INDEPENDENT REVIEW

Of the care and treatment received by George and Charles prior to an incident of homicide.

Summary Report

Feb 2025

Contents

Section 1: Overview of the incident of homicide

1.1 George (not his real name) was admitted for treatment under Section 3 of the Mental Health Act 1983 (amended 2007) to an acute admissions ward within a mental health trust.

1.2 On the fifth day of his admission he violently assaulted a fellow patient, Charles (not his real name), resulting in Charles being transferred to a critical care unit in a neighbouring acute trust, where he died of his injuries four days later.

Section 2: Investigation terms of reference and methodology

2.1 In the summer of 2022, NHS England formally commissioned Facere Melius, a healthcare consultancy, to undertake an independent investigation to review the care, treatment and management George and Charles received from the four months leading up to the incident. This was commissioned in line with NHS England's Serious Incident Framework, published in March 2015.

2.2 The main purpose of an independent investigation is to ensure that mental health-related homicides are investigated in such a way that lessons can be learnt effectively to prevent recurrence and improve patient safety. The investigation process may also identify areas where improvements to services might help prevent similar incidents and mitigate risk to mental health care service users and the people with whom they come into contact.

2.3 Terms of reference for the investigation were agreed in Summer 2022 with NHS England, Facere Melius and those agencies involved. They were shared with Charles' immediate family, who were able to add comments and raise questions that they wanted answers for. These were considered and addressed throughout the investigation process, and were reflected in the full report. The terms of reference for this investigation can be found in appendix one.

2.4 The Facere Melius review team used a range of qualitative and quantitative techniques and methodology to undertake the investigation. They reviewed all the available records relating to George and Charles' contacts with the NHS and other support services. This process included collation and review of the clinical records available for George and Charles.

2.5 The review team also reviewed various national and local policies and guidelines relating to the care and treatment George and Charles received. Examples include National Institute for Health and Care Excellence (NICE) guidelines and reports by the Royal College of Psychiatrists.

2.6 The review team had meetings with or received information from many of those who were involved with the care and treatment of Charles and George. Meetings also took place with individuals who were in leadership and management positions.

2.7 The review team would like to thank those staff who met with them and engaged in the process, as well as managers who supported them and enabled the interviews to take place.

2.8 The review team met with Charles' family to understand more about him and his mental health history.

2.9 Following the document reviews and interviews, the team verified the accuracy of the chronology of events, identifying key themes. These were fact-checked, analysed and assimilated wherever possible, and the information triangulated. This included reviewing the actions taken by staff involved in the incident and providing specialist advice on whether their professional practice was in line with national and local guidelines and good practice. A team of independent advisers provided support in drafting the report. A draft report was then quality assured by a Facere Melius editorial board, whose members provided additional support, guidance and advice.

2.10 On completion of the review, the draft report was shared with the trust and other stakeholders, including the victims family as part of the factual accuracy process. All stakeholders were consulted on recommendations before publication of the report.

2.11 The identity of the professionals involved in the care and treatment of Charles and George have been anonymised, and their official titles have been used instead of their names, where necessary.

2.12 A team of independent investigators formed the Facere Melius review team, none of whom currently have any professional association with the mental health trust involved. These included a director of nursing (mental health services), and clinical investigators with operational experience in mental health, forensic and substance misuse services. Additional support was provided by a senior police adviser, and an ambulance adviser (emergency operations centre).

2.13 The editorial board consisted of independent, out of area individuals:

- director, Facere Melius
- editorial and assurance oversight adviser, Facere Melius senior associate
- editorial standards adviser, Facere Melius senior associate
- executive lead for mental health and forensic services
- pharmacist adviser

Section 3: Context and relevant factors

Effects of the Covid-19 pandemic

3.1 During the period under review, the effects of the Covid-19 pandemic were still having an impact on NHS services. This took the form, among other things, of increased and prolonged staff absence through sickness.

3.2 Like many other mental health trusts in England in this period, the trust had a high number of staff vacancies.

The trust's serious incident investigation

3.3 At the time of the assault on Charles by George, the normal process was for the trust to carry out its own serious incident investigation, known as a level 2 investigation. The trust carried out a 72-hour review, which was sent to NHS England. The trust was then advised by NHS England that this incident met the criteria for a regional independent investigation (known as level 3), and it was agreed that a level 3 investigation would be undertaken in lieu of the level 2 local investigation. This approach was agreed by the trust and NHS England. The trust also undertook a desktop review of the health records of George. They were unable to talk to the staff who had been involved in the care of Charles and George because of the ongoing police investigation. As part of this independent investigation, the Facere Melius review team have taken these two reviews by the trust into account.

Section 4: Background – Charles

4.1 At the time of the incident Charles was 55 years old.

4.2 He had a history of psychotic symptoms, which included disturbed, confused and disrupted patterns of thought. He also had a history of amphetamine misuse and schizotypal personality traits, which can present as eccentric or unusual thinking, beliefs or mannerisms.

4.3 His most recent interaction with mental health services occurred eight years prior to his last admission. According to GP records, the last prescription issued for his antipsychotic medication (aripiprazole 10 mg daily) was five years before his current admission.

Section 5: Key events leading up to Charles's admission

5.1 Police were called by Charles's landlord to his address due to concerns about his mental health. They forced entry and found his house was in disarray and records show Charles was exhibiting signs of serious mental illness. A social worker then made a referral to local mental health services, however the referral was closed the following day when the mental health team were unable to contact the social worker who had made the referral. Just over a week later, another social worker made a welfare check and was concerned about Charles's mental health: he was observed to be hearing voices, self-harming, acting erratically and displaying signs of paranoia. So an urgent referral was made to the Single Point of Access service. This is a 24-hour, seven day a week service that provides the first point of contact for people who need a referral to mental health services and support in mental health crisis.

5.2 The day after this second referral, during a home visit, mental health staff found Charles's house in disrepair, and there were difficulties in engaging with him; he was not able to have a comprehensible conversation, was very agitated and did not consent to them entering his home. Because of his forensic and illicit drug history, it was decided that another visit was needed the following day to attempt to engage Charles and assess his mental health with support from social services. Charles once again refused entry to his home, was shouting and aggressive, his behaviour was erratic and he was showing signs of a serious mental health disorder. As the team were unable to assess his mental health, they decided that a MHA assessment and a warrant to enable access to his home were needed.

5.3 The mental health team requested a Section 135 warrant of the Mental Health Act 1983 (MHA, also referred to hereafter as the Act). This allows the police to enter a person's home and take a person to (or keep them at) a place of safety so that a mental health assessment can be done. The police must have a warrant from the magistrates' court allowing them to access a person's home.

5.4 While the warrant was being obtained, attempts were being made to locate an appropriate bed in a mental health facility for Charles. A bed in a facility with a seclusion unit was thought to be needed, because Charles had not been

taking his antipsychotic medication for some time and he had an extensive forensic history.

5.5 Charles was then detained under section 2 of the MHA, which allows for a person to be admitted to hospital for up to 28 days to assess whether they are suffering from a mental disorder, the type of mental disorder, and/or how the person responds to treatment. Following this assessment, a bed was allocated for him in an acute admission ward, which included a seclusion room.

Commentary

C.1 As the trust were unable to follow up contact with the social worker, who made the initial referral this resulted in the referral being closed. Eight days elapsed between the first and second referral, during which time his mental health would potentially have further declined.

C.2 There was no evidence in Charles's records that either social worker had undertaken a risk assessment of the situation. The initial referral had very basic information and no indication of the seriousness of the concerns about Charles. The Initial Response team made various unsuccessful attempts the day after the referral was made to make contact with the social worker who had made that initial referral. Considering that the police had raised concerns about him following their visit, it would have been important that the mental health team were able to speak to the social worker to gain more information about Charles to understand what had prompted the referral and get the help Charles required. It was only when the second referral was made that the Initial Response team received the information about the police visit days earlier.

C.3 It is also important to note that Charles had not had any contact with mental health services since 2014, and from around 2017 appeared to stop taking his antipsychotic medication. There is a high risk of relapse when this medication is stopped abruptly. Withdrawal of antipsychotic drugs after long term therapy should be gradual and closely monitored to avoid the risk of acute withdrawal syndrome or rapid relapse. Patients should be monitored for two years after withdrawal of antipsychotic medication for signs and symptoms of relapse. (National Institute for Health Care and Excellence (NICE) website: British National Formulary (BNF), Treatments and summaries, Psychoses and related disorders, monitoring).

C.4 The review team recognise that this period of Charles's care and treatment is outside of the scope of terms of reference for this investigation, but consideration might need to be given to reviewing the time after 2017, when

Charles stopped taking his antipsychotic medication, to understand what action was taken, and to identify if there is any learning.

Section 6: Key events during Charles's admission and inpatient stay

6.1 On admission to the ward, it was noted that Charles was reluctant to engage: he avoided eye contact and had a blank facial expression. His inpatient consultant psychiatrist, the ward staff nurse and the named nurse explained his rights under the MHA, orientated him to the ward and his room, and introduced him to the staff on duty. Each patient is allocated a named nurse. These nurses are responsible for the delivery of safe and effective care during a patient's inpatient stay, and are responsible for ensuring that all documentation, including risk assessments and care plans, are relevant and up to date. Charles was told that he would be on four-hourly intermittent observations. Charles was difficult to understand as he mumbled and spoke quietly. The initial diagnosis was recorded as 'Psychotic symptoms perpetuated by amphetamine abuse; schizotypal personality traits; possibility of schizophrenia'. He was prescribed antipsychotic medication to start that night, and further medication for his agitation and sleep problems to be taken when needed.

6.2 During his first few days on the ward Charles was presenting as extremely thought disordered. He was incoherent and reluctant to take his medication, which he threw on the floor. He was agitated, unkempt and showed signs of self-neglect. He appeared uncomfortable when on the open ward, and tended to stay in his room. He was then placed on 15-minute intermittent observations. This is a regime for patients who pose a potential but not immediate risk. Staff are required to observe the patient at irregular and unpredictable intervals over a prescribed period. They must also make sure that the required number of observations are done within each hour, and that there is not an excessive time interval between them.

6.3 A care coordination and risk management plan was developed that recorded why Charles had been admitted and the agreed plan for his care and treatment. It set out the actions that would be taken to ensure his safety (observations) and management of any risks. At this point Charles was not prescribed any section 17 leave (under the Mental Health Act [1983]). This meant that he was not able to leave the ward. The plan was shared with Charles.

6.4 After two days on the ward, during a medical assessment, it was noted that Charles was still displaying grandiose delusions, appearing unkempt and

dishevelled and showing ‘blunted affect’ (meaning he had reduced emotional reactivity). He lacked insight into his mental health deterioration and did not demonstrate capacity regarding his current admission or treatment. The clinical plan was to continue monitoring his mental state for changes in mood and any self-harm or suicidal thoughts and any risk behaviours. His observations were reduced to general level observations. This is the minimal level of observations and is for patients who are considered to be at a low risk of vulnerability, suicide, self-harm, or harm to others, in line with trust policy.

6.5 On day three of his admission Charles was granted section 17 leave by his consultant psychiatrist. Section 17 is an aspect of the MHA under which a person detained in hospital is authorised by the doctor or clinician in charge of their care to leave the hospital under certain conditions as part of their recovery plan. He was to be allowed short-term day leave between the dates specified if he needed to attend any hospital appointments and escorted leave to local shops and hospital grounds for limited periods, generally up to 20 minutes or an hour. The frequency and duration of such periods of leave was to be granted at the discretion of nursing staff. His consultant psychiatrist, who was Charles’s responsible clinician, completed the form H17L in Charles’s electronic patient records, as required by the trust policy: ‘Only the patient’s responsible clinician can grant leave of absence to a patient detained under the [Mental Health] Act’. There were no significant changes to his risk assessment.

6.6 Charles continued to remain largely withdrawn alone in his room, and not engaging with other people, but was taking his medication, and beginning to appear more on the ward.

