VERITA

IMPROVEMENT THROUGH INVESTIGATION

# Assurance report into the progress from the recommendations made from the independent investigation into the care and treatment of Mr J

A report for NHS London

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# 1. Introduction

**The incident**

**1.1** Mr J stabbed Mr V, a member of the public, with a knife on 24 April 2014. Mr V died of his injuries. Mr J was arrested the same day and later told the police he had also committed a serious assault with a knife against a member of the public a few days earlier.

**1.2** Mr J pleaded guilty to manslaughter on the grounds of diminished responsibility at the Old Bailey in February 2015. He was sentenced to a hospital order with restrictions and detained at a high-secure unit.

## 2. Summary of the care and treatment

**2.1** Mr J was first referred to mental health services at South London and Maudsley NHS Foundation Trust (the trust) in 2011. His behaviour had become increasingly concerning, including responding to auditory hallucinations to the point that his family had fled their home because they were concerned for their safety. He was sectioned under the Mental Health Act on 1 April 2011 and admitted to Gresham psychiatric intensive care unit (PICU) He remained on the ward until early July when he was granted leave. He was discharged from his section in September 2011.

**2.2** Mr J was first referred to the Croydon Outreach Assessment Support Team (COAST) early intervention service during his first admission. The home treatment team saw him briefly after he was discharged from hospital and before he became part of the COAST caseload. He was routinely seen by his care coordinator and attended regular medical reviews. Mr J complained about the side effects of from his psychotropic medication during his medical reviews. In February 2012 his medication was gradually changed to a different type of antipsychotic medication. Mr J began a medication-free trial period in May 2012.

**2.3** Mr J's mother attended the COAST office on 22 August 2012 to say she was concerned that he was showing early signs of relapse. He had a medical review on 30 August and it was agreed that the medication-free trial should continue. His care coordinator noted that Mr J's personal care was deteriorating in early October, though his mood was good and he showed no signs of psychotic symptoms. Mr J was arrested on 21 October 2012 for assault. He was detained under Section 2 of the MHA and admitted to the PICU on 23 October. After his admission, staff learnt that Mr J had assaulted a neighbour and was reportedly seen by another neighbour carrying a knife. During his first few weeks on the PICU, Mr J was violent towards staff and other patients and he refused medication. He was transferred to an acute ward on 14 November and discharged on 29 November 2012.

**2.4** Mr J was charged on 6 December with threatening a member of the public with a knife. Witnesses did not wish to pursue the matter and the so police took no further action.

**2.5** In the early part of 2013, Mr J started to improve from his previous relapse and showed partial insight into his illness.

2.6 Mr J was arrested on 27 July 2013 after an unprovoked attack on his sister. He later assaulted a custody officer and a police officer. He was detained under Section 2 of the MHA on 30 July for treatment of an acute psychotic episode. He was violent towards staff and patients during the first few weeks of his admission and needed to be closely monitored. Mr J's Section 2 expired on 26 August and he was found to be non-detainable which meant that staff had no legal recourse to keep him on the ward. Ward staff encouraged him to stay on as an informal patient, but he declined so was discharged on 27 August 2013 and returned to his mother's home.

2.7 Mr J was seen regularly by his care coordinator and for medical review during the rest of 2013. He seemed well and was believed to be taking his medication.

2.8 Mr J's mother had a carer's assessment on 8 January 2014. She said Mr J had appeared restless and she thought he might have finished his medication. She said he seemed preoccupied and did not seem to be sleeping as well as usual.

2.9 The care coordinator assessed Mr J on 15 January 2015. He denied hearing voices and said he was taking his medication.

2.10 Mr J was seen on 5 February by a psychiatrist and the care coordinator. He presented as well, and he did not appear to have any psychotic symptoms or paranoia. He said he was taking his olanzapine but continued to experience side effects. No risks were identified during the interview.

2.11 On 6 March 2014 Mr J's mother told the care coordinator that he was taking his medication. She described him as well and sociable. The care coordinator planned to write to the recovery team with a view to beginning the discharge process.

