collect it that day.
20/3/2017	The local authority noted that the safeguarding plan had been received and that the Section 42 enquiry was closed.

<sup>43</sup> The Care Act 2014 (Section 42) requires that each local authority must make enquiries or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect.

## Appendix F – Care and service delivery problems

### Care delivery problems

Problem number	Date	Description
<b>Related to Mr A's care and treatment</b>		
CD1	20/12/2016	Inadequate care plan
CD2	21/12/2016	Inadequate assessment
CD3	24/12/2016	Inadequate assessment
CD4	24/12/2016	Delayed follow up
CD5	27/12/2016	Delayed follow up
CD6	27/12/2016	Inadequate assessment
CD7	28/12/2016	Lack of professional curiosity
CD8	29/12/2016	Inappropriate reduction of risk rating
CD9	1/1/2017	Lack of professional curiosity
CD10	3/1/2017	Incorrect record keeping
CD11	3/1/2017	Lack of attention to severity of illness
CD12	4/1/2017	Inappropriate observations
CD13	5/1/2017	Inadequate risk assessment and management plan
CD14	5/1/2017	Lack of adherence to medication plan
CD15	6/1/2017	Incomplete physical health assessment
CD16	6/1/2017	Incorrect physical health assessment
CD17	6/1/2017	Absence of recording of decisions
CD18	6/1/2017	Incomplete nursing care plan
CD19	7/1/2017	Inappropriate nursing plan
CD20	10/1/2017	Inadequate risk assessment and management plan
CD21	10/1/2017	Incomplete prescribing records
CD22	10/1/2017	Lack of regular treatment (medication or therapy)
CD23	11/1/2017	Inadequate risk assessment and management plan
CD24	12/1/2017	Inadequate risk assessment and management plan
CD25	13/1/2017	Inadequate care planning
CD26	14/1/2017	Inadequate risk assessment and management



Problem number	Date	Description
<b>Related to Mr O's care and treatment</b>		
CD27	3/1/2017	Inadequate safeguarding practice
CD28	4/1/2017	Inadequate physical health assessment
CD29	4/1/2017	Inadequate care planning and risk management planning
CD30	9/1/2017	Inadequate care planning and risk management planning
CD31	10/1/2017	Inadequate observations
CD32	10/1/2017	Inadequate care planning
CD33	10/1/2017	Inadequate safeguarding practice
CD34	13/1/2017	Inadequate care planning

### Service delivery problems

Problem number	Date	Description
<b>Related to Mr A's care and treatment</b>		
SD1	26/12/2016	Failure to deliver planned services
SD2	4/1/2017	Delay in communication with primary care
SD3	7/1/2017	Lack of staff
SD4	9/1/2017	Lack of one-to-one time