6.7 After around two weeks on the ward, there was a welfare check undertaken due to reports that Charles was shouting. He became extremely hostile and threatening to the staff member, who disengaged. A clinical lead nurse and two nursing assistants came to assist. Charles made racist remarks to a member of staff and assaulted another member of staff. He would not consent to take oral medication to calm him and staff attempts to de-escalate the situation were unsuccessful, so action was taken in line with the trust’s prevention and management of violence and aggression (PMVA) restraint reduction policy. This provides guidance for the positive and safe management of incidents in which staff face an explicit or implicit challenge to their safety, well-being or health. Charles was physically restrained and taken to the quiet room, known on the ward as the ‘chill out’ room.

6.8 Because he continued to act aggressively and to resist, he was given an intramuscular injection of lorazepam (rapid tranquillisation). After administration of this injection, Charles was monitored at regular intervals,

although on a number of occasions during this time he refused to have his vital signs (such as blood pressure, pulse, temperature) monitored, but his hydration and respiratory rate were always recorded. An incident report was submitted, in line with trust policy.

6.9 In the days following this violent incident, Charles appeared more settled in behaviour, and expressed some remorse for his violent outburst. He engaged with staff and peers, and began to participate in some occupational and speech and language therapy and group activities, but continued to be unkempt and remained mostly solitary in his room. He began to use his escorted leave periods without raising concerns, and to take his prescribed medication.

6.10 During this period on the ward, Charles made several assertions to staff about various conditions that might have had some bearing on his behaviour and mental health. He claimed to have hearing difficulties, and referred to using hearing aids. He also made assertions about having a history of strokes and transient ischaemic attack (TIA – a mini-stroke). He mentioned being dyslexic, and this was why he had difficulty processing and understanding written texts (and possibly some oral communication).

6.11 Charles' mental health assessment concluded that he continued to show signs of psychotic illness, had no insight into his mental health, and did not have capacity to consent to an informal admission. The assessment team decided that a section 3 of the MHA would be considered. This allows for a person to be detained in hospital for treatment for up to six months. Charles gave consent for his mother to be contacted as his nearest relative. She provided further information to the assessment team. 'Nearest relative' is a legal term used in section 26 of the MHA: it gives one member of the family certain rights and responsibilities if a person is detained in hospital under the MHA. It is not the same as next of kin, who do not have any rights under the MHA.

6.12 Charles disclosed information to a member of staff that could have had safeguarding implications. There is evidence of effective recognition of safeguarding concerns as this disclosure was recorded in line with the trust's incident policy. And a safeguarding alert was raised in line with the trust's adult safeguarding policy.

6.13 Staff supported Charles at this time and suggested that he might want to report the information to the police; Charles declined to do so.

6.14 The safeguarding alert was reviewed by the Safeguarding and Public Protection (SAPP) triage worker and was to be discussed by the safeguarding team for a decision.

6.15 Following an MHA assessment, almost a month after his initial admission, Charles was detained under section 3 of the Act.

6.16 During his time as an inpatient Charles was engaging with the occupational therapy team and the team were considering a rehabilitation inpatient pathway for him. As he was still acutely unwell, however, and there were still concerns around Charles going absent without leave if he had unescorted leave (which would form a part of the rehabilitation regime), the timescales/pathways were unclear for when he could move to such a facility. The occupational therapy team's plan was to put him on the waiting list for an inpatient rehabilitation bed in the area, and for his current care team to consider options for unescorted leave.

Commentary

C.5 Members of staff who are involved in an incident in which a patient has to be physically restrained should have undergone prevention and management of violence and aggression training in line with their occupational role, and this training should have been up to date. Both the nursing assistant and staff nurse who were involved in the incident with Charles, and the staff involved in the monitoring of Charles after the incident were appropriately trained as required by the trust's restraint reduction policy. Because the other nursing assistant involved in the restraint was an agency staff member, the trust's training records do not include them. Normal practice when agency staff are employed is that the agency confirms to the trust their training status.

C.6 Staff acted on Charles's reports of various conditions, including deafness (and use of hearing aids) and dyslexia. The speech and language therapy team had a plan to assess his literacy, and to assess his self-reported dyslexia informally by observation of his therapeutic cookery sessions. The records show that the therapy teams were aware that Charles's reports of such disabilities and conditions could have been part of his delusional thinking, and that his mental health difficulties and drug use could have led to significant cognitive deficits. Nevertheless, staff might have considered arranging a specialist assessment for Charles's possible learning difficulties such as dyslexia. There is no evidence that his self-reported hearing difficulties were investigated further, for example in the form of hearing acuity tests.

C.7 The staff involved with Charles's care and treatment could find no reference on health information exchange systems to the other physical health issues that Charles reported (strokes or transient ischaemic attacks), or when conducting physical health examinations and observations.

C.8 Although his records (form H17L) show the general conditions (including date parameters) for this leave, the trust's policy on leave states that 'it is of particular importance [for the nurse in charge] to maintain an accurate record of short-term leave'. This should also show actions to be taken if the patient goes missing. Considering that there were concerns about Charles going absent without leave, these requirements would have been of even higher importance, but there is no evidence in his records of such documentation.

C.9 His mother as 'nearest relative' was contacted appropriately by the approved mental health professional before the MHA assessment of Charles for detention under section 3 of the MHA.

C.10 There was evidence of appropriate discharge planning for Charles's possible transfer to a rehabilitation inpatient facility once he was well enough, and he had been involved in those discussions with staff from the rehabilitation team and ward staff.

C.11 Throughout this period Charles's care and treatment was in line with expected practice. His mental and physical health were assessed and monitored appropriately.

Section 7: Background - George

7.1 George was 32 years old at the time of the incident. He had an extensive forensic and mental health history going back ten years and he had his first admission into the mental health service for suspected drug-induced psychosis.

7.2 He had a diagnosis of paranoid schizophrenia and autism spectrum disorder (ASD) and a history of use of illicit drugs. His forensic history included possession of a firearm in a public place, and threats to and assaults on both males and females, including NHS staff, other patients, and the public. He had also been subject of a multi-agency public protection arrangement (MAPPA, see glossary).

7.3 He was detained under the Mental Health Act on a number of occasions and received treatment in psychiatric intensive care units (PICUs.)

7.4 In the last five years George's mental health started to stabilise, there were no more violent incidents recorded and he engaged well with his clinical team. He continued, however, to express some unhappiness with the side effects of his medication. He remained relatively well during this period, in which he completed his university education, passed his driving test and secured employment.

Section 8: Key events leading up to George's admission

8.1 When antipsychotic medication is prescribed for a person, it requires close and regular monitoring (NICE website: British National Formulary (BNF), Treatments and summaries, Psychoses and related disorders, monitoring). George, therefore, had regular appointments which involved taking blood samples and being monitored for any side effects and physical health problems.

8.2 Several months before his admission during a consultation with the community consultant psychiatrist and his clinical team, George stated that he wanted to stop taking all of his antipsychotic medication because of the side effects he was experiencing – although he was reluctant to discuss in detail what these were.

8.3 The psychiatrist then spoke to George alone, and discussed the potential side effects and offered some possible solutions, such as reduction of the dosage, and the possibility of other underlying causes, making extensive attempts to persuade George to reconsider these decisions and encouraged George to discuss his plan with his family. He explained to George that by coming off both antipsychotic medications his chances of relapse were extremely high. The consequences then for his welfare, level of functioning and risk to others would be extremely high given his history.

8.4 George was insistent, however, that he stop taking one of his antipsychotic medications (clozapine) immediately, and then over the next year reduce and eventually stop his other one (aripiprazole).

8.5 In his letter to George's GP, his community consultant psychiatrist concluded that George had the capacity to make the decision, albeit an unwise one, to stop taking one of his antipsychotic medications.

8.6 Following the consultation, on the same day George telephoned his CPN. In this call he told her that he was going abroad for a family celebration; he had not told his consultant psychiatrist about this at his last appointment with him.

Following this call his CPN spoke to his consultant psychiatrist, and it was agreed with George (and his parent) that he would remain on his current medication regime until he returned to the UK. Another appointment with his consultant would then be arranged for after his return home.

8.7 George was provided with enough antipsychotic medication to last him while he was overseas, and for some additional medication to help with his anxiety about travelling and his forthcoming wedding. The exact dates that he was travelling are not known but are likely to have been a period of three weeks.

8.8 On his return home, George did not attend his booked medication monitoring appointment, and in a call with the community psychiatric nurse, he advised he had stopped taking one of his antipsychotics (clozapine) two weeks previously; an appointment was booked for him to see the community psychiatrist almost two weeks later.

8.9 George then did not attend his annual health check appointment, six days later, and there was a further telephone conversation between George and his CPN, during which George told her that he had stopped all his medication over six weeks previously. This was inconsistent with the information he had given her previously. If this was correct it meant that he had stopped taking his medication before he was due to travel abroad. He was again advised of the risks involved in suddenly stopping his medication. George told her he had no ill effects and that his parent was aware that he had stopped.

8.10 The following day, his risk assessment was updated. In George's risk profile, his risk of violence/harm to others was recorded as 2: significant risk. His risk of severe self-neglect/domestic was also recorded as 2: significant risk. Potential risk to staff was recorded as 'Yes'. The 'clinical symptoms indicative of risk' category showed that there was a current 'early warning of relapse'. The other categories did not indicate significant risk. The profile indicated that a risk management plan had been developed.

8.11 The CPN had a telephone conversation with his parent, who said that his mental health and behaviour had deteriorated over the recent days and they thought he might have also been using illicit drugs (cannabis). The CPN advised them not to encourage him to restart his antipsychotic medication as this would need to be done with medical supervision, and it would need re-titrating to establish the correct dosage required and monitoring of George's response to the medication. George's parent told his CPN, however, that the family had succeeded in encouraging George to take all his normal doses of his medication that day.

8.12 The CPN discussed the situation with her colleagues, who agreed that George should attend emergency department (ED) for a medical review. His CPN liaised with the NHS 111 service, who then arranged for an ambulance to be sent to George. When the ambulance service team arrived, they found George was expressing suicidal thoughts and threatening to act on them. They took him to the acute trust emergency department.

8.13 On arrival at the emergency department (ED), George was initially seen by the triage team and assessed by the ED medical team. There was some discussion about why he was in the ED, as there was confusion about whether he was attending because he required physical health monitoring/intervention, or because of the relapse in his mental health and suicidal thoughts. This was eventually resolved: it was the decline in his mental health that was established as the reason for his admission. The medical review of George concluded that there was no medical intervention needed, such as blood tests (which are needed if a person is to be started on a regime of the antipsychotic clozapine) and that he was fit to be assessed by the Psychiatric Liaison team. The Crisis Resolution team were also involved in assessing George.

8.14 George was reluctant to engage with the assessment(s). His interactions were largely restricted to saying he was depressed, anxious and experiencing suicidal thoughts, and that he needed to be hospitalised. The assessing teams were concerned that he did not have full capacity to make an informed choice about his treatment as his judgment was impaired. Following a mental health assessment by the Psychiatric Liaison and Crisis Resolution and Home Treatment teams, it was decided that George needed a Mental Health Act 1983 (MHA) assessment.

8.15 While arrangements were being put in place for this, it was noted that George had left the department. He was missing from the ED for nearly 45 minutes before this was discovered and the police contacted, and it was just over three hours before he was found and taken back to the department.

8.16 The MHA assessment took place and found that George was experiencing a relapse in his schizophrenia, had a mental disorder, and needed admission to hospital for treatment. An application under section 3 of the MHA was made. Discussion then started with the bed management team to source an acute admissions bed or a bed in a psychiatric intensive care unit (PICU) for George.

8.17 When unable to source a bed locally or elsewhere nationally in the private sector, it was agreed with the Psychiatric Liaison team that George didn’t

need seclusion, as he was presenting as calm, settled and co-operative, he did have a significant history of violence, including serious assaults on clinical staff, intimidation, and targeting women and could therefore be a high risk to others. It was agreed that the Psychiatric Liaison team would regularly monitor George until a suitable bed could be found.

8.18 During this period of waiting for a bed, the Psychiatric Liaison team noted a change in George's presentation in the early hours of the following morning: he was pacing about, becoming agitated, and wandering outside of the ED. The Psychiatric Liaison team, after discussion with the local police and Street Triage team, felt that at this time the most therapeutic pathway would be to implement section 136 of the Mental Health Act 1983. This allows the police to take a person to a place of safety, for their own safety or that of other people, for up to 24 hours, with a possible 12-hour extension.

