NHS
Midlands and East

Briefing: Lessons learned from a ‘near miss’ in mental health services
- Access to secure beds

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niche
HEALTH & SOCIAL CARE CONSULTING

Introduction

About this report

This learning document relates to a requirement for a mental health hospital placement for a prisoner (Mr N) on remand, who was released from custody unexpectedly.

NHS England (Midlands & East) commissioned an independent investigation as defined in the NHS England serious incident framework. It was felt that the risks presented by Mr N on release from prison were of sufficient concern to regard this as a 'near miss' event, and that learning should be drawn out in order to be shared across systems.

Deciding whether or not a 'near miss' should be classified as a serious incident should therefore be based on an assessment of risk that considers both:

- the likelihood of the incident occurring again if current systems/process remain unchanged; and
- the potential for harm to staff, patients, and the organisation should the incident occur again.

NHS England commissioned Niche Health & Social Care Consulting (Niche) to carry out the independent investigation. The subsequent report was shared with the stakeholders involved and published by NHS England. Niche was asked to develop this subsequent learning document setting out the issues and lessons learned, so that other healthcare providers and commissioners might benefit from these key insights.

Responsibilities

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.

Our independent investigation and this learning document is limited in scope and has been drafted in line with the provisions set out in the terms of reference supplied by NHS England (Midlands and East) alone and is not to be relied upon for any other purpose. Our responsibility is to NHS England alone and no other party may place reliance upon our report or summary other than for the purposes of shared learning.

Relevant, specific areas of healthcare to which this learning relates

- Prison mental health and communication with local services.
- Responses of local mental health services to an urgent need for a secure or PICU bed.
- Management of acute mental health presentation in emergency departments.
- Management of extreme challenging behaviour in an acute mental health service.
- Decision making about referrals and admissions to secure services overseen by NHS England specialised commissioning.

About Niche

We have been supporting the NHS and social care for over 25 years with modelling, analytics, evaluation, investigations and governance. We undertake some of the most high profile investigations in the country. We regularly provide articles, information and events to help both NHS and public sector healthcare clients to learn from untoward events.

Case summary

Mr N had been on remand in prison custody since early December, with a trial date set for January. He faced charges of criminal damage on Trust premises in the previous November, and a public order offence in the December.There were concerns about his mental state in prison, and he had been referred to the prison inreach mental health team provided by a mental health trust local to the prison. This was not the trust where he had been previously treated. He was seen by a prison consultant forensic psychiatrist for assessment in late December, and it was advised to continue antipsychotic medication.

In the January it was noted that he was paranoid, and had anxieties around court and the criminal justice system building a conspiracy against him. When seen for a further psychiatric assessment in February he became hostile and physically aggressive.

The decision to request a Mental Health Act (MHA) assessment was made by prison healthcare clinicians after the information was received from probation that he was to appear in court by video link in mid-February, and was likely to be released. The charges against Mr N were dropped and it was arranged that he would be kept in custody under a probation service ‘recall notice’ for the next two days to allow time for an MHA assessment to be arranged, and a bed found.

A referral was made to the local services bed manager, when the two medical recommendations had been completed for Section 2 MHA.

Mr N was released from prison in mid-February. He had been seen by two Section 12 MHA approved doctors and medical recommendations were completed, recommending that he be admitted to hospital under Section 2 MHA.

Mr N had recently been under the care of the local mental health trust, and local substance misuse services. He had been physically violent and threatening in both services some weeks earlier.

Mr N was seen by an Approved Mental Health Professional (AMHP) who was minded to complete an application for detention under Section 2 MHA, but a suitable bed could not be found. He was therefore released from prison, given a sum of money and placed in a taxi to take him to his home town.

In the evening of the following Saturday, Mr N approached a police officer in by flagging down his car, and said he was hearing a voice telling him to kill or harm people, and that his father-in-law had placed a microchip in his head. The officer noted that he appeared ‘otherwise calm and rational’, and contacted the local mental health trust street triage team. A discussion about the use of Section 136 MHA (1983) was noted, and it was decided that he did not require this. The police accompanied him to the local hospital Emergency Department (ED).

