EXECUTIVE SUMMARY

OF THE

INDEPENDENT INVESTIGATION INTO

THE MENTAL HEALTH CARE AND TREATMENT OF

‘PATIENT E’

COMMISSIONED BY THE FORMER NORTH EAST STRATEGIC HEALTH AUTHORITY

Contents

The Panel

An independent panel was appointed to undertake the investigation and the members of the panel were:

(a)	Mr Kester Armstrong	Barrister (Chair)
(b)	Dr Miriam Naheed	Adult Consultant Psychiatrist, Cumbria Partnership NHS Foundation Trust
(c)	Mr Christopher Almack	Former Assistant General Manager in Working Age Adults, North Yorkshire Health
(d)	Mrs Margaret Barrett	Head of Adult Care Services, Gateshead Council

1. Terms of reference

The investigation panel was appointed by the North East Strategic Health Authority (SHA) to enquire into the health care and treatment of patient E and to prepare a report and make recommendations to the SHA.

The investigation was established under the terms of the Health Service Guidance (94) 27, as amended June 2005, following the conviction of patient E in February 2009, for the manslaughter of victim E.

The investigation panel's terms of reference were as follows:

To examine the circumstances of the health care and treatment of the above patient, in particular:

- the quality and scope of the health care and treatment, in particular the assessment and management of risk;
- the appropriateness of her treatment, care and supervision in relation to the implementation of the multi-disciplinary Care Programme Approach and the assessment of risk in terms of harm to herself and others. This should take into consideration other family members in receipt of services, as well as those who may be in a carer role;
- the standard of record keeping and communication between all interested parties;
- the extent to which her care corresponded with statutory obligations and relevant guidance from the Department of Health;
- prepare a report of the findings of that examination for, and make recommendations to the North East Strategic Health Authority (the new body responsible for commissioning investigations at the time of publication).

The investigation panel met on:

13 December 2010

24 - 25 February 2011

4 - 5 May 2011

18 - 19 July 2011

15 - 16 August 2011

22 - 23 September 2011

26 - 30 September 2011

21 - 22 November 2011

9 - 13 January 2012

30 January - 1 February 2012

15 - 18 May 2012

The panel heard evidence from 16 witnesses and considered a significant body of documentation in excess of 8000 pages.

All of the witnesses who gave formal evidence have had the opportunity to amend and approve the transcript of their evidence.

The purpose of this investigation was to endeavour to illuminate the events which culminated in the death of victim E. It is not the purpose of this report to attribute blame to individuals. For this reason and in order to encourage candour in relation to the various contributions to the investigation, the professionals who came into contact with patient E are not identified by name. Furthermore, patient E and all those with who had a personal relationship with patient E are afforded similar anonymity.

This report is an executive summary of the full report prepared by the investigation panel, it outlines the panel’s conclusions and recommendations following its investigation.

2. Background

In 2008, patient E assaulted victim E, inflicting serious head injuries which resulted in victim E's death in hospital. There were no independent witnesses as to what transpired in the family home when victim E sustained the injuries. Patient E has always maintained she was not responsible for harming victim E and that the injuries must have been the result of an unwitnessed fall. At the criminal trial however, the jury rejected this explanation and found patient E to be responsible for the attack. Patient E was acquitted on the charge of murdering victim E, but was convicted in relation to the lesser charge of manslaughter.

Patient E had a long history of mental health difficulties interwoven with alcohol abuse and had spent a significant part of 2008 as an inpatient on Bede 2 ward of South Tyneside District Hospital (Northumberland, Tyne and Wear NHS Foundation Trust provide mental health services at South Tyneside District Hospital) during two admissions that year. In respect of each of these admissions, patient E had been sectioned pursuant to the Mental Health Act 1983. During the course of the second admission, patient E had become a voluntary patient prior to her discharge on 29 May 2008.

Patient E had demonstrated difficulty engaging with health professionals during the two hospital admissions in 2008. This reluctance was replicated upon discharge and at the time of the assault, patient E was not accessing any meaningful support from any mental health professional in the community.

Whilst the investigation panel's terms of reference were principally directed at the care and treatment afforded to patient E, it was impossible however to consider the case in isolation from that of victim E who had significant health problems.

3. Conclusions

The investigation panel carefully considered whether victim E's death could have been avoided or prevented. The panel determined that all the available evidence does not support such a grave and unequivocal conclusion.

The only certain way in which the tragedy could have been avoided was if victim E and patient E had not been together alone at victim E's home at the time. Any such separation of victim E and patient E could only have resulted either from patient E's long term detention in hospital with no provision for leave or by some enforced separation of them in the community. The panel considers that neither of these options would have been necessarily realistic or sustainable.

The investigation panel, with the benefit of hindsight, was able to point to a number of deficits in relation to the care afforded to patient E and the management of patient E's final discharge from hospital. Whether a more robust regime of monitoring of the home situation between May 2008 and June 2008 would have had a material bearing upon the outcome of this case can only be a matter of speculation. There were however, a number of factors which militated against a more successful intervention being possible.