8.19 George was then taken by the police to a section 136 suite, while the search for a suitable bed continued. A 136 suite is a facility for people who have been detained by the police under section 136 of the Mental Health Act. It provides a 'place of safety' while potential mental health needs are assessed under the Act, and any necessary arrangements made for ongoing care. Police officers remained with George in the 136 suite. Following a joint assessment of risk later that morning, it was agreed that the police officers would leave, as George was calm and not presenting any management difficulties.

8.20 The 136 suite staff recorded, however, that they 'would have preferred [the] police to remain' given George's 'history of risk to others and potential unpredictability'. They added that when they discussed this decision with George he said that he was willing to wait patiently for a bed as he felt he needed to be admitted to hospital.

8.21 A doctor from the Psychiatric Liaison team submitted an incident form later in the day indicating that there was still no suitable bed to be found for George.

8.22 A bed in an acute male admission ward had become available in the late afternoon. The AMHP (allied mental health professional), who had been involved in the MHA assessment of George, agreed that his admission to the ward could go ahead as his risks of violence were historical. George was admitted to this ward under section 3 of the MHA early in the evening.

Commentary

C.12 The community treatment team had been working with George for five years. When the Facere Melius review team spoke to his community

consultant psychiatrist, they said that they had cared for George for a long time, when George was an inpatient and in the community. They said that George had initially been difficult to engage with, but when his diagnosis of autism became known to the team, they were able to adapt their approach and provide him with more effective support. The consultant said that George was appreciative of the efforts they had made in treating him, and felt that George recognised that they had effectively managed his antipsychotic medication regime, with which he had been compliant. As a result, he had completed his education, and this was something he was proud of. The consultant said that George had generally been quite respectful, engaging and appreciative.

C.13 However, his community consultant psychiatrist also said that when George's male care coordinator was replaced by a female CPN, they reminded the team to be careful with this patient because of his history of unpredictable violence, including violence directed at women. Information gained by the Facere Melius review team, including verbal testimony, highlighted George's build and physical presence, with one person mentioning that although they were not personally afraid of George, he was 'huge…well-built and strong…you wouldn't want to confront him', and he was the one patient in their career that this person was 'mindful' of.

C.14 The female CPN had been working with George for about eighteen months and they had built up a good rapport. She told the Facere Melius review team that during this time she would meet with him regularly at one of the community bases, never at his home. She said that he was always well involved with his care, and compliant with his medication. She was aware of his clinical and forensic history, but for the majority of the time she spent with him he was stable.

C.15 George's risk assessments were updated regularly and any new risks reflected appropriately in line with the trust's clinical risk assessment and management strategy. Considering George's history, however, it might have been expedient to develop a crisis plan to address any potential risk of violence George might have posed when she was with him, and actions to be taken when warning signs became apparent (Royal College of Psychiatrists, *Assessment and management of risk to others: good practice guide* [extracted from CR201], p.11).

C.16 In his discussions with the Facere Melius review team, George's community consultant psychiatrist explained that clozapine was the only antipsychotic medication that seemed to work for George, to the extent that he described him as much better, a different man, and engaging well with the team treating him. He added, however, that George complained a lot about the

side effects, despite the attempts to alleviate these by reducing the dosage. He suggested that the reason George had stopped taking his antipsychotic medication was probably these side effects, and he might have been worried about the impact they could have on him.

C.17 When George missed his appointment for his medication monitoring after he returned from his travels, he received a follow up phone call from his CPN and he told her that a few weeks earlier he had stopped taking one of his antipsychotics (clozapine). This medicine was known to be very effective in supporting George's mental health. Although he was warned of the risks of stopping this medication, an appointment for him to see his community consultant psychiatrist was not arranged until almost two weeks later. This would have meant that he would be nearly four weeks without taking this drug. There was a possible missed opportunity here for his consultant to see him earlier and review his medication and mental health.

C.18 The records show that the Street Triage team were contacted when it was known that George had gone missing from ED. If and when he was located, Street Triage and the police agreed that they would consider using section 136 (of the MHA) and take George to the 136 suite. When they found George, however, the police brought him back to the ED. This was a missed opportunity to prevent any further delay in the MHA process and ensure that George was in a more appropriate environment. The Facere Melius team have not had the opportunity to speak to the police, ED or Street Triage teams which had been involved to understand more about the decision to return George to the ED.

C.19 An ED environment, although technically a place of safety, would probably have been overly stimulating for George because of his deteriorating mental health, and in particular because of his autism. A 136 suite would have been a calmer, less stimulating environment, and it might have been preferable to move George to the 136 suite earlier, when he first went missing from the ED.

C.20 PICU wards are specialist wards that provide inpatient mental health care, assessment and comprehensive treatment for individuals who are in an acutely disturbed phase of a serious mental disorder, with behavioural difficulties which seriously compromise the physical or psychological well-being of themselves or others. They are normally locked wards and provide a more secure environment than that which is provided on an open psychiatric ward. Patients should only be admitted to a PICU ward if they display a significant risk of externally or internally directed aggression, absconding, vulnerability or risk of suicide (The National Association of Psychiatric Intensive Care & Low Secure Units (NAPICU), *National*

Minimum Standards for Psychiatric Intensive Care in General Adult Services (updated 2014), section 2: 'Admission criteria'.)

C.21 The NAPICU guidelines also state: 'While historical factors will play an important part in assessment, current symptomatology should be the prime consideration in determining whether admission [to a PICU ward] is appropriate.'

C.22 In making this difficult decision on where best to admit George, the teams treating him had to take into account his risk of violence, given his historic record of highly unpredictable and unprovoked assaults on staff and other patients. This forensic history, however, dated back eight years, a fact emphasised by the AMHP who had been part of the team that carried out George's MHA assessment. This history of violence was documented and available on electronic patient information systems that were accessible to all assessing clinicians who came into contact with George after his admission to the ED.

C.23 This historic record had therefore to be balanced against consideration of his compliant and settled behaviour at the time of his admission to the ED and 136 suite – and there had already been a considerable delay in finding him a bed.

C.24 On the other hand, George had stopped taking his antipsychotic medication some weeks previously, which would have been a trigger for his relapse, and his mental health had started to deteriorate. He was also reported to have been using cannabis, which might have contributed to his early presentation as fairly calm. Furthermore, his previous episodes of violence occurred while his behaviour was apparently settled and not causing concern.

C.25 At the time of George's admission to the ward, he was presenting with symptoms of a relapse in his schizophrenia, but when he was assessed in the emergency department` and later at the 136 suite, he showed no behavioural difficulties that could have seriously compromised the well-being of himself or others.

C.26 When the Facere Melius review team spoke to George's community psychiatrist they said that their view was that there was nothing that strongly indicated that George should have gone to a PICU, particularly as he had not demonstrated violent behaviour for some years. The psychiatrist also felt that such a unit would have been an unduly restrictive environment for George. This was also the view of George's inpatient consultant psychiatrist.

C.27 The review team interviewed several staff who had been directly involved with George's care. The admission ward manager acknowledged the difficulty of this admission decision, but stated that it was usual practice to admit a patient with George's presentation and history to an acute ward, which also had a seclusion unit. The plan was that if George showed any signs after admission to the ward of meeting the criteria for admission to a PICU, a transfer would be requested.

C.28 The review team concluded, therefore, that on balance it might have been expedient for George to be admitted to the acute admission ward because of the difficulties in finding a bed for him. The existing clinical records, and testimony from staff when interviewed, do not provide evidence, however, of rigorous and thorough formal assessments of the risk George potentially posed on such a ward, given his history of violence (including on previous admissions to this ward) and the fact that he had not taken his medication for some time. This will be discussed in more detail in the section below.

C.29 As a consequence of the difficulties in sourcing a suitable bed for George, there was a delay of around 36 hours before the section 3 of the MHA could be implemented and the care and treatment he needed could begin. During the extensive delay there was a period of over twenty hours when he was kept in the ED, where, given his history of violence, and the fact that he had been off his antipsychotic medication for several weeks, he could have posed a risk to himself and others.

C.30 During this long stay in the ED and the 136 suite there appears to have been no consideration given to putting together a medicine management plan for George that could have included the blood tests needed before resuming clozapine. This would have taken into account the fact that he had not been taking his antipsychotic medication for some time, had been using cannabis, and had then taken a recent dose of his medication unsupervised.

Section 9: Key events from George's admission and inpatient stay

9.1 On admission on Friday evening, George's section 3 MHA papers were received by the admitting nurse, who was also designated his named nurse, and he was informed of his rights under the Act. He had an initial physical and mental health assessment by the doctor on duty. It was decided that there would be a senior review of George following the weekend by the ward

consultant psychiatrist. Observation levels were established. George's antipsychotic medication was to be discussed with the specialist registrar on the following day. George was orientated to the ward and placed on fifteen-minute intermittent observations.

9.2 George's previous risk assessment, which dated from his period of treatment in the community, was reviewed by his named nurse. Of the 53 assessment indicators/symptoms of risk (which included clinical symptoms, behaviours, treatment-related indicators, and history), there were 31 that were indicated as not being present. These included drug use and ideas of self-harm. No change was made to the risk profile, which recorded George's risk of violence/harm to others as 2: significant risk.

9.3 George was reviewed again a few hours later by the duty doctor. George was considered to be showing symptoms of schizophrenia: he was responding to internal stimuli and had poor insight. Physical health checks were performed with limited success (he refused to be weighed, and there was some difficulty in taking a blood sample). The doctor prescribed medication for anxiety and help with sleeping (lorazepam) in case George became agitated.

9.4 The following day the doctor on duty discussed with the speciality registrar restarting George's antipsychotic medication. They decided that he would be started on one of his regular antipsychotic medications (aripiprazole 30 mg). The starting of his other one (clozapine) was for further consideration and discussion, after the weekend, with the wider team at the multidisciplinary review meeting as there was uncertainty about how long he had not been taking it, and whether it should be re-prescribed for a patient with compliance issues.

9.5 The nursing progress notes for that day record that George had a visit from his parent in the morning and later from his siblings. He was wearing the same clothes as the previous day, and appeared unkempt. Although his mood was recorded as settled, he appeared flat and distracted at times. He showed no evidence of delusional thoughts or beliefs.

9.6 George became restless and requested some supportive medication that had been prescribed (lorazepam) as needed the previous day. He took his first dose of the antipsychotic (aripiprazole) at lunchtime. His risk profile recorded 'further deterioration in MH' [mental health]. He remained on intermittent observations and it was recorded that he was pleasant in his interactions with staff and other patients, but he appeared withdrawn.

9.7 The following day the nursing progress notes record that George was not attending to his self-care and still appeared unkempt. His behaviour was described as settled, there was minimal engagement with staff or his peers, but he was polite and pleasant when he did so.

9.8 George reported a cigarette burn on his finger sustained two days previously. This was examined by the doctor on duty and treated appropriately. George had declined taking his prescribed medication (aripiprazole) that day, and told the doctor that he preferred a different one (clozapine). The doctor explained to him that this involved risk and needed re-titrating. This means that adjustments to dosage are carefully monitored for effectiveness and side effects, and physical health checks are carried out before starting a new medication regime.

9.9 The doctor also told George that his request for a different medication would be discussed the following day at the multidisciplinary team meeting when his consultant psychiatrist would be present. The doctor encouraged George to continue taking the medication that had been prescribed (aripiprazole), as it would help alleviate his symptoms. The doctor also noted in George's records their uncertainty whether George '[would] follow through', but it should continue to be offered.

9.10 After the weekend the ward manager returned to work after a two-week period of sickness absence, and their role had been covered by another ward manager. Over the next two days they were involved in recruitment interviews and was not always present on the ward.

9.11 The ward manager worked Monday to Friday. They were also at this time covering the clinical lead nurse vacancy (which is another band 7 role that supports the ward team in developing the clinical aspects of patient care).

9.12 On the Monday morning George agreed to take his antipsychotic medication (aripiprazole).

9.13 The specialist registrar in his police statement said that he had seen George on the Monday morning (as he was a new admission). He spoke to George briefly, and George informed him that he was fine and did not want to speak to anyone.