Because of his history of challenging behaviour and aggression whilst an inpatient, a PICU bed was sought but could not be found. He remained in ED for three days while the mental health trust attempted to find a bed. He was then admitted to an acute ward, directly into seclusion, where he remained for 23 days.

He was assessed by clinicians from low and medium security, and discussions took place with NHS England specialised commissioning. It was considered that he was presenting with challenges that were not manageable in either low or medium security, and he was therefore referred to high secure. He was admitted to a high secure hospital where he remained for five months, before being transferred to medium security.

Key findings

We identified a number of findings, both positive and also areas where significant improvements were required. These are summarised as follows:

- The NHS healthcare system had no control over the release of Mr N from prison in February, and the intention had been to treat his psychosis in prison, and keep this under review. When it became obvious that he was to be released imminently, an AMHP assessment and recommendations for Section 2 MHA were obtained.

- Prison healthcare clinicians and the assessing Section 12 doctor believed a Low Secure service was appropriate. Efforts were made to find him a local Low Secure bed urgently, and this was refused. The level of security would normally be agreed by the clinician who carries out the gate keeping assessment, when one is requested through NHS England specialised commissioning. Within the service specification the level of urgency is decided by the assessor, not the referrer, and there is no process in place to challenge this.

- In this case the Low Secure referral was simply refused, and usual bed management processes were actioned simply as a default position rather than as a positively agreed, clinically appropriate action.

- There was no escalation of this issue by prison healthcare clinicians to involve NHSE specialised commissioning and local low secure clinicians in finding a solution.

- Efforts then moved to obtaining a bed through local bed management structures which were not successful.

- There was no escalation to the local Trust executive team to alert senior staff that a patient who had been deemed to require detention in hospital may be released into the community.

- The process of accessing a secure gatekeeping assessment through NHS England specialised commissioning did not include a process for responding to an urgent referral, with no opportunity to have multi professional urgent case management discussions to problem-solve and source a shared solution.

The good practice we identified is found in the following key areas:

Acute mental health presentation in the emergency department:

- Positive working relationships between the police, ED and trust Mental Health Liaison Team helped to ensure that Mr N was kept safe until a solution could be found.

- The Mental Health Liaison Team provided good support and psychiatric advice during his stay in ED.

- The ‘VISA’ tool provides a quick assessment of need in relation to mental health that is easily applied in an emergency department. In this case staff were able to use this tool to provide meaningful feedback about Mr N to senior managers and clinicians to aid decision making.

Staff support:

- The mental health trust recognised that staff were distressed and traumatised by the experience of caring for Mr N, and provided informal and formal support structures.

Identified learning points

Communication by prison healthcare clinicians with local services:

- The inquiry was made to the local low secure unit, based on Mr N's assessed needs.
- The actions taken by prison healthcare staff in response to the news that Mr N would be released imminently were timely and appropriate in arranging an MHA assessment and communicating with local services.
- Prison healthcare clinicians need to maintain oversight of the progress of the request for a Low Secure bed, and involve NHS England specialised commissioners in a request for an urgent admission.
- The absence of a pathway for urgent referrals to NHS England specialised commissioned services reduced the options available.

Urgent need for a secure bed:

- Local bed-management systems should have escalation routes so that senior personnel are sighted on challenging situations where more resources are needed to seek solutions.
- Local commissioners should ensure there are pathways to access to secure beds in cases of urgent need.

Crisis management:

- The local mental health system became effectively 'paralysed' by the lengthy period of seclusion of Mr N. It was not possible to continue admissions, or assessments under Section 136 MHA for other patients.
- A formal structure for managing strategy, communications and problem solving, and maintained formal records of decisions and actions would have assisted the Trust.

The process would have been strengthened by using business continuity management structures, with formal recording of requests and decisions made.

Assessments for secure beds:

- The speed of assessment, decision-making and transfer to High Secure was at that stage an appropriate and timely response to the situation in which the local clinicians and Mr N found themselves in, and this is commended as an example of systems working swiftly and effectively.
- Within the NHS England Specialised Commissioning Service specification the level of urgency for a secure bed is decided by the assessor, not the referrer, and there is no process in place to challenge this.
- A standard operating procedure with clear timelines, a pathway for urgent referrals and an escalation process would assist with this process.

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