2.12 On 7 March the care coordinator assessed Mr J again. He did not appear to be experiencing any psychosis. Mr J was given a prescription for 28 days of olanzapine.

2.13 Mr J attacked a 15-year-old boy with a knife on 6 April. Trust staff were unaware of this incident at the time. It was only when Mr J was arrested for the index offence that he confessed to the assault.

**2.14** Mr J was assessed at home by the honorary associate specialist on 16 April 2014. Mr J said he had run out of medication three to four days before (if not earlier) but denied any symptoms of psychosis. His mother said he was sleeping well, and both said that Mr J was not showing any signs of relapse. It was agreed that the honorary associate specialist would see Mr J in four weeks and that his mother would act as a liaison in the interim. He was given 28 days of olanzapine. This was the last time that Mr J was seen by the trust.

**2.15** Mr J attacked and killed Mr V, a stranger, eight days later on 24 April 2014.

## 3. The independent investigation

**3.1** In November 2017, NHS England, London Region, commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Mr J.

**3.2** The purpose of the independent investigation was to discover what led to the adverse event and to audit the standard of care provided to the individual. The independent investigation did not identify root causes but found that some things that could have been done better.

**3.3** The terms of reference from the independent investigation also outlined the need to carry out a six-month quality assurance review to independently assess whether the recommendations have been fully implemented and adequately monitored and assured by NHS England. This report outlines the results from the independent quality assurance review.

**Findings from the Independent investigation**

**3.4** The independent investigation found the following issues:

*Risk assessment and risk management*

**3.5** Mr J did not have an adequate risk management plan to effectively manage the risk of his mental health deteriorating or the risk of his violence increasing. This was a serious failure in his care.

*CPA and care coordination*

**3.6** Poor quality of the records in relation to Mr J's care planning. He was seen regularly, and his progress notes were updated but this information was not incorporated into risk assessments or an effective care plan.

*Discharge planning and aftercare*

**3.7** Healthcare professionals involved in Mr J's care discussed and oversaw his discharge from an inpatient setting to the community in 2011, 2012 and 2013 but this was not always documented in line with trust policy.

*Forensic services and MAPPA*

**3.8** The COAST did not engage with the police, probationary services or MAPPA to discuss the management of Mr J. Stronger links with these and forensic services may have facilitated better risk management and a more robust care plan for Mr J.

*Medicines management and compliance*

**3.9** Clinical staff did not assure themselves adequately that Mr J was taking his antipsychotic medication. Collectively, clinical staff did not adequately explore alternative options to giving Mr J oral antipsychotic medication.

*Safeguarding*

**3.10** Mr J had a history of violence that at times encroached into the family home, leading to at least one instance when the family fled the family home because they were worried for their safety. We found no evidence to suggest that the COAST ever considered Mr J's younger siblings to be at risk. Mr J's notes record that his younger siblings were not considered to be at risk but the rationale for this decision was not documented in the notes.

## 4. Recommendations arising from the independent investigation

**4.1** The independent investigation team made six recommendations. These are listed below.

**R1** The COAST service managers must undertake a case note audit to assure themselves that service user records are being completed in line with trust policy. This audit should assess risk assessment, and care planning.

**R2** Service managers must ensure that service user records are completed in line with the trust discharge policy.

**R3** The trust should assure itself that the correct systems are in place to enable staff to readily access advice from trust forensic services.

**R4** The trust should assure itself that guidance and information is available to frontline staff in relation to engaging with the police and probationary services.

**R5** The trust should assure itself that it has appropriate support and guidance in place for staff to explore treatment and management options for high risk service users.

**R6** The trust should assure itself that members of the COAST understand and can effectively implement the trust safeguarding policy as part of their assessment of patients their families and/or carers.

## 5. Approach to this review

5.1 The terms of reference from the independent investigation outlined that there should be an assurance follow up review, six months after the report has been published, to independently assure NHS England and the commissioners that the report's recommendations have been fully implemented.

5.2 This independent quality assurance review focuses on the following documentation:

- The action plans developed by the trust and associated documentary evidence such as policies and procedures, minutes of meetings, screenshots and training records.