9.14 There was a multidisciplinary team (MDT) daily review that same morning. This is a meeting at which a variety of professional staff discuss individual patient cases. Core team members usually include psychiatrists, psychiatric nurses, clinical psychologists, social workers and occupational therapists. There were ten members of staff present on this day, including the consultant

psychiatrist, a clinical lead nurse, the duty doctor, the ward manager, and a number of others from the wider clinical team.

9.15 The only record of this MDT meeting is in the trust's electronic patient record system progress notes, and these provide only limited information about what was discussed and agreed at the meeting. There was some reference to George's first few days on the unit and how he had presented. The notes also record that during his previous admission in five years ago he had been intimidating and hostile. George's current risk was recorded as 'no change'. There was no record of any decision about his medication (because at this point the consultant psychiatrist, had not assessed him), but it was noted that George had asked for his previous medication (clozapine).

9.16 The progress notes record that changes to his care plan were to include [section 17] leave, observation status and medication (although a care plan for George had still not been developed at this stage). A later progress note indicates that his self-care had improved, he was showing minimal engagement with others, but was pleasant when he was engaged with. There were no abnormalities in his thoughts, beliefs and perceptions. His mood was noted as a little flat, and mainly euthymic (stable). It was further noted that George remained on intermittent observations, and had several visits from family members and spent time both in his room and in the communal areas. The current risks identified were further deterioration in mental health and that he was not always taking his medication.

9.17 George's named nurse was on the early shift that day, 07:30 – 13:30, but was unwell and after this shift was off sick for a number of days. The Facere Melius review team were told that there would normally be a named second nurse who could be a support worker or preceptor nurse, although it was not confirmed who took on this role in George's case.

9.18 The following morning, George again took his prescribed medication.

9.19 At the MDT meeting that morning the progress notes are again cursory and incomplete. The notes do record that George's section 17 leave was approved by the responsible clinician (his consultant psychiatrist). This was recorded on form H17L contained in the trust's electronic record system, as required by the trust's *Leave and Missing Persons Policy*. George's leave was to be active (which means he could ask to take short-term day leave) over an 18 day period. The H17L form specified that he was to be allowed escorted leave to attend any acute hospital appointments, and escorted short-term home leave or leave to the local shops with two members of staff for 40 minutes or so.

9.20 The notes also record that George's consultant psychiatrist attempted to see him and review his mental health the previous day, but George refused to meet with him. The plan was to try again the following day.

9.21 When the cardiac physiologist attended the ward mid-morning on the forth full day of his admission, to perform an electrocardiogram (ECG) on George (a simple test to check the heart's rhythm and electrical activity), the progress notes record that George was 'on leave from the ward'. There is no record of where exactly George was or who he was with. This was the second time they had tried to perform the ECG; on the previous attempt the day before it was recorded that it was not possible because George was in the shower.

9.22 Later that afternoon the consultant psychiatrist reviewed George's records and had a face-to-face meeting with George. Also present in this meeting were three other doctors who would also be involved in George's care and treatment. During this review it was noted that George appeared distracted by and verbally responding to internal stimuli (mumbled whispers). He had poor insight to his psychosis and accepted that he was mentally unwell in some way, which he tended to describe as depression. He alluded to previously experiencing visual hallucinations, but said he no longer had these and was not experiencing any other kind of hallucinations. He had told the medical team that he had no thoughts of self-harm, suicide or of harming others. His medication was discussed and George explained that he did not want to take the antipsychotic medication he had been prescribed (aripiprazole) and his preference was for another one (clozapine).

9.23 The consultant psychiatrist told the Facere Melius review team that he was aware of George's risk history, and therefore questioned him carefully during this review about how he was interacting with other patients, and how he was feeling. This was in addition to the screening questions he would normally ask in such a review. He said that George showed no indication of agitation or annoyance with other patients.

9.28 George told the medical team that he wanted to take some section 17 leave that day and that he would like them to update his parents, which they did. The medical team met with George's parents. One parent said they thought he had not been well for approximately six months and that since returning to the UK recently, he had been more isolated and reclusive, not taking his medication, and his diet and sleep were poor. They felt that nothing in his behaviour had been alarming - just that he was not sleeping and getting lost in his thoughts. He had been demonstrating unusual behaviour by researching a religious faith that had nothing to do with his or his family's background. His parents were encouraged that he was agreeing to take his medication. The

medical team explained about the section 17 leave and that they would be working with George and his parents on a collaborative approach.

9.29 When George's medical team reconvened in a review call, George's consultant psychiatrist told them about the information he had received from George's community psychiatrist. This was that George was known to have assaulted people, which had resulted in serious injury in the past, and that he could be very volatile and unpredictable. This was despite seeming previously calm. The psychiatrist said that staff needed to be aware of George's potential risk of harming others without warning and to be extra careful in monitoring his risks.

9.30 It was agreed that the plan for George would be that once his blood results had been received and were normal, he would be put back on his preferred medication (clozapine), with monitoring in place for re-titrating. He was to be granted further escorted leave in the parameters agreed and to continue the engagement with his parents. Medical staff were also to be briefed on his history of unpredictable aggression towards others, and advised to be extra careful about his risks of violence.

9.31 Later that day arrangements were made for George to visit his home to get some personal belongings and some food. The time he left is not recorded. The trust pool car was used and George was accompanied by two nursing assistants.

9.32 In the early evening of the fourth day of his admission, the ward nurse allocated to George recorded in the progress notes that he appeared unkempt. Although he was settled in behaviour, and polite and pleasant in interactions, he only engaged minimally with staff and peers. There was no significant change made in his risk profile.

Commentary

C.31 George was admitted to the ward on a Friday evening. His first two full days on the ward were therefore over the weekend period when there is a lower level of senior staff on duty compared with the weekday period.

C.32 At weekends, if the qualified nurse(s) on duty (who are band 5 or 6) needed support or advice, this would be in the form of on-call arrangements with a senior member of the nursing staff. Consultant psychiatrist cover was also provided via an on-call system.

C.33 These are not unusual arrangements, but they meant that neither the consultant psychiatrist who would be treating George nor the ward manager was involved in the arrangements for admitting George to the ward. This decision was taken by the bed management team, who are experienced clinicians.

C.34 The bed management team told the Facere Melius review team that they follow the NAPICU guidelines on criteria for admissions of new patients. Their usual approach is to admit to a general acute ward unless there is clear evidence that the patient would meet the NAPICU criteria. They take into account the patient's history and any previous admissions. In George's case they said that he had a previous admission to the same acute admission ward five years ago without causing concern. This conclusion does not seem to take fully into account the fact that while George was on the ward eight years prior he seriously assaulted a staff member.

C.35 The bed management team also told the review team that there is quite a high risk threshold on the co-located admission wards within this particular unit as they all have seclusion rooms, and staff who are trained in the prevention and management of violence and aggression.

C.36 Each weekday there are two trust bed management meetings at which all new inpatient admissions and potential discharges are discussed. These meetings provide a forum for discussing availability of beds, which leads to further discussion of priorities for new admissions.

C.37 From a review of the available records there is no evidence that on George's admission or in the days following, a care plan or an observation and engagement plan were developed. When a person moves from one service to another (such as community to inpatient care) because of a change in their health and needs, the impact of that change should be reviewed and a care plan developed to address this change. A care plan is a statement of care and treatment which is also the record of who is involved in supporting the person, and it should be shared with them. It should focus on their goals and aspirations. As part of any care planning, there will be a necessary element of assessing for personal safety and the safety of others.

C.38 George's risk assessment on admission showed no indication of drug use or ideas of self-harm. Yet George's parent had told his CPN that he was using drugs, and he had told the ambulance staff and the Psychiatric Liaison team that he was having suicidal thoughts – all of which was documented in his records.

C.39 This calls into question the accuracy and validity of the risk assessment as recorded. The trust policy outlines 'when to assess risk', and identifies certain key points when risk should be assessed. These include 'when admitting… [and] when there are major changes to presentation … [and] when alerted by carers/relatives to their concerns eg about changes to presentation/personal circumstances…'

C.40 Although George's risk assessment was reviewed, his risk profile remained unchanged. Given that he had, as noted above, been using drugs and stating ideas of self-harm, had not been taking his antipsychotic medication for some time, and there was a relapse in his symptoms that was severe enough for him to be admitted under section 3 of the MHA, a higher risk score might have been appropriate.

C.41 A management of violence and aggression (PMVA) plan should also have been considered and developed. Such a plan helps to ensure the safety of both the patient and healthcare staff by identifying and mitigating potential triggers for violence and aggression. Considering George's history of violence, this should have been an important aspect of his care and would have provided a clear plan for managing a crisis if it arose and having strategies in place for de-escalation.

C.42 The trust's *Medicines optimisation policy* states that the trust considers medicines optimisation 'to be an integral component of the delivery of care to mental health…' It does not appear that there was any pharmacist involvement or medicines optimisation plan during the first hours and days of George's admission, other than a discussion about starting some antipsychotic medication (aripiprazole) over the weekend, but restarting clozapine (which he had been taking for some time while in community care, and then stopped) would not be reviewed until the third day of his admission.

C.43 George declined to take his aripiprazole medication on the second full day of his admission, he was reviewed by a junior doctor, but no other action was deemed necessary.

C.44 At each shift change, which occurs three times a day (07:30, 13:30, 20:30) there is a nursing handover. This is the process where important and accurate information about the patients, tasks and staffing is communicated to the next shift to ensure the continuity of safe and effective patient care. For the admissions ward this process involved a system called situation, background, assessment and recommendation (SBAR) to facilitate such a handover. The SBAR data is then recorded in the progress notes for each individual patient on the electronic patient system.

C.45 There is no evidence in the records seen by the Facere Melius review team that the nursing staff had been briefed at this point about the additional information that had been received about George's capacity to appear calm but to be capable of unpredictable violent assaults.

C.46 Given that George was granted escorted short-term leave on the fourth day, it would have been important to ensure that all staff working on the ward, and particularly those escorting him on leave, had been provided with this information about his serious risk.

C.47 Nursing staff have a vital role to play in the effective implementation, recording and evaluation of leave that is granted to detained patients. Although authorisation of leave can only be granted by the patient's responsible clinician (in George's case this was the inpatient consultant psychiatrist), short-term local leave (within the parameters set by the patient's responsible clinician in form H17L) is at the discretion of nursing (or junior medical staff).

C.48 The trust policy provides guidance on what should take place before a patient goes on leave. This includes actions recorded on the Section 17 – leave of absence form (H17L) and a copy should be placed in the patient's health record.

C.49 Before the patient goes on leave, 'the nurse in charge/named nurse should satisfy themselves that earlier assessments remain valid'. There are references to a patient leave care plan, which should include action if the patient should go missing. The section 17 leave of absence checklist provided in the policy mentions 'has a risk assessment plan been formulated'. The policy states that 'it is of particular importance [for the nurse in charge] to maintain an accurate record of short-term leave'.

C.50 Trust documents also detail 'when to assess risk', and states that a patient's risk must be assessed at certain key points. These include 'as part of planning and agreeing leave'.

C.51 Since George was only granted short-term escorted leave, for up to 40 minutes, it would have been important that details of the time he left, was due to return, and actually returned to the ward, were accurately recorded. A record should also have been kept of what he was wearing and to verify that his risk had been assessed. *The Mental Health Act 1983 Code of Practice* also stipulates (ch.27.22: 'Recording leave') that an up-to-date description of the patient should be available in their notes, along with a photograph of the patient (with their consent). There is no evidence that the

Facere Melius review team have been provided with to indicate that any of these important actions regarding George's short-term leave were recorded.

C.52 In meetings with the trust to explore how the ward recorded which patients were on leave at any given time, the Facere Melius team were told that this information was written on a whiteboard in the ward office, and it was wiped off at the end of each day. This may have given staff an overview on the day of who was on short-term or day leave and possibly the time they had left, but would not have provided a robust audit trail or fully met the requirements of the policies and guidance cited above.

C.53 It is understood that being granted leave from the ward is an essential part of a patient's care plan, and forms part of the principle of therapeutic optimism, but such periods of leave can also be a time of risk (*Mental Health Act Code of Practice*, section 27: 'Leave of Absence', and the trust policy cited above).

