Assurance of recommendations to strengthen care provided by Hertfordshire Partnership University NHS Foundation Trust (HPFT) following the death of Ms M

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INTRODUCTION

During 2019 NHS England commissioned Anne Richardson Consulting Ltd to carry out an Assurance Review on their 2018 independent investigation report of a review into the care provided for Mr O after the death of a young woman Ms M in December 2015. Our aim was to assure progress with recommendations made for Hertfordshire Partnership University NHS Foundation Trust (`the Trust') to strengthen services. We were wanting to understand whether and how risks associated with care provided for people with similar mental health problems had been reduced.

During 2018, our initial review of care was carried out alongside a Multi-Agency Review (MAR) managed under the auspices of the Hertfordshire Domestic Abuse Partnership. The MAR included membership from the Trust, Avon and Wiltshire Mental Health Partnership NHS Trust, the National Probation Service, Avon and Somerset Constabulary, and the Hertfordshire Constabulary. Recommendations were made for several services as a result of that comprehensive review. However, this report concerns changes relating solely to recommendations made for the NHS. The review was undertaken by Lawrence Moulin and Anne Richardson[1].

BACKGROUND

Mr O first came to the attention of the Trust in July 2013 after an episode of self-harm led to attendance at an Accident and Emergency department. He was discharged from their care in October 2013 with support from the Trust community services.

In February 2015 following another episode of self-harm, Mr O came under the care of an Intensive Support Team in Somerset where he had been living. He disclosed violent fantasies relating to the murder of women and rape. In March of that year he threatened to kill a Community Psychiatric Nurse and was detained by police under Section 136 of the Mental Health Act (MHA). Following a MHA assessment he was deemed not to be suffering from a mental disorder but, given the risk that he posed, Mr O was immediately arrested and was remanded in custody at HMP Bristol.

Mr O pleaded guilty to two threats to kill and in early May 2015 as a condition of bail, he

1. [1] Lawrence Moulin, a Clinical Psychologist. was the lead investigator for the initial independent report commissioned by NHS England. With over 30 years' experience working in the NHS and at the Department of Health, his most recent post in the NHS was as the West Midlands Strategic Health Authority Lead for mental health and learning disabilities, with oversight of homicides and suicides, safety and service performance. He has also worked with the Care Quality Commission as a Specialist Advisor. Anne Richardson, is Director of Anne Richardson Consulting Ltd.

returned to his parents' home to await sentencing. Within two weeks he had called the police to request that he be sectioned under the MHA, and he had harmed himself to such a degree that he needed treatment in the Accident and Emergency Department.

After treatment for his injuries, Mr O was admitted to the Trust for three weeks as a psychiatric inpatient and then he was discharged back to community support. Later that year, in July 2015, police were informed that Mr O had made a threat to kill his girlfriend's brother and, after threats and suicide attempts at the beginning of August, Mr O was readmitted.

Mr O was diagnosed with Emotionally Unstable Personality Disorder (EUPD), with narcissistic and dissocial (psychopathic) traits. His behaviour was volatile, with rapidly changing mood, and he presented different challenges and risks. At times he was provocative towards staff and on occasions he used implicit and explicit threats. However, Mr O was also intelligent and could be socially engaging; he challenged those who endeavoured to diagnose and formulate his clinical presentation and pattern of behaviour.

When Mr O insisted he was going to leave the ward on 10th August, he was held under Section 5 (2) of the Mental Health Act (MHA) and the next day, due to his threatening behaviour he was moved to an all-male ward with access and exit controlled.

An assessment under the MHA was carried out on 12th August but, as Mr O agreed to be bound by a behavioural contract, he was not detained. Mr O's behaviour continued to challenge the staff and the senior team. His presentation and clinical challenges made it very difficult to develop a consensus on his diagnosis and treatment requirements, and three senior consultants reached different conclusions about the level of risk he presented. Our report raised concerns about this and about the quality of the care planning.

In September 2015 Mr O went on leave, continuing to be supported by Community Mental Health Services, and on 2nd October he was formally discharged. On 2nd December 2015 Bristol Crown Court sentenced Mr O to nine months in prison suspended for two years, and the Court established a Rehabilitation Activity Requirement and a Mental Health Treatment Requirement (MHTR). A Probation Officer was appointed and completed the sentence plan with Mr O two days after the Court hearing. However, this was not agreed or shared, as the guidance recommended, with Mr O's Community Psychiatrist or the Community Psychiatric Nurse.

In mid-December Mr O saw his GP for a repeat prescription and his mental state did not give cause for concern; the GP did not judge him to present a threat. On 23rd December Mr O met Ms M, with whom he had been in contact through an internet dating site and tragically, she was found dead on 24th December 2015.