The principal concern of the investigation panel relates to the discharge planning which underpinned patient E's discharge to the community in May 2008 and the absence of robust community support for patient E or any provision to enable the impact of the discharge upon victim E's welfare to be effectively monitored.

The failure of the mental health professionals treating patient E to appoint a care coordinator for patient E, during either of the admissions to hospital in 2008, meant that there was no opportunity available to explore the extent to which patient E could be engaged in professional support in the community, irrespective of the difficulties which may have been encountered in securing patient E's cooperation with any such interventions.

The investigation panel was also concerned that the professionals involved with both patient E and victim E attached insufficient importance to the warnings which came from a number of sources, concerning the potential risk posed by patient E to victim E. There was a disparate quality to the recording of this information, so that the complete picture became obscured. Had there been a more complete understanding of the difficulties which both patient E and victim E were experiencing caring for each other, there may have been an enhanced level of monitoring of the situation following patient E's final discharge from hospital. It is not at all clear however, that this would have altered the eventual outcome to this case as it is apparent that the fatal assault of victim E by patient E was a spontaneous act with no suggestion of premeditation.

The investigation panel was informed that in 2007/2008 the safeguarding procedures in relation to vulnerable adults in South Tyneside Council dated from 2003. However, the implementation of safeguarding practice was in its infancy at this time. Awareness amongst many health and social care professionals of the importance of instituting protective measures in relation to vulnerable adults (and the knowledge of the procedures in place to achieve this) was in the process of being developed.

4. Recommendations

1. The investigation panel considers that the Care Programme Approach (CPA) policy of Northumberland, Tyne and Wear NHS Foundation Trust should contain a specific provision that during inpatient admissions, patients with no previous community input should be placed on enhanced care coordination. (Under the latest Department of Health CPA guidance this would mean placing all these individuals on CPA, without having to make the decision at which level they would be placed on, as the process has been simplified since 2008).

2. In light of the above recommendation, the investigation panel further recommends that inpatient services should identify a CPA coordinator within three working days of a patient's admission. This should be written into the acute inpatient services operational policies. It should firmly place the responsibility on the inpatient team to identify a CPA coordinator. Furthermore, it is recommended that the CPA coordinator should be present at the discharge meeting to agree and arrange an aftercare package of care.

3. The investigation panel recommends that community mental health teams respond urgently to requests from inpatient services for the allocation of a CPA coordinator and that within five working days from the time of referral the allocated CPA coordinator makes contact with the patient. This minimum standard will require adding to the Community Mental Health Team's (CMHT) current operational policies.

4. The criteria for acceptance into the Community Mental Health Teams and the allocation of a CPA coordinator, should operate on the basis of a patient's needs and not be simply led by the diagnosis. An inclusion criteria runs the risk of excluding patients who may well benefit from a service. In this case, the rigidity of working solely with diagnostic led criteria (as opposed to addressing patient E's complex needs) resulted in the exclusion of patient E from follow up

mental health care in the community. The investigation panel recommends that the operational polices of community mental health teams are adapted to remove such restrictions and to institute a more holistic approach to the criteria for admission to these services.

5. Specifically, a diagnosis that a patient is suffering from a personality disorder and/or alcohol related difficulties should not result in any exclusion of the patient from community services following their discharge from hospital.

6. The Sainsbury risk assessment tool used at the material time was considered by the investigation panel to be weak in relation to the protection of vulnerable adults. There should be provision within the risk assessment process to prompt and record issues relating to the safeguarding of vulnerable adults and children.

7. The investigation panel recommends that the risk assessment tool which is adopted is a dynamic tool with the capacity to record ongoing incidents of risk and warnings so as to enable a more cohesive and comprehensive risk management plan to be developed, monitored and reviewed throughout a patient's admission. Reliance upon mechanistic tick box risk assessments should be avoided.

8. The investigation panel has established that the expressions of concern, alerts and relevant risk incidents were not recorded consistently within the risk profile documentation. Instead, the panel found that although records were made of these warnings, they were distributed throughout the nursing records and as such it would be very difficult for staff to assess the developing overall picture in relation to risk and this therefore hindered the effective review of ongoing risks. The investigation panel recommends that third party information relating to risk should be kept as a composite record which is updated and is immediately available to all health professionals who have access to the

records. This record should routinely be considered at Multi Disciplinary Team (MDT) meetings.

9. Written notes from the weekly consultant ward review did not show recorded evidence of discussion on risk assessment and risk management. The panel recommends that a minimum standard is set for medical staff that at every MDT meeting (or at least weekly) a joint risk review is conducted by members of the MDT and recorded within the medical notes. The panel further recommends that Northumberland, Tyne and Wear NHS Foundation Trust undertakes clinical audits of MDT records to assess the quality of risk assessment and management plans that are being considered and recorded therein.