C.54 It is questionable, furthermore, whether it was appropriate to approve this section 17 leave for George at this point, when some considerable time had passed since he stopped taking his antipsychotic medication, and a consistent regime of restarting it had not yet been put into place. He had suffered a relapse in his mental health condition after stopping his medication. There was also the information passed on to the medical staff that day that George could be highly volatile and capable of unpredictable aggression and violence.

C.55 The trust's *Serious incident: review of care records* identified in the section 'Issues/learning identified' that there was 'no…clear legal framework around [George's] [section 17] leave status'. Because of the shortcomings in the updating of George's risk assessment and status, it is possible to conclude, therefore, that his periods of short-term leave at this time were not entirely safe. As stated in the Royal College of Psychiatrists *Rethinking risk to others in mental health services* (2016, updated 2017), CR201:

C.56 'A risk assessment is not a standalone entity; rather, it is a constantly changing component of a patient's care plan. A risk assessment should always form the basis of a dynamic risk formulation and be linked to a clinical management plan. An out-of-date, static risk assessment is unlikely to be of clinical utility, and may cause harm by distracting from the establishment of more immediate clinical priorities.'

C.57 On George's fourth full day on the ward, there is no evidence that a care plan, a prevention and management of violence and aggression plan (PMVA), or a risk management plan had been developed. A review of

George's health records, and meetings the Facere Melius review team held with staff, confirmed that George received no one-to-one time with either his named nurse (who was off sick) or another member of the ward team. The progress notes indicate this should have happened twice a week. Such therapeutic sessions form an important part of patient care, they provide personalised care, foster therapeutic relationships, and enhance patient engagement in their treatment plans. These sessions allow for regular monitoring of the patient's mental state, early identification of potential issues, and tailored interventions to support recovery (Barker, P. (2017), *Psychiatric and Mental Health Nursing: The Craft of Caring*).

C.58 Following the medical review and the additional risk information that had been shared with George's medical team, his risk level was not changed and no safety plan was put in place, and nursing staff appear to have been unaware of this important information.

Section 10: Key events on the day of the attack

Staffing levels

10.1 On the day of the incident, staff on duty for the morning shift (07:30 – 13:30) met the trust's requirements for safe staffing levels that were in place at that time. This was for two qualified nursing staff to be on duty with three nursing assistants (non-qualified members of staff who assist patients with their daily care). For the night shift it would have been one qualified nurse with four non-qualified staff.

10.2 One of the qualified nurses was the nurse in charge of the ward, the other was a preceptor (a newly qualified nurse who is supported and supervised by an experienced qualified nurse). There were three additional nursing assistants (six in total, of which four were agency staff) as there were two patients on line-of-sight observations (this is where the patient remains in staff view, in person, at all times).

10.3 The ward manager, a qualified band 7 nurse, who is not included in the minimum safe staff levels, was away from the ward that morning at meetings.

10.4 On the afternoon shift (13:30 – 20:30) there was only one qualified nurse on duty, as the other nurse on that shift was off sick and a replacement could not be found. This meant that the ward was below the required qualified staffing levels for that shift. Others on the shift were an apprentice nurse (a band 2), who works alongside a qualified nurse while studying for a nursing

qualification. There were again six nursing assistants as there were three patients on line-of-sight observations.

10.5 Also present on the ward that day was a qualified nurse, but she was on maternity leave, and attending as one of her 'keeping in touch' days, and would not have been part of the ward complement.

10.6 The ward caters for 16 patients and was at full occupancy, with some detained under MHA sections, and others who were voluntary patients.

Multidisciplinary team meeting

10.7 Records seen by the Facere Melius review team indicate that it was at the multidisciplinary team (MDT) meeting first thing in the morning of the incident that the ward team were first told about the warning passed on by George's community psychiatrist, that George can appear calm and then out of nowhere assault people, 'so staff need to be aware [of] risks'. Staff who attended this meeting included the qualified nurse on duty and members of the therapy teams, as well as the consultant psychiatrist and members of his medical team. The ward manager was not present because they were at another meeting.

Commentary

C.59 At the time of the admission of Charles and George to the acute admissions ward, the Covid pandemic was still taking its toll on levels of nursing staff across the NHS. Shortfalls in staffing levels on wards, as noted above for some shifts on the ward, were partly a consequence of sickness absence caused by Covid-related illness (including long Covid). The ward manager had been absent from the ward for two weeks prior to the incident.

C.60 NHS national data indicates a national staff vacancy rate of 10% recorded in the month before the incident, with 39,000 unfilled posts. This had risen from 9.2% during the same period the previous year (NHS Digital website: NHS vacancy statistics England). The acute admission ward at this time had vacancies in qualified nursing (bands 6 and 7), but were over establishment for band 5 qualified nurses and band 3 non-qualified nursing assistants.

C.61 Days lost nationally to absence from Covid-related sickness among nursing staff rose sharply by 43% in the two months leading to the incident. There was a 17% increase in staff absence caused by anxiety, stress and depression since March 2020, a rise that can be at least partly ascribed to the added pressures on the profession caused by the pandemic. (Royal

College of Nursing website, press release July 2022: 'NHS England sickness absence data…'). Sickness levels for the acute admission ward in the month before the incident were 9.51%, and 13.21% in the month of the incident; the target for sickness levels across the trust at this time was 5%.

C.62 It is noted that the male acute admission ward had a consultant psychiatrist vacancy at this point, which meant that one consultant psychiatrist had joint responsibility for two acute admission wards, one male and one female.

C.63 Information obtained by the Facere Melius review team from meetings with staff and from police statements indicated that some staff had been briefed about the new information relating to George's risk of unpredictable aggression and violence, and in particular that his apparent presentation could be very deceptive. A few of those interviewed could not recall, however, exactly when this briefing had taken place, although one staff member was clear that it was at the MDT meeting on the morning of the incident (which is confirmed in the record of the MDT meeting). One person mentioned that they were shocked that they had not been given this information earlier.

C.64 George's community psychiatrist told the Facere Melius review team that when they became aware that George was an inpatient on the acute admission ward they made a point of contacting George's inpatient consultant psychiatrist to share their knowledge and experience of George, and the kind of serious risk that George posed to others.

C.65 The Royal College of Psychiatrists college report CR201, (p.24): 'Principles' states that 'risk is dynamic, can alter overtime, and must be regularly reviewed'. It highlights the importance of risk assessment being carried out within the multidisciplinary team 'allowing sharing of information and application of different perspectives'. 'Tips for psychiatrists' (p.33) includes the point that when assessing risk psychiatrists should 'consider whether you and your colleagues are safe', to be 'curious and look beyond face values', and to 'consider the unpredictability of an evolving disorder or new presentation'.

C.66 No action appears to have been taken to address this additional information about George's risk, such as a review of his risk assessment/profile, and the development of a risk management plan. At this stage, there was still no record that a care plan, a prevention and management of violence and aggression plan, or observation and engagement care plan had been developed. The trust's records management practice policy and guidance sets out the requirement for when risk assessment, formulation of risk and risk management planning is required. This includes 'when risk should also

be reassessed: …when alerted by other members of the care team about major changes to presentation/personal circumstances.'

What is known about Charles on the day of the incident

10.8 The progress notes completed for Charles by a member of the night shift recorded that there were no concerns about his appearance or behaviour. The multidisciplinary team meeting (MDT) that morning concluded that he had been settled in his behaviour, although he had been heard to be shouting in his room and might have been responding to internal stimuli. His appearance was described as unkempt. There were no changes recorded to his care plan or risk profile.

10.9 From information gained from the statements given to the police, that afternoon one of the peer support workers went to see Charles in his room. Charles told him that he had not slept well for the last few nights, but appeared in a good mood. It was agreed the support worker would take him out later that afternoon (section 17 short-term leave) to get his hair cut. The support worker reported that Charles was calm, but was delusional in his conversations. They returned mid afternoon and Charles went back to his room.

What is known about George on the day of the incident

10.10 The progress notes for George completed by the night shift reported that he spent much of the night in and out of his room, chatting to peers and pacing around the ward. His mood was described as flat but he was pleasant on interaction and had accepted all his medication (aripiprazole). No change of any significance was noted and his risk profile remained unchanged.

10.11 That morning George attended a distress tolerance group on the ward, facilitated by the psychology department. It was recorded that George's manner caused no concern, but he asked to leave fifteen minutes before the end of the session. His eye contact was poor, but he was able to engage with the exercises.

10.12 Later that morning one of the patients on the ward approached a member of staff and told them that George had 'pushed him with force' in his chest. The patient said that this incident was unprovoked. A member of staff went to speak to George, who said 'I pushed him because he was in my way and I wanted to get past'. The member of staff discussed with him how he could have handled this situation better, and if such an encounter was to arise again how he could act differently, for example by verbally asking if the person could move out his way. The progress notes record that George seemed to accept

this and remained calm throughout the conversation, with no evidence of agitation or aggression.

10.13 Following the discussion with George, the nurse spoke again to the patient who had been pushed to reassure him that the incident had been satisfactorily dealt with. This was recorded as an incident in line with the trust policy on incident reporting.

10.14 During the afternoon George asked the nurse in charge about going out on leave. He was told that this would not be possible until the staff had returned from their break (that is, after 15:30).

Commentary

C.67 The intervention by the nurse in response to the incident of pushing by George and the subsequent incident report was in line with trust policy, designed to de-escalate potentially violent incidents. The nurse involved in the incident and the ward manager told the Facere Melius review team that the patient who said he had been pushed by George would often get involved with other patients' activities and his behaviour could be difficult to manage as a result. This factor might have influenced the level of seriousness which the nurse judged the incident to represent.

C.68 A senior member of the nursing staff, who was not clinically involved with George, told the review team that they had noticed him on the ward before this pushing incident. When they read the report on the pushing incident, they reached the same conclusion as the nurse involved and the ward manager: that it 'wasn't anything out of the ordinary', as the patient who had been pushed was known to invade other patients' space (a symptom of his mental health disorder), and this was typical of his behaviour.

C.69 The way in which these members of staff perceived this incident and how it was handled – the nurse involved at the time, and those who reflected on the events afterwards - indicates that there was an element of confirmation bias in their thinking. They interpreted George's pushing the other patient as a response to a person who was habitually annoying, and felt that there was therefore no need to consider its possible wider implications, or to escalate George's risk profile.

C.70 George's inpatient consultant psychiatrist told the review team that in hindsight this pushing incident was a possible indicator of George's growing risk of aggression. If it had been discussed with a greater element of professional curiosity by George's care team, this incident might have been taken more seriously.

C.71 It was also mentioned by staff and observed when the review team visited the ward that it was a challenging environment for staff to work in, and for patients. The corridors are very narrow and confined; there is not a lot of space or opportunity for separation. The general environment of the ward is poor, and there is limited outside space. Such an environment does not provide much scope for the improvement of the mental health of the patients, many of whom are vulnerable and unstable, or for them to feel safe. On the contrary, the review team heard that there was often a hostile atmosphere and there were frequent arguments.

C.72 This type of environment may have had a particular impact on a patient like George, who had autism spectrum disorder, which meant that he was highly susceptible to an overly stimulating situation. The trust told the review team that the entire unit is transferring to a new, more suitable site next year.

C.73 The trusts' '*Restraint reduction policy*', states that 'care plans must be reviewed after each incident…the risk assessment and risk history must also be updated'. At this stage there was still no care or risk and safety plan in place for George. Considering the information passed on at the MDT meeting that morning about George's risk of suddenly becoming dangerously violent towards others, even when looking calm and well, this incident was a possible 'red flag', and should have led to a review and update of his current risk status. There should also have been consideration of actions to enhance the safety of staff, other patients, and George himself, such as observation levels being escalated (from intermittent to line-of-sight).

C.74 As noted above, the staff had also been told about the information passed on by George's community psychiatrist about his very unpredictable and potentially violent behaviour. Both of these factors should have led to the development of a robust and safe risk management plan.

C.75 The trust '*Restraint reduction policy*' states that 'certain features can serve as early warning signs to indicate that [a patient] may be escalating towards physically violent behaviour.' In a list 'not intended to be exhaustive' are included signs like 'increased or prolonged restlessness…pacing'; as noted above, George was reported on the night before the incident as being restless and pacing about. Another such sign is 'verbal threats or gestures'; the pushing incident on the morning of the incident would fall into this category.