We know that Ms M's death continues to be a source of terrible anguish for her family.

We hope that the conclusions drawn in this review of progress as well as the inquest due to take place in 2020 will provide a degree of reassurance that significant steps have been taken to strengthen the services provided for people with the pattern of behaviour that Mr O exhibited.

RECOMMENDATIONS FOR THE TRUST TO STRENGTHEN CARE

In our 2018 report, summarised in the overarching report of the MAR, we made recommendations in four areas. These were:

- Risk Assessment and Management
- Communication
- Mental Health Treatment Requirements made by the Court, and
- Trust Discharge procedures.

METHODOLOGY

Over eighteen months has passed since our independent report was submitted and this has given time for some change to be embedded. For each of the recommendations, our team assessed the degree to which changes have been (or are being) made and whether change had been:

A = Recommendation fully implemented.

B = Mostly implemented; some difficulties with delivery.

C = Partially implemented.

Our team met with the Trust Medical Director, two Consultant Psychiatrists and Clinical Directors, one who shared responsibility for Mr O's care, the Head of Safer Care and Standards, the Consultant Social Worker (Adult Safeguarding)/AMHP and the Senior Service Line Lead Forensic and Norfolk Services.

We were able to see documentary evidence relating to the provision of additional risk formulation training for staff and understand the changes that have been made in practice.

FINDINGS

RISK ASSESSMENT

Our 2018 recommendation, elaborated in operational terms was as follows:

`*We recommend that in the light of this report within 6 months current practice in the Trust for assessing risk be thoroughly reviewed and, in the light of that, a plan developed. Over the following 12 months, training in risk assessment should be refreshed in line with current best practice and the evidence concerning the most effective way to support staff to deliver a high standard of care*.

Following our conversations with members of the Trust senior team, we heard how issues relating to the management of this case and the subsequent death of Ms M continue to resonate within the Trust. Immediately after our report and the report of the MAR were disseminated, the contents were discussed in full at the Trust Board. This was followed by a multi-agency learning event attended by over fifty staff. Following this, several steps were taken to strengthen services. For example:

1. Whilst the current forensic service within the Trust is provided in line with the RCPsych standards[2], the Trust is now also participating in a national pilot, led by a Trust Clinical Psychologist, which is focused on the development of guidance for patients who are leaving secure services or prison.
2. Back to Basic Psychiatric Training for independent assessors & frontline community clinicians commenced in September 2019 as part of a rolling programme with an aim to refresh participant's knowledge and skill of assessing and managing common psychiatric presentations and several changes are now evident in clinical practice. The Trust is also writing a business case for simulation training initiative which will support demonstration of and training around dynamic as well as static risk.
3. The Senior Team has undertaken a `deep dive' into two clinical ward environments to audit quality of care; formulation of service-user needs, and to understand whether risk is being managed effectively.
4. A Sexual Safety `Task and Finish Group' was convened in August 2019 in response to recommendations made by the Care Quality Commission. Including attention to vulnerable people on wards, this work should help to reduce the risk of harm to service users and provide staff with better

[2] The document is available from the Royal College of Psychiatrists appended to the Secure Service guidance which they publish.

information on how to respond when a sexual threat is posed: a flow chart has been written in partnership with staff from the Sexual Assault Referral Centre (SARC). It also includes guidance on support for victims.

5. A new category has been introduced into the electronic patient record relating to `formulation'. The intention is to support staff to understand the importance of relating assessment of risk, formulation, care planning and risk management closely together and to record clinical rationale.
6. New training in risk assessment and management has been introduced. Whilst this is not part of mandatory in-service training, it is identified within the Trust as `essential' training.
7. Routine practice in risk assessment has been strengthened. Whilst use of the HCR-20[3], a questionnaire-based assessment of risk which can be used to enhance a narrative risk history was always available, training in its use has been strengthened.
8. `Clinical summits' are now held to discuss complex cases. These have highlighted the challenge presented not only on the wards, but in the community of managing those patients who self-harm and/or present a risk of harm to others. Clinical summits are helping to ensure that such patients are being managed appropriately.
9. A `Risk Panel' has been established, managed by the Head of Safeguarding, which can be called by any member of staff who has concerns about a patient. Input from specialised forensic psychiatry into the panel is also now assured.
10. The Crisis Team has been re-modelled to make a specific link with one of the inpatient wards.
11. A sexual safety `task and finish' group has been held. Part of the Royal College of Psychiatrists (RCPsych) sexual safety collaborative[4], this group triggered a survey of how safe people feel on the wards.