- Documentary evidence from Croydon CCG (the commissioning CCG) who regularly monitored the trust action plan to gain assurance that services were clinically safe, effective, promote good patient experience, and that the requirements stipulated within the contracts held between the Croydon CCG and the trust, the NHS Constitution and Fundamental Standards of Care regulations were met.

5.3 A full list of the evidence reviewed is outlined in appendix A.

**Action plan**

5.4 In November 2017, the trust developed an action plan following the Verita investigation. This outlined all the recommendations and the actions needed to put them in place. The actions were reviewed by lead clinicians in the Quality Sub-Committee and directly monitored by the trust Board of Directors to ensure that lessons have been learnt.

5.5 Croydon CCG, the commissioners of the trust has an internal governance structure in place which allows for oversight and scrutiny of the action plan at a number of levels. The independent investigation report action plan was regularly reviewed at the trust's Serious Incident panel. This meeting was attended by a multi-disciplinary team of medical, nursing and managerial personnel and representatives from the CCG. Once the report and action plan were considered 'fit for purpose' the action plan was monitored via the monthly serious incident meetings held with the CCG and the trust. Once there was consensus between the

trust and commissioners that actions have been taken and are embedded, the action plan was closed down.

**5.6** Since this incident, the trust has introduced an electronic toolkit called '*the perfect ward*'. This toolkit makes quality inspections and audits much easier and more efficient. Despite the name of the toolkit, it is usable across all clinical areas, including wards, and community settings. The toolkit enables live reporting, makes it easier to spot ongoing issues and makes the interpretation of data more up to date.

**5.7** The table below shows the actions taken by the trust to implement the recommendations and the outcome.

| Recommendation | Actions taken | Outcome |
|---|---|---|
| **Recommendation 1:**<br><br>The COAST service managers must undertake a case note audit to assure themselves that service user records are being completed in line with trust policy. This audit should assess risk assessment, and care planning. | • Clinical supervision templates were amended to include discussing how clinical staff document risk assessment and care planning.<br><br>• The Team Manager from COAST undertook random qualitative audits of risk assessments, care plans and risk management plans on a quarterly basis.<br><br>• The audit reports were reviewed in clinical supervision sessions and any gaps in individual performance were addressed monthly.<br><br>• Exception reports were provided to the Clinical Service Lead to demonstrate that action was being taken. | • The findings of the audits undertaken indicated that risk assessments and care plans were completed appropriately.<br>• The final audit carried out and signed off in September 2107 demonstrated that the quality of care plans and risk assessment had improved and there were clear links between risk assessments and care management plans.<br>• The monitoring of this recommendation is now being managed via the perfect ward electronic toolkit. |
| **Recommendation 2:**<br><br>Service managers must ensure that service user records are completed in line with the trust discharge policy. | • Audits of records were carried out for a six 6-month period of patients discharged home. In addition, an operational policy was updated to include expected standards and audit arrangements in relation to the discharge and transfers of patients. | • The outcome of the audit showed that records did include details of the patient's discharge.<br>• This recommendation is being monitored via the perfect ward electronic toolkit. |

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| **Recommendation 3:**<br>The trust should assure itself that the correct systems are in place to enable staff to readily access advice from trust forensic services. | • A forensic services review was carried out to ensure there are adequate systems to provide advice to other clinical teams within the trust. There is now a new operational policy for the Forensic Community Services. This makes it clear that advice and signposting should be given to referrers if necessary and that advice should be given regarding alternative provision for those not accepted into the service.<br>• A forensic team member met with the COAST team to clarify their criteria for acceptance on forensic team caseload and how to make referral to the team if necessary. All COAST team members now have access to the forensic leaflets, referral forms and referral guidelines through the COAST team shared folders on the trust's intranet. | • There is a system in place for COAST clinical staff to access forensic support and advice as required.<br>• The monitoring of this recommendation is now being managed via the perfect ward electronic toolkit. |
| **Recommendation 4:**<br>The trust should assure itself that guidance and information is available to frontline staff in relation to engaging with the police and probationary services. | • The trust has updated the risk management policy to highlight the need for staff to liaise with the Police and Probation service and to engage with the police if necessary to inform risk assessments.<br>• A bulletin was devised and disseminated to staff and put on the internet providing guidance on how to access police information for risk assessments.<br>• All staff undergo a level of Promoting Safe and Therapeutic Services training now. Liaison with the police is included in the course content. | • There is a system in place for clinical staff frontline staff to engage with the police and probationary services.<br>• Information is readily available providing staff with advice on how to make contact.<br>• The monitoring of this recommendation is now being managed via the perfect ward electronic toolkit. |