C.76 He also left the distress tolerance group that same morning before the session had finished – another possible sign of restlessness or poor concentration (which is also one of the warning signs in the list).

Section 11: The incident – Charles assaulted by George

11.1 Approximately an hour before the incident, an alarm call for assistance sounded in another ward, co located with the male acute admission ward. Normal practice at that time was that the name of the person allocated as 'response nurse' would be highlighted on the ward rota (which sets out the list of the day's tasks and duties). This was the nurse who would respond to an alarm call from another ward to offer support.

11.2 The Facere Melius review team were told that the qualified nurse and one of the nursing assistants left the admissions ward to support the neighbouring ward staff with their incident. They were also told that the ward manager gave the qualified nurse permission to respond to this alarm. The ward manager would have been aware that this left only non-qualified nursing assistants and an apprentice nurse on the admission ward.

11.3 Evidence from recordings reviewed from the ward's CCTV cameras and statements made by those who were interviewed by the police indicate that at 15:02 a staff member let Charles back into his room on returning from his escorted leave. Between 14:59 and 15:02 George left his room twice, walked part of the way down the corridor towards Charles's bedroom, but each time he turned back towards his own room. It seems probable, therefore, that George would have seen Charles and his escort return from his leave from the ward.

11.4 About eight minutes later he walked back down the corridor towards Charles's room and tried to enter. As the door was locked, George knocked on the door. At 15:11 the door opened. The CCTV footage shows George threw a punch, entered the room out of view and the door closed. Seconds later he left the room, and walked back to his own room. On the way, he passed another patient and a member of staff in the corridor.

11.5 A few seconds later a fellow patient went into Charles's room and alerted a member of staff (the apprentice nurse) who entered Charles's room and found him lying on the floor. The member of staff realised that Charles was seriously injured. The member of staff left the room, alerted a colleague and activated the alarm that sounds through most of the building.

Commentary

C.77 Evidence provided to the Facere Melius review team from police statements and meetings with trust staff indicated that only staff who are trained in prevention and management of violence and aggression and/or immediate life support would be eligible for inclusion as response nurse on the ward rota. However, if a nurse was to leave the ward to respond to an alarm call elsewhere, there should always be sufficient staff left on their ward to keep it safe.

C.78 The trust also provided guidance on the nurse call system. This outlined the trust's guiding principles and was developed to ensure patients and visitors could summon help from staff members if they needed assistance. Each area in the trust was expected to develop its own local operational procedure. The documented procedure, for the wards (including the male acute admission ward) has not been provided.

C.79 In meetings with trust staff, the review team were told that at the time of the incident the response nurse would be highlighted on the ward rota. This rota, however, does not include in its list of tasks and duties for the day who would be responsible for responding to alarms. It appears that this was an ad hoc arrangement.

C.80 The admission ward rota for the day of the incident did not identify a response nurse. When the alarm on the other ward sounded that afternoon, therefore, the ward manager made a judgement call in allowing the nurse and nursing assistant to leave the ward.

C.81 In March 2024 the trust introduced a new shift coordination rota to replace the previous ward rota procedure. This identifies more clearly each day's 'task allocation', with a permanent category indicated on the document where the name of the response nurse is to be added to the sheet.

Section 12: Response to the incident

12.1 At the time of the incident, the ward manager was in their office, which is located at one end of the ward, near the main entrance, stairs, and lift. They noticed on the CCTV monitors in their office a commotion outside Charles's room which is the first in the sequence of patient rooms in that part of the ward corridor. They immediately went to investigate.

12.2 On entering Charles's room, the ward manager could tell that Charles was badly injured. They checked Charles for vital signs. The ward manager

instructed a member of staff (the apprentice nurse) to fetch the resuscitation equipment. A few seconds later the qualified nurse and nursing assistant, who had been attending the incident on the other ward, responded to the alarm, returned to the male acute admission ward and entered Charles's room.

12.3 A clinical nurse lead, who worked in the physical treatment centre, also responded to the alarm and entered the room.

12.4 Meanwhile, at 15:13:52, George had come out of his room and was standing with his hands held against the doorframe, apparently facing his own room.

12.5 At some point while initial support for Charles was being administered, a member of staff was told to call the emergency services. This call was time stamped as received and answered at 15:14:50. The ambulance service categorised the call as level two (based on the information given: that the patient was breathing but unresponsive). This normally means that there would be a target response time of 18 minutes, but the call handler said that the ambulance could take as long as an hour because of current service pressures.

12.6 The ward manager started appropriate immediate life support for Charles with the help of the nursing assistant and clinical lead, while another nurse provided help with the equipment. This included gaining airway access for an oxygen mask. They also started cardiopulmonary resuscitation (CPR).

12.7 Among the equipment that had been brought was a suction machine, which is used to help them breathe by maintaining clear airways. There was difficulty with the machine being used on Charles, as its suction facility did not seem to be working, even though its battery indicator showed that it was activated. A second machine was tried, with a similar outcome.

12.8 A member of staff ran to the ground floor doctors' office to alert them that they were needed, because it was known that the alarm would not have sounded in that area. Three doctors went immediately to the admissions ward.

12.9 Over the next few minutes two of the doctors entered Charles's room and found him unresponsive and in cardiac arrest. They took over the resuscitation procedure from the ward manager, who was then able to leave the room and start trying to find out what had caused Charles's injuries.

12.10 The ward manager was told by a nursing assistant that George had been seen leaving Charles's room at the time of the incident. The ward manager then instructed two nursing assistants to keep George in line-of-sight observation. They also told a member of staff to call the police, and then they contacted their line manager.

12.11 Approximately seven minutes after the first emergency services call, a second call was made, as Charles's condition had deteriorated and CPR had been started. The response target for the ambulance was then escalated to category one – which is for a target of seven minutes.

12.12 Approximately seventeen minutes after George entered Charles's room, two members of the ambulance service arrived and entered the room, followed soon after by a third member of the ambulance crew. They began treating Charles to supplement the resuscitation efforts being made by the doctors present. The medical and ambulance teams were able to stabilise him.

12.13 A police officer and police community support officer arrived just after 15:46 accompanied by a member of trust staff. All three walked along the corridor to where George was standing. Within the next six minutes, four more police officers arrived, two of whom entered Charles's room and spoke to the medical team. The other two joined their colleagues outside George's room. The police officers arrested George, handcuffed him, and took him into custody at a local police station.

12.14 The ambulance team who had been treating Charles transferred him to hospital just after 16:00, approximately 50 minutes after George entered Charles's room.

Commentary

C.82 Although the attack was seemingly unprovoked, George's forensic history showed that he was capable of such violent behaviour even while appearing calm and polite. The day before the incident, his community consultant psychiatrist had warned the consultant psychiatrist treating George about his capacity for extreme violence while appearing to pose no threat. As mentioned previously, this information was not passed on to the ward staff until the morning of the incident. It is unclear how this information was communicated, and to whom. Those who did have the information appear not to have acted upon it: George's risk profile was not amended to reflect this information, and no management or safety plan was put in place, which might have included putting him under line-of-sight observation.

C.83 With the benefit of hindsight, it is possible to identify a number of signs in the days and hours before the attack that could have been seen as warnings of a possible escalation in agitation and potential for violence in George :

- George had been reported on several occasions, including the night before the incident, as pacing restlessly in his room and on the ward
- he had pushed with force another patient on the ward on the morning of the attack, apparently for no reason
- when he asked to go on section 17 leave that day, he was told that this could only happen later in the day
- he was pacing the corridor at the time Charles returned from his section 17 leave and returned to his room – moments later George went to this room and attacked Charles

C.84 The Facere Melius adviser with specialist/expert knowledge of ambulance services confirmed from the evidence available that the categorisation by the ambulance call handling team of the two emergency calls received from the trust about the incident was appropriate: category 2 for the first call, and category 1 for the second, on the basis of the information provided by the caller on each occasion. They also confirmed that the arrival time of the ambulance team at the ward location was within national standards for both the first call and the second one some minutes later.

C.85 The hospital progress notes refer to trust staff starting CPR on Charles almost immediately, before the first emergency call was made. This does not correlate with the ambulance call logs and recordings, and creates an element of confusion in reconstructing the precise sequence of events that day.

C.86 Because of staff absence through sickness, staffing levels on the ward on the day of the attack only included one qualified nurse on duty when normally there should have been two, with one apprentice nurse, and six nursing assistants, three of whom were occupied with 'within eyesight' observations of patients. When the alarm sounded for the other ward, that qualified nurse left the ward (after checking with the ward manager). This meant that there was no qualified nurse physically present on the ward, and this was therefore not the safest course of action. The review team have been advised that '*It is the view of the Trust that the ward was not unsafe as the ward manager was in their office which is located at one end of the ward and immediately went to investigate when the commotion was spotted on the CCTV monitors in the office'.*

C.87 As a consequence, when George attacked Charles , the ward manager and the qualified nurse both had to become involved with providing Charles with immediate care. This was done promptly and professionally.

C.88 Because they were dealing with this essential response to Charles injuries, there were initially no suitably qualified and experienced staff in the first few

minutes after the attack to take charge of managing the situation on the ward. Neither was any member of staff able to ascertain immediately what had happened or who was responsible for causing Charles's injuries, or to consider the risk to other patients and potentially to staff. The clinical manager, the line manager of the admission ward manager, was off site at the time of the incident. Once they were informed about it they left immediately, but it took some minutes for them to arrive and begin to manage the situation on the ward.

C.89 The consequence of this was that the perpetrator was not under any kind of observation or restraint for six minutes after the incident. Ensuring that the perpetrator was under control should have been an immediate priority. The police arrived 34 minutes after the attack, and it was another five minutes before more police arrived and George was handcuffed and arrested.

C.90 A number of the trust staff who became involved in the incident during this time said in their interviews with the police, and later with the Facere Melius review team, that there was chaos on the ward, with many people, including patients, coming and going. No staff member initially took full control of handling the distress and behaviour of all the other patients, or of leading the response of staff to the crisis, such as calling emergency services.

C.91 A detailed review of one of the CCTV cameras, for the period of time between the attack on Charles and his transfer to hospital there had been 29 trust staff on the ward who came to provide support. A total of five ambulance and six police staff were also involved. This number may well have been higher, as this camera only covered one area in the ward. Many of the other patients on the ward had also come to see what was causing the commotion. Because the alarm on the ward continued to sound for some time, more people arrived to see what was happening or to offer assistance. This was clearly a very difficult and distressing situation to manage, with events unfolding rapidly.

C.92 Some trust staff members acted instinctively by ushering patients away from Charles's room and keeping them distracted for some time – some stayed on well past the end of their shifts. This would have gone some way to alleviating the situation.

C.93 It is acknowledged that there were a number of circumstances that combined to make this situation difficult to manage: shortage of staff, alarms sounding on other wards that caused ward staff to leave, and the fact that the attack happened without any possible warning signs earlier that day (noted above) being recognised.

C.94 A member of staff had to be sent to request the assistance of the junior doctors, because at that time they did not have pagers to alert them to the incident. It was only after these doctors arrived in Charles's room to take over the life support process that the ward manager was able to start finding out what had caused Charles's injuries.

Section 13: Subsequent events

13.1 The ambulance team transferred Charles to the critical care unit at a neighbouring acute trust. He remained there in a critical condition. A clinical nurse lead and an agency nursing assistant accompanied Charles to hospital and remained there, keeping the trust informed of his condition. They were later replaced by two other members of male acute admission ward staff.

13.2 The admission ward manager contacted Charles's family to tell them about the incident and another ward manager helped with arrangements for the family to travel to the hospital. Once the family arrived in the critical care unit the mental health trust staff left. The clinical manager was nominated as the point of contact (also known as carer contact) for the family and kept in regular contact with them in the following days. This was in line with the trust's policy and guidance on Duty of Candour.

13.3 Four days after his admission to the acute hospital, Charles died.

13.4 Eight days later a trust senior manager made contact with George's mother to offer support and explain that the trust was not able to undertake any internal investigation until the police process was completed and they had been given permission to go ahead. Further contact was subsequently made by email to reiterate the offer of support and arrange the return of George's personal belongings.