Services for people with personality disorder (PD) have been reviewed and, £1m has been agreed for provision of a community-focused service linked with community teams, consistent with NICE[5]

[3] The Historical Clinical Risk Management-20 (Douglas, Hart, Webster, & Belfrage, 2013) is a comprehensive set of professional guidelines for the assessment and management of violence risk. The questionnaire embodies a Structured Professional Judgment (SPJ) model of violence risk assessment and is applicable to adults aged 18 and over who may pose a risk for future violence.

[4] https://www.rcpsych.ac.uk/improving-care/nccmh/sexual-safety-collaborative.

[5] https://www.nice.org.uk/guidance/cg78

guidance. The Head of the Trust Psychology service has undertaken research to identify the number of people who might need the service and, to date, the following steps have been taken:

1. A formal, written care pathway for people with PD has been developed and was launched in November 2019. This sets out how staff can identify those (like Mr O) with complex needs who show high levels of risk to themselves and/or others. This work is still at an early stage but is designed to deliver a range of positive outcomes, including: reduced waiting times; improved access to psychological treatments; improved access in a crisis; improved experience for families and carers, and reduced costs associated with out-of-area treatments.
2. A 'stepped approach to care' is being developed so that clients with PD can be supported to improve their readiness to engage with evidence-based therapeutic interventions.
3. Fifteen new Personality Disorder posts are being created with ten clinicians already in post. The intention is for the new staff to support community teams to develop their skills for working with people with personality disorder and act as a focus for the delivery of effective treatment: Dialectical Behaviour Therapy (DBT[6]).
4. Training is currently being offered for staff in the Adult Community Teams. This has been developed with help from experts by experience and includes information about how personality disorders develop and are maintained, as well as basic interventions, including positive risk management.

COMMUNICATION

Our recommendation in this area, elaborated with an outline of the operational steps that would be necessary for implementations read as follows:

We recommend that in the next 6 months the in-service training programme is reviewed, alongside staff access to HPFT policy documentation, to ensure that relevant policies relating to inter-agency communication are implemented.

[6] Dialectical Behaviour Therapy (DBT) is a treatment based on cognitive behaviour therapy (CBT) that has been shown to be helpful for people with personality disorder, particularly EUPD (formerly known as borderline personality disorder) who commonly experience emotions very intensely, who have a high risk of self-harm and challenging behaviour.

Several steps have been taken by the Trust to strengthen communication. For example:

1. To improve communication and joint working with primary care, the Trust has developed a scheme called `GP Plus'. GP Plus practitioners are mental health nurses who will be employed in surgeries across the county to improve communication, liaison and treatment.
2. The Trust has offered a programme of mental health-related training to GPs.
3. Now, on the day that a new patient is admitted, an electronic communication is sent to the GP to ensure that timely and relevant information is provided and can trigger more effective information sharing.
4. `Back to Basics training (see above) now also includes information relating to the importance of maintaining an effective balance between patients' rights (for example, to confidentiality) and staff responsibility to share information that has a bearing upon safety, public protection and the legal framework.
5. `SWARMS'[7] and `safety huddles' are now held routinely on the ward and in community services after patient safety incidents to improve levels of communication between staff at all levels and to identify any immediate safety actions.

A recommendation for NHS England was also included in the report of the Multi-Agency Review Panel; it read as follows:

`*That NHS England consider issuing a communication to all NHS Services, alerting them to the importance of information sharing, particularly when levels of risk of harm to self and/or others is high, drawing attention to guidance that currently exists'.*

Our team understands that this matter was discussed in December 2018 with the National Independent Investigation Governance Committee (NIIGC). The matter was also discussed at the national Medical Director forum and the national Caldicott Guardians forum. A letter from Professor Tim Kendall was then sent on 20th June 2019 to all NHS Mental Health provider organisations, the National Clinical Director for Mental Health, all Mental Health organisation and Medical Directors. The letter reminded recipients of current

[7] Swarms are used for problem-solving and to improve practice after patient safety incidents. A swarm is a short meeting of as many healthcare staff as can attend, held as soon as possible after an incident to discuss causes and consequences. Swarms have been shown to improve reporting, and management of risk. `Safety huddles' are similar.

legislation, regarding the importance of sharing information, within the confines of the Caldicott principles, particularly when high risk patients are moved or transferred between healthcare providers and it recommended highlighting these matters to staff. The NIIGC recorded the recommendation as `completed' in September 2019.

TRAINING TO SUPPORT DELIVERY OF MENTAL HEALTH TREATMENT REQUIREMENTS

Our recommendation can be summarised as follows:

We recommend that in the next 6 months changes be made to the in-service training programme so all staff are aware of the use of Mental Health Treatment Requirements (MHTR) that may be applied by the Court; that the Trust and Probation services support staff when an MHTR is applied; review their guidance, and support staff to come together to develop a shared understanding of their roles and responsibilities.