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| **Recommendation 5:**<br>The trust should assure itself that it has appropriate support and guidance in place for staff to explore treatment and management options for high risk service users. | Several actions were undertaken to ensure that this recommendation was implemented:<br><br>• The medicines management policy was updated to reflect that poor insight should be highlighted as a predictor of poor compliance to early intervention teams, and that when identified it is important that all medication monitoring options are explored.<br><br>• The trust has revised how the community care plans are recorded on the electronic clinical notes system. A single Recovery and Support plan is now used which includes:<br>- early warning signs and triggers<br>- how to access help in a crisis - how and who the crisis plan should be communicated to.<br><br>• To provide assurance on the new systems, the trust audited the knowledge of 2 Team Leaders from each Borough on how to access advice from Pharmacy. | • Updated guidance and support are in place for clinical staff.<br><br>• The monitoring of this recommendation is now being managed via the perfect ward electronic toolkit. |
| **Recommendation 6:**<br>The trust should assure itself that members of the COAST understand and can effectively implement the | • The trust moved to a new training software monitoring platform on 30 November 2016. This provides a full overview of learning and performance data.<br>• The COAST team now has a designated Safeguarding lead who oversees adult and child safeguarding referrals. | • Copy of the audit report received. This showed that all COAST team members had attended mandatory |

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| trust safeguarding policy as part of their assessment of patients their families and/or carers. | • A local adult safeguarding folder and children development of local safeguarding tracker is now maintained on the COAST team shared folders on the ICT network which all staff can access.<br>• Safeguarding is part of the supervision structure within COAST with records reviewed in supervision | safeguarding with exceptions for unexpected staff absence.<br>• The audit has provided assurance that a high quality of care is provided and that the safeguarding policy is understood and embedded effectively. |

## Overall summary

5.8 This external quality assurance review comprised of a review of documents and policies provided by the South London and Maudsley NHS Foundation Trust and Croydon CCG.

5.9 I have received evidence showing that there was a clear process in place for reviewing the action plan from the independent investigation within the trust and that Croydon CCG audited and monitored the progress of actions. These two organisations had signed them off as they were completed.

5.10 The documents received show that the recommendations from the independent investigation report have been completed and embedded into practice.

### Good practice

5.11 Since this incident, the trust has introduced an electronic toolkit called *'The perfect ward'*. This toolkit enables a bespoke, digital and more comprehensive approach to monitoring quality.

### Recommendation

**R1** The trust should continue implementing the perfect ward to further promote quality inspections, audits and the interpretation of data.

**Appendix 1**

## Documentary evidence

- A copy of the trust action plan and updated action plans
- Copies of audits undertaken in relation to:
    - service user records/ risk assessment and care planning
    - discharge policy
    - delivery of safeguarding training
- Minutes of the Croydon CCG and South London and Maudsley Hospital (SLaM) serious incident management and learning group meeting
- Minutes of the serious incident panel meeting between SLaM and NHS Croydon CCG
- Minutes of the SLaM serious incident review group
- Minutes of the NHS England, London Pre-Publication meeting
- Copies of the trust action plans and updated versions
- Serious incident review group tracker document
- Email correspondence between SLaM
- Copies of training programmes in relation to safeguarding plus attendance lists
- Updated medicine management policy
- Crisis and safety plans
- Croydon care plan audit summary report March 2019
- Safeguarding training compliance report
- Clinical risk assessment and management of harm policy
- Screenshots from trust intranet
- Southwark forensic CMHT Referral Meeting
- Draft operational policy for the forensic community service.

**Appendix 2**

## Example questions from the perfect ward app