10. The panel considers it would be appropriate for a review/audit to take place in relation to the quality of the mental health nursing care planning process. This should include:

- the dating and signing of the care plan by both the nurses and patient;

- a change in the care planning documentation, to include a section for making day to day progress recordings in relation to nursing interventions and a separate section to record the evaluations of the effectiveness of the care plan interventions;

- consideration of whether or not the MDT care plan adds value to the nursing care planning communication process.

11. There was a considerable amount of information held in the nursing communication sheets relating to identified care plans rather than in the care plans themselves. The panel considers that this detracted from the effectiveness of the nursing care planning process. It is therefore recommended that consideration be given to a review of the use of this

documentation to ensure that information is recorded in the most appropriate place.

12. The clarity and legibility of all clinical records are essential qualities to enable appropriate and effective treatment to be delivered. The investigation panel recommends that standards of record keeping are subject to regular review.

13. The panel recommends that where a vulnerable adult is identified within the risk assessment process as being cared for by a patient (upon discharge in May 2008, patient E resided with victim E), a carer's assessment must be offered as part of the patient's management plan. If the assessment cannot be carried out the reasons for this must be clearly stated within the risk assessment and MDT notes and consideration should be given to registering an alert under the safeguarding procedures.

14. The panel recommends that whenever a social or health care service has any concerns in relation to a service user, insofar as the potential risks that that individual may pose to a vulnerable adult or child, this information should be passed onto all the services involved, including the GP's involved with the patient and the vulnerable person.

15. When meetings are held at hospital to consider the discharge arrangements for a patient, it is important that all the agencies who are likely to be involved in the discharge arrangements are invited to attend and do attend insofar as this is practicable.

16. When a patient is discharged from hospital following an inpatient admission, on the day of discharge there should be a preliminary discharge letter sent to the patient's GP outlining the discharge medication and follow up arrangements. A full account should be sent to the patient's GP by the discharging medical team within seven days of discharge describing the

patient's progress during the admission, the medication the patient has been prescribed, the follow up treatment which has been arranged and any risks that have been identified.

17. Where there are concerns in relation to a vulnerable adult living at the patient's home, it would invariably be appropriate for there to have been some professional oversight of home leave in order to inform the decision making process prior to discharging a patient. This should not be confined to self-reporting from the patient but should include full inquiries being made of family members whose views should be given such weight as is considered to be appropriate. When undertaking any such assessment the duty of care owed by health professionals extends beyond the patient so as to include consideration of the risk to others.

18. The investigation panel recommends that mandatory training in relation to safeguarding vulnerable adults should be offered to practitioners across all agencies, including GPs, to foster a collaborative approach (involving collective responsibility) when issues arise which relate to safeguarding vulnerable adults. There should be a robust audit of the efficacy of the delivery of this training.

19. All agencies should be mindful of their individual responsibility to initiate safeguarding procedures in relation to vulnerable adults where appropriate. There should be no assumptions made that other agencies will necessarily have done so.

20. When a MDT identifies that a patient is implicated in concerns relating to a vulnerable adult this issue should become a standard item for review within the MDT meetings.

21. When a patient is considered to present a risk to a vulnerable adult, unless it is considered inappropriate to do so, consideration should always be given to involving that patient directly in any safeguarding procedures which relate to the vulnerable adult.

22. Before discharging a patient to a home environment in which a vulnerable adult is believed to reside, consideration should be given to exploring issues of the mental capacity of the individuals involved and whether they are capable of self-determination in relation to the decision to live together.

23. The effective functioning of the safeguarding vulnerable adults procedure relies upon accurate recording of information shared at safeguarding meetings and effective distribution of minutes to all of the professionals involved in the multiagency process. To enable the protection procedures to function appropriately, safeguarding duties should be a priority for the individual practitioners concerned, including attendance at meetings.

24. Where risks have been identified and safeguarding procedures have been initiated, cases should not be closed by social services or other agencies until there has been a satisfactory resolution of the concerns. In any event all decisions should be clearly recorded and shared with all agencies involved.

25. Safeguarding adults boards are encouraged to utilise the Association of Directors of Adult Social Services (ADASS) guidance note, *'Carers and Safeguarding Adults – Working Together to Improve Outcomes*' (2011) to review local practice and learn from the findings of this investigation.

26. When a patient, who has been subject to detention under Mental Health Act 1983, becomes an informal patient (either by being discharged from the detention or as a result of the expiry of the section) there should be a clear

record made in the patient's clinical notes as to the reasons for the change in status.

27. All clinical notes, including psychology, should be integrated within the patient's records and be readily accessible to all professionals involved in the individual's care.

28. GPs surgeries should consider the viability of instituting a *'usual doctor'* system whereby a patient is assigned to a particular GP within the practice to assist in the continuity of care and communication with external agencies.

29. The investigation panel was informed as to an eight day delay in the processing of important information sent by fax to GP 6 by patient E's Counsellor 1 in January 2008. GPs practices should review internal communication systems to ensure that information is received by the patient's GP promptly.

5. Glossary

ADASS	Association of Directors of Adult Social Services
CMHT	Community Mental Health Team
CPA	Care Programme Approach
MDT	Multi Disciplinary Team