At the time of the tragic death of Ms M, the Trust had guidance for staff on requirements that might be set by the Courts for the provision of treatment. However, it did not appear that the guidance had been followed. Now, the Trust senior team report that:

1. A joint presentation and discussion of findings from the review reports was held with Probation services to discuss findings and agree the action to be taken.
2. As a result, commissioning of provision was strengthened and, now, a half time Clinical Psychologist and a full time Psychology Assistant have been appointed to support the delivery of Court requirements and to liaise with health and Probation staff.
3. The Risk Panel has revised Guidance for staff on Mental Health Treatment Requirements[8].
4. A Memorandum of Understanding has been developed with the Police concerning management of and liaison about patients with mental health problems who have a forensic history.
5. A Police Security & Liaison Group with membership from Hertfordshire Constabulary and Trust staff has been established and has met twice to date. The group monitors joint working in keeping with the Hertfordshire Partnership Protocol for the prevention and management

[8] Mental Health Treatment Requirements. Guidance for Probation Staff October 2018 and Mental Health Treatment Requirements. Guidance for Psychiatrists and Health Staff October 2018

of crime in mental health settings which aims to support efforts to prevent, manage and detect crime where the suspect is a patient receiving mental health or learning disability services.

6. A sub-group established by the police and crime commissioner's office is looking at the scope of early intervention with those who might offend and the Senior Service Line Lead for Forensic Services attends. Information is shared about, for example, the arrangements for a Single Point of Access to the Trust when patients need to be seen. This helps the Police to know what is possible and available.
7. A bid has been made for a significant further health/probation project and the outcome is awaited at the time of writing.

DISCHARGE PROCESSES

Our recommendation in relation to the need to strengthen procedures in relation to discharge from hospital can be summarised as follows:

We recommend that the Trust further strengthens its practice in relation to patient discharge to ensure that discharge meetings always occur; that a care plan is always written, that care coordinators are present at discharge meetings; and that the arrangements to follow-up patients within 72hrs after their discharge from hospital are maintained.

Since the reports of the reviews of care were published, several steps have been taken:

1. Crisis Resolution Team staff are now included in Discharge planning meetings as a matter of course.
2. The Crisis Team is now based within the acute wards to ensure people are managed and supported as they move into and out of acute inpatient facilities.
3. Steps have been taken to strengthen the involvement of families in Discharge planning meetings.
4. The Trust has strengthened its arrangements for follow-up of patients after they have been discharged from hospital by having a target to see all patients within 72 hours[9].

CONCLUSIONS

The Trust has taken many steps to strengthen services since Ms M was killed by Mr O in December 2015 and the impact of this tragic event continues to be felt by the

[9] Transfer and Discharge Policy, July 2019 (HPFT Operational Policy).

staff who discuss the case frequently. It is clear that Ms M has not been forgotten.

Inevitably, progress with the recommendations that were made to strengthen services continues beyond the steps taken in the immediate aftermath. Our team has drawn the following conclusions in relation to our assurance of this process.

1. In our view, the establishment of the Multi-Agency-Review under the auspices of the Hertfordshire Domestic Abuse Partnership has helped to support engagement of and conversations between partners representing the range of different agencies that were involved with Mr O. Police, Probation, Health, Primary Care, and NHS Commissioners were thereby helped to develop a shared understanding of the challenges that Mr O presented and Hertfordshire is to be commended for this.
2. Risk assessment and management are being strengthened in significant ways at several levels (individual level, team, ward, governance and through audit). Furthermore, significant investment has been made to strengthen services for people with personality disorder (PD). Although we expect that risk assessment and management will continue to improve, and we know that the PD service is still very much in the early stages, our team considers that this recommendation has been implemented in full (A) although the impact upon outcomes has yet to be demonstrated fully.
3. Communications have been strengthened across the Trust and between the Trust and its partner agencies particularly in relation to access to services and when a patient is discharged. We believe that there is more progress that can (and will) be made in this area (B) as new arrangements for liaison teams bed in.
4. Training to support delivery of mental health treatment requirements (MHTR) set by the Court has been delivered. Other steps to improve liaison between Police, Courts, forensic expertise, and general mental health services have also been taken (A).
5. From December 2019 MHTR and MAPPA are now listed as Alert options on the Electronic Patient Record.
6. Discharge processes have also been strengthened through new arrangements to engage the crisis/home treatment team(s) and families in Discharge meetings. The

Trust has strengthened their arrangements to follow up discharged patients within 72 hours and follow-ups commonly occur more quickly. (A).

In conclusion, our team has no further recommendations to make. We are content to report that progress with recommendations has been good.