Section 14: Police investigation and the trust's actions after the incident

Police investigation

14.1 This was a very serious incident, and it would have had a traumatic impact on the patients on the acute admission ward who had witnessed it, and the staff who had been involved. When the police arrived after the attack on Charles by George, their focus would have been on apprehending the perpetrator (George) and maintaining the integrity of the crime scene and any evidence.

14.2 The Facere Melius review team were told by some trust staff that initially the police wanted to shut down the ward and transfer the remaining patients to another area. The police were advised by a senior clinical manager that this was not a practical or sensible option: these were highly vulnerable patients and there was no spare bed capacity in the trust.

14.3 After George was arrested and taken into custody, the police followed normal procedure and ordered the rooms of both Charles and George to be locked and secured with crime-scene tape. Police officers were stationed outside the rooms until the next day, as these were now classified as crime scenes. Some of the trust staff and patients on the ward were spoken to by the police almost immediately. These officers made written notes on what was said, and some staff found this process very stressful.

14.4 One very traumatised member of staff who had gone home after the incident because they were so upset was called back in by the police soon after they arrived home so that they could take initial information from them.

14.5 The police were leading the investigation, and in a conversation with a senior trust manager who was liaising with them as a single point of contact, told them:

'[that there was to be] **no** group reflection or sharing of what happened, heard, felt, were involved in until they have signed statements – the reason for this is to ensure the integrity of witness testimony and ensure the witnesses' accounts are not tainted.'

14.6 In the weeks and months that followed, police took formal statements from staff who had been involved in the incident and its aftermath.

The trust's post-incident actions

14.7 This incident was unprecedented on the ward; staff told the review team that there had been serious incidents on wards in the trust in the past, but never one as serious as this. This was therefore a unique, challenging and shocking incident for the trust and its inpatient staff, but also for the police, and it needed a clear system of leadership and control to ensure that there was immediate and effective management of the situation. One of the early measures taken to that end, as mentioned above, was the establishment of a senior trust manager as the single point of contact to liaise with the police.

14.8 In the introduction to the trust's *Incident policy*, they quote:

'It is important to recognise that serious incidents can have a significant impact on any staff who were involved or may have witnessed the

incident…staff may want to know what happened and why, and what can be done to prevent the incident happening again.'
[NHS England, *Serious Incident Framework*, 2015].

14.9 In order to provide a forum for this kind of immediate post-incident process to be facilitated, it is usual, once the incident is contained, for those who were involved to meet together to find out how everyone is feeling, their initial reactions, whether anyone needs any immediate support, and how they could access it. Staff told the Facere Melius review team that there were some such meetings for the ward staff, and the medical team had their own meeting.

14.10 Evidence seen by the review team indicates, however, that these meetings were ad hoc, not formally or centrally coordinated, and did not appear to include all the staff who had been involved in or witnessed the incident and what followed.

14.11 Two days after Charles died, when this news had been confirmed to the ward staff, a multidisciplinary meeting was arranged to develop a plan on how to support staff and patients as they processed this news, and with the ongoing police investigation – which would from that point be a homicide enquiry. The patients on the ward were told about Charles's death and offered one-to-one support.

14.12 In the days (and possibly weeks) after such an incident, a more formal post-incident debrief would normally be held. Critical incident debriefing is a structured meeting where the group reviews the facts of what happened, and discusses the feelings and reactions that they experienced during and after the incident. It is not a counselling session or a reprise of the earlier post-incident sessions that would usually take place immediately after the incident.

14.13 Such debrief sessions can be important in helping the trust and staff to identify what went well during the incident, anything that could have been done better, and also to consider opportunities for learning and improvement of practice.

14.14 Because the police, as noted above, had instructed the trust that there was to be no group reflection or sharing of what happened, it was not possible for the trust to arrange such a debrief until many months later. What the trust told the review team is that they did undertake a number of actions to provide individual support to staff. These included, for example:

- immediately making telephone calls to staff to check on their well-being
- offering them support for the formal police interviews
- providing information on well-being

- providing access to weekly support from a psychological therapist (for staff and patients) about how to normalise reactions, grounding techniques, and coping strategies

14.15 The trust would normally have started its own internal serious incident review, but were unable to do so because of the ongoing police investigation. The trust was able, however, to complete a detailed initial report (known as a 72-hour report) a number of weeks after the incident. This set out the details of the incident, immediate actions that were taken to ensure patient and staff safety, and identified areas where learning or action was required.

14.16 Following this initial incident report, the trust commissioned a more detailed review of George's care records (a desktop review). The trust's reviewer had access to George's electronic records, and staff statements that were taken by the police. They did not have information on staff training records, ward rotas, observation records or medication charts. As there was a police embargo on talking to staff, the reviewer was not allowed to interview any of the staff involved. The draft report produced seven months after the incident identified a number of areas of learning, for example, record keeping, care planning, risk assessments (including escalation of risk), and section 17 leave.

Commentary

C.95 This was a critical incident and as such immediately establishing a more collaborative system of leadership and control between the police and senior trust staff should have been adopted as soon as was practical. This would have provided a framework within which the police and the trust could have worked together to maintain understanding on both sides, and adopt the best approach to take to facilitate both the police investigation and the safety and welfare of the patients and trust staff.

C.96 Critical incidents as serious as this need formal structures of leadership and control. Bronze, silver, and gold command is the hierarchy generally used by emergency services for major incidents. This is also known as a strategic, tactical and operational structure. A command structure of this kind could have been agreed and established between the police and the trust's senior management team. In the apparent absence of such an arrangement, staff were seemingly just taken aside and spoken to by the police, without any information about what was to happen or what was expected of them. There was little communication or opportunity for these staff to be supported by colleagues while they were being questioned.

C.97 The review team were told by staff they spoke to that some of them, who were still feeling deeply shocked and traumatised, felt the actions of the police when they arrived soon after the incident and in the days that followed were rather insensitive and heavy-handed (one described the experience as ‘brutal’). The police and senior trust staff did not create a mutually satisfactory way of enabling the police to carry out their initial enquiries, while maintaining the trust staff’s ability to continue running the ward professionally and safely. As it was, staff felt that control of the ward, which was still populated by a large number of vulnerable and distressed patients, was taken over by the police – for example, the police determined who was allowed to enter or leave the ward.

C.98 Later in the police investigation, when detectives arrived to start a more formal, structured stage of interviewing and taking of statements, staff felt less stressed and upset by this experience. This was because by this time there was more consultation and communication between the police and senior trust staff on how this part of the process was to be managed. For example, a support process was established by the medico-legal department that included provision of a minute taker during interviews, and all staff were offered support from the clinical management team.

C.99 There might be learning here for both organisations on how such an investigation in future might be handled in a way that is more sensitive to the environment in which it takes place.

C.100 Because the police had told trust staff not to talk about the incident among themselves or with others, this limited the trust’s ability to offer their staff and patients the support they would normally have provided. Some staff had an incomplete picture of what had happened during and after the incident. If staff members were able to attend one of the initial meetings convened by the senior trust team, these were not always able to provide all the information and support that might have helped give them closure. One of the trust staff who met with the review team described this period as ‘neglectful’ of the feelings and needs of their colleagues at this time.

C.101 On the other hand, what the review team learned was that some staff members showed initiative and offered and provided emotional support to their colleagues if they saw or heard that they were struggling. It is inevitable that after such a disturbing incident the staff (and patients) involved will respond in different ways, and have different needs in processing what happened. It would be difficult for any organisation to manage all these expectations, especially when the police had placed restrictions on what could be discussed and shared. The review team saw evidence from a number of sources that some staff felt well supported, but

some individuals, for various reasons, did not. Under these restricted circumstances the trust did what they could to support their staff.

C.102 Although there were some debrief sessions arranged by the trust much later, once they had been given permission by the police to discuss the incident, some staff chose not to attend. Others told the review team that when they did attend these sessions there was some anger expressed to the senior staff about the way in which the aftermath of the incident had been handled, such as the lack of communication, and the fact that they were not allowed to talk about it. This was frustrating for those who would normally be in a position to support staff, because they were unable to discuss the incident and thereby help to alleviate individuals' confusion and distress, or help to clarify what had happened.

C.103 Another limiting factor for the trust because they were only able to carry out a document review of the incident, and the investigator leading it was unable to speak to staff, was its inability to fully identify learning and any areas for improvement, or conversely what had been done well. This meant that some aspects of the learning and improvement process that the trust would normally carry out were delayed.

Section 15: Summary and analysis of the key themes

15.1 This section provides a summary and analysis of the most significant themes that have been identified.

15.2 The review team would like to acknowledge that there is an element of hindsight in what follows, and it is important to see these themes in the light of a number of mitigating factors; these are identified in the relevant sections below. The purpose of this review is not to apportion blame, but as stated in the introduction to this report, it is to highlight learning points (especially in the context of processes and systems and their efficacy – 'work as done' versus 'work as prescribed'), and ways of avoiding recurrence of incidents of this kind.

Admission to the acute admission ward

15.3 The decision to admit George to the acute admissions ward was complex: he had already spent over 36 hours waiting for a bed to become available. This pressure and urgency to find a bed for George may have taken precedence over more careful consideration of admitting him to a PICU ward. The Facere Melius review team were told, however, that it was possible he might not have fitted the criteria for such a ward, or that it would have been the best clinical

environment for him. He was appearing calm and compliant in the emergency department and section 136 suite facility, and his records indicated that he had been managing well in the community with no recent incident of violence or aggression. These factors seemed to influence the decision that on balance a bed on the acute admission ward would be suitable.

15.4 Not enough attention was paid, however, to the fact that George had stopped taking his medication some weeks previously, and a decline in his mental health had occurred as a consequence, to the extent that he was put on a section 3 of the Mental Health Act. It was while he was following a regime of antipsychotic medication that was regularly monitored in the community that his mental health stabilised. He was then able to finish his studies, hold down a job, and consider his future progress with a reasonable amount of optimism.

15.5 On the other hand, he had an extensive history of becoming suddenly violent, when appearing calm. He was known to have made a serious attack on an NHS member of staff in 2014 when an inpatient, and there had been other incidents over the years arising from his threatening and unpredictably violent and aggressive behaviour.

15.6 Although these factors would have been known about when the decision was made to admit him to the acute admission ward, there should have been a more comprehensive and robust plan in place to mitigate the risks George posed. This plan should have included taking into account the fact that he was admitted at the beginning of the weekend, and there was no discussion with the consultant psychiatrist and the ward manager (or the person covering that post that day) about this admission, and what measures should be put in place to ensure the safety of George himself, the ward staff and other patients. This might have included ensuring that there were enough suitably trained and qualified staff on the ward.

15.7 A plan should also have been put in place to ensure that there was clinical input to expedite George's restarting a suitable regime of antipsychotic medication. As it was this did not start to happen until the day of the attack on Charles, when records show that the plan was to restart him on clozapine. By then at least seven days had elapsed since he had first sought medical help. The primacy of urgently restarting his antipsychotic medication (clozapine) appears to have been lost sight of by many of the clinical teams that came into contact with him over this period.

Staffing

15.8 At the time of the incident staff levels across the NHS, including in the mental health sector, were problematic. This was partly because of the negative impact of the Covid pandemic, but difficulty in recruiting staff, leading to a high

number of vacancies, was an ongoing problem. There was also a far higher rate of staff absence through sickness at that time (partly due to Covid-related conditions), which also resulted in higher levels of stress-related sickness absence.

15.9 This pattern of staffing challenges nationally could also be seen in the number of qualified nursing shifts on the acute admission ward that could not always be at full establishment. In the three months leading to the incident, the number of actual staff hours worked by qualified nurses on the ward on daytime shifts was regularly well below the planned staff hours. On the other hand, the actual staff hours recorded for non-qualified staff was consistently far higher than the planned hours, in most cases over three or four times the total hours planned.

15.10 Some of these high figures might have been because of the tasks non-qualified staff carry out, such as line-of-sight observations of patients. If there are two or more such patients on the ward at any one time, there is a need to increase the number of such staff to cover this requirement.

