NHS England and NHS Improvement
Media statement
3 February 2020

PUBLICATION OF INDEPENDENT INVESTIGATION REPORT INTO THE CARE AND TREATMENT OF MR N IN DERBYSHIRE

Findings of an independent investigation into the circumstances surrounding the care and treatment of Mr N have been published.

Mr N was released from prison whilst detainable, but no suitable bed could be found. Mr N approached a policeman saying he was hearing voices telling him to kill people. The policeman took him to the local Emergency Department where he spent two days waiting for a bed. He was transferred to an Enhanced Care Ward and placed in seclusion, before his transfer into higher secure services after a couple of weeks.

This was a near miss and investigated due to the potential for learning across the NHS.

Dr Nigel Sturrock, Medical Director at NHS England and NHS Improvement – Midlands, said: "The risks identified in the case of Mr N on his release from prison were of sufficient concern to regard them as a 'near miss' event. When these events occur, we work closely with the relevant organisations to ensure that lessons are learned and any necessary improvements are put in place to prevent similar incidents occurring in the future.

"The aim of this independent investigation is to enable the providers of care, and the whole of the NHS, to learn lessons and make improvements for the benefit of future patients, their carers and the public. We commission these reports so that the NHS is open and transparent with the families involved and the wider public about what took place and what the NHS is doing to fix it."

The investigation team's view was that there were issues in initially finding Mr N a suitable bed and a lack of escalation when no bed was found. The team also found that the system did not respond flexibly nor as a comprehensive, integrated system and failed to take ownership allowing Mr N to fall through the gaps.

The team did acknowledge that Derbyshire Healthcare took ownership of Mr N's clinical need, however they identified that the decision to admit him to seclusion escalated his behaviour and was excessively restrictive. A lack of senior oversight and support of the clinical team on the enhanced care ward was also identified, and the investigation team felt this allowed the situation to continue.

The report makes eleven recommendations for Derbyshire Healthcare NHS Foundation Trust, Nottinghamshire Healthcare Foundation NHS Trust, NHS England (Specialised Commissioning) and Derby & Derbyshire Clinical Commissioning Group.

All organisations have come together and developed a joint action plan in response to the recommendations made in the report.

Dr Nigel Sturrock continued: "The organisations involved in providing and commissioning Mr N's care have taken swift action to address the findings outlined in the independent report. Each of the recommendations have been addressed and improvements made to ensure everything possible has been done to prevent a similar incident happening in the future."

A copy of the full independent investigation report and the action plan is available at: https://www.england.nhs.uk/midlands/publications/independent-investigation-reports-for-midlands/

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Note to editors

- The independent investigation follows the NHS England Serious Incident Framework[1] (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.[2] The terms of reference for this investigation are given in full in Appendix A of the report.

- The main purpose of an independent investigation is to ensure that serious untoward events 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.

- The aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.

- This investigation was commissioned by NHS England and NHS Improvement as a level 3 independent investigation, as a 'near miss'. It was felt that the risks presented by Mr N on release from HMP Nottingham were of sufficient concern to regard this as a 'near miss' event, and that learning should be drawn out that could be shared across systems.

- The independent investigation was carried out by Dr Carol Rooney, Head of Investigations for Niche, with expert advice provided by Dr John McKenna, retired Consultant Forensic Psychiatrist.

- The service user has been anonymised in this report. It is important that the wider health service learns as much as is possible from these reports. Anonymising the contributors encourages full discussion of the events and decisions surrounding a mental health service user. However, if failings are found then both organisations and individuals can still be held to account for their actions.

- NHS England and NHS Improvement work together to lead the National Health Service (NHS) in England and support it in delivering improved care for patients.

- The NHS in England deals with over 1 million patients every 24 hours and employs more than 1.5 million people, putting it in the top five of the world's largest workforces. NHS England and NHS Improvement shares out more than £100 billion in funds and oversees Trusts and providers offering NHS care. It strongly believes in health and high-quality care for all, now and for future generations.

- For media enquiries, please email england.memedia@nhs.net. Out of hours please call 07623 503829.

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

[2] *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*