15.11 As mentioned previously, the ward manager had been off sick for two weeks and was also covering two posts. There was also a vacancy for a consultant psychiatrist. On the afternoon of the incident, the qualified nursing staff levels on the ward were below full establishment. This was exacerbated when the only qualified nurse left the ward to attend an incident on another ward. This left the ward manager (in their office) as the only member of staff left on the ward with qualified nurse qualifications.

15.12 All of these factors would have adversely affected the pressure on staff working in a busy ward with full patient occupancy, some of whom would have been very difficult and complex cases to manage. It was also noted that the confined space and generally unsuitable environment were a factor in giving rise to some issues with challenging behaviour of patients, some of whom had a history of violence and aggression.

15.13 When George attacked Charles on that day, therefore, this happened in circumstances when staff were overstretched and less well equipped than would normally be the case to deal with such a crisis. For example, the possible indicators identified above that George's behaviour might have been escalating had not been picked up by staff

Care planning

15.14 Risk assessment and care planning are fundamental aspects of the provision of therapeutic and safe care. A care plan provides a structured approach for a nurse to connect with and support a patient so that their needs and difficulties

can be addressed and to plan for when their health improves. The trust policy on The Care Programme Approach explains in the introductory section how this approach provides an overarching framework for the 'assessment of care, support and planning, treatment and review' for people referred to the trust's services.

15.15 An initial care plan should have been formulated on George's admission to the ward. This would then have provided a template so that when more information became known, it could have been expanded upon to include further elements of care and treatment.

15.16 It should also have included his observation care plan and any safety plans. George was not given any individual one-to-one care time with the nursing team; this would have allowed them to get to know George, build rapport with him and assist in planning the care he needed.

15.17 Throughout George's short stay on the acute admission ward, no care plan was discussed or developed with him. Recovery from an acute relapse in mental health must involve the service user so that they can start to gain a sense of control, which is an important part of helping them to get well. The care plan documents the needs of the service user and the interventions that will help support and facilitate their recovery. George was a complex individual, and these important aspects of his treatment were therefore particularly important.

15.18 After the incident, a member of the clinical staff completed the care plan for George later that evening. This would not have been completed with any input from George – which should have been an essential element of the planning process.

Risk assessment

15.19 'Risk assessment and risk management is at the heart of effective mental health practice' (*Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach,* Department of Health. HMSO, 2000).

15.20 Use of structured risk assessment tools is recommended by various bodies, including the Royal College of Psychiatrists (RCP: CR201, cited earlier), and the Department of Health (*Best Practice in Managing Risk*, 2009). George's risk was assessed with the use of such a tool in the community and when he was admitted to the acute admission ward.

15.21 However, those assessing risk using such a tool should take into account that risk is dynamic and can be affected by circumstances that can change over

the briefest of time-frames. Recording a history of risk of violence to others is vitally important. Although risk cannot be eliminated, it can and should be rigorously assessed, managed or mitigated (CR201).

15.22 George's risk assessment was regularly updated by his community psychiatric nurse, including shortly before his admission to the acute admission ward. After his admission there is reference to the team treating George reviewing this risk assessment, but it remained static and without updates.

15.23 This review has questioned the validity of the risk assessment process and risk assessment scores while George was on the acute admission ward. These did not fully reflect the fact that he had been referred there after a relapse in his mental health condition so serious that he needed to be sectioned under the Mental Health Act (1983). This was probably triggered by the fact that he had stopped taking his medication for some considerable time, had been a recent user of illicit drugs, and had recently experienced a major life event.

15.24 He had a long history of verbal and serious physical violence towards others, and such incidents occurred and his risk escalated when he was experiencing a relapse in his mental health.

15.25 The fact that he had been stable for a number of years until this relapse appears to have overridden this important information about his violent history in the conclusions made by the team carrying out these risk assessments after his admission to the ward. Even after George's community psychiatrist explicitly warned this team about his capacity for unpredictable violence and aggression, no change or update to his risk assessment was made. There was no formulation meeting, and no safety plan was put in place to mitigate this risk.

15.26 If this had happened, the pushing incident on the morning of the fatal assault on Charles might have been taken more seriously, along with some of the other indicators identified in this review that demonstrated that his risk of violence appeared to be escalating after his admission to the ward.

Record keeping and communication

15.27 Information sharing and communication are essential components in providing safe and effective care for patients. Key information about George's capacity for unpredictable violence was passed on promptly from the community to the inpatient service, but it was not appropriately or effectively shared with all of the staff who were involved in George's care.

15.28 It is not possible to determine from George's records exactly when this information about his risk was received. Although there is a mention in the record of the MDT meeting on the morning of the attack that staff were to be made aware of George's risk, there is no indication of how that was to be done. The nursing staff present at the meeting became aware of the information for the first time at this point. There is no record of whether or how these nursing staff passed it on, or what anyone else did about it, for example by reviewing and updating George's risk profile.

15.29 The standard of record keeping in George's case (and to some extent in Charles's) generally fell short of the trust's own requirements. For example, there was no admission care plan, no observation and engagement plan, and poor recording of section 17 leave (see below), which are all set out as required in the trust's record management policy.

'Health records are legal documents recording what is the intended and actual care and treatment of a service user. Record keeping is an integral part of practice and good record keeping is the mark of a safe and skilled practitioner. "Poor records mean poor defence, no records mean no defence"'.

Section 17 leave

15.30 Leave granted to patients under section 17 of the Mental Health Act (MHA) forms an important part of a detained patient's care, which includes facilitating their chances of recovery – but it can also be a time of risk. It is therefore essential that the policies and guidance cited earlier are followed exactly.

15.31 The granting of section 17 leave for both Charles and George was documented appropriately by their consultant psychiatrist (who was the responsible clinician qualified to grant such leave). In both cases, however, the leave was granted very soon after their admission on the ward, and it seems unlikely that staff would have had sufficient time to gain a clear picture of the risk such leave might pose. In George's case his first section 17 leave was taken on the same day he was first seen by his consultant psychiatrist.

15.32 In Charles's case his records showed that he was at risk of absconding, and George had gone missing twice during his time in the emergency department of the acute hospital to which he had been taken before his admission to the acute admission ward. George also had a history of unpredictable violence, and had been re-admitted because of his mental health relapse after he had stopped taking the medication that had been successful in keeping him stable for some time.

15.33 There was no safe and robust record-keeping system for managing the practical aspects of section 17 leave, including short-term leave. This should

have included, for example, qualified nursing staff assessments and recording of any risks associated with the leave, an up-to-date description of the patient, including the clothes they were wearing, the times of the patient's departure from the ward and arrival back (within the parameters set by the responsible clinician), and the purpose of the leave.

15.34 The overall impression gained by the Facere Melius review team is that the practical and essential elements of record keeping relating to section 17 leave were not entirely congruent with national guidance or the trust's own policies.

Medicines management / optimisation

15.35 George had stopped taking his antipsychotic medication (clozapine/aripiprazole) for some time; this medication had kept him stable and safe for some years during his time of treatment in the community.

15.36 The evidence reviewed suggests that there was inadequate focus on the probability that the primary cause of George's mental health relapse, both in the ED and on his admission to the acute admission ward, was his non-compliance with medication, possibly exacerbated by his use of cannabis. This lack of focus was consistent across various medical and nursing staff.

15.37 The procedural aspects of section 3 and section 136 (police emergency powers) of the MHA appeared to take precedence over taking steps to address the medicines-related root cause of George's relapse when he was first assessed by the mental health teams in the ED, and later on his admission to the ward.

Police investigation

15.38 The initial stages of the police investigation could have been more sensitively conducted, with due attention paid to the fact that the incident took place in a ward containing very vulnerable and distressed people. By prohibiting staff from discussing the incident, they added to the general sense of confusion and trauma.

15.39 A senior trust manager was established as the single point of contact. This enabled the police to access records, patients, staff and the ward to facilitate their gathering of information for their investigation. However, the prohibition the police placed on staff discussing the incident hampered the trust in their efforts to ensure that their staff were properly supported.

15.40 This was a critical incident, and if a more collaborative critical incident protocol had been in place, it would have provided a structure for the police and the trust to work together to manage the complex situation. This would have enabled the agencies involved to address areas such as staff and patient

welfare, any public safety issues, communication with staff, and arranging for the ward to return to normal functioning.

Support to staff

15.41 This was an unprecedented and traumatic incident for all of those involved, patients and staff. Many staff felt that they were offered well-being support, but it is evident that some felt unsupported after the incident. The trust did what it could to provide such support, but the prohibition by the police on allowing any staff to talk about what had happened increased the level of distress many of them were experiencing.

15.42 Although there is a high level of risk on acute mental health wards, the trust's response to this incident highlighted the challenges of meeting the needs and demands of the police and ensuring the welfare of their staff. A number of steps were taken to offer support, but the police prohibition on allowing them to talk about the incident resulted in an absence of an immediate and systematic plan to address the trauma and confusion that was widely felt among the staff.

15.43 At times of crisis of this kind the trust should have a culture and leadership that enables it to fulfil its stated policy of prioritising the well-being of its staff.

Section 16: Actions the trust have taken since the incident

16.1 Seven months after the incident, at a trust serious incident review meeting, a plan was presented which set out the actions required to address some of the key areas of learning that had been identified in the internal desktop review.

16.2 Most of the actions specified in this plan involved introducing regular monitoring of areas such as record keeping, risk assessment, and care planning. A new proforma was to be used and completed by the nurse in charge to record the correct procedures had been followed in the granting and management of section 17 leave. This process would also be regularly audited.

16.3 One-to-one qualified nursing sessions were to be offered to all patients a minimum of twice a week, and this would be audited weekly by clinical leads.

16.4 All on-call medical staff were provided with pagers to ensure that they could be alerted to incidents at the earliest opportunity.

16.5 The trust have taken other actions since the incident in addition to those noted arising from the action plan outlined above.

16.6 In July 2024 a local operational procedure for the mental health clinic (where the acute admission unit is located) was implemented that sets out the arrangements for responding to alarms that are activated when an emergency incident occurs, indicating that additional support is needed. This includes the requirement for each shift to have an allocated response nurse and clear delineation of what their responsibilities are.

16.7 The Facere Melius review team were told that staffing levels of non-qualified staff (support workers) on the acute admissions ward have been increased from three on day and evening shifts to five on days and four on nights. The qualified nurses on duty during daytime shifts remain at two on daytime shifts and one on night shifts. The review team were also told that there were currently no staff vacancies on the ward.

16.8 A trust safer staffing report dated June 2024 identified that there were still some concerns about the nursing workforce. This was considered overall to be inexperienced. They also identified that there was a high level of acuity and complexity of patient need and the related requirement for observation, engagement and seclusion.

16.9 The report also indicated that staff turnover was reducing, but retention continued to be a challenge. Recruitment of healthcare support workers in areas that include the male acute admission ward had been successful. Some of these staff had progressed to qualified nursing degree apprenticeship programmes.

16.10 The Care Quality Commission (CQC), the health and social care regulator, undertook an unannounced focused inspection of the acute admission wards in late 2022. This was in response to information they had received that raised concerns about the safety and quality of the service.

16.11 Their investigation commented on a number of aspects in the service provided. Some of these are outlined below.

16.12 On the positive side, they found that there were enough nursing and support staff to keep patients safe, and that vacancy rates had fallen. Some changes on the acute admission ward medical team included the appointment of a permanent consultant psychiatrist. In response to recent incidents, the trust had devised a safety briefing that was given to all new staff and those who were unfamiliar with the ward. Agency staff were provided with basic risk information about patients.

16.13 Bank and agency staff were being used to support the wards when acuity was high, and a checklist had been introduced to ensure that those not familiar

with the wards knew what was expected in order for them to fulfil their duties effectively. All bank and agency staff had a full induction.

16.14 The CQC team found that staff understood what incidents to report, in line with the trust policy. Managers usually debriefed and supported staff after an incident, but some staff felt that they would have benefited from more support, and did not always feel that they were fully involved.

16.15 Of the co-located wards on the hospital site, the acute admission ward, where George and Charles had been patients, had the lowest proportion of incidents relating to violence and aggression.

16.16 Negative areas included the fact that mandatory training in some areas fell below the trust's compliance targets. The environment was found to be unfit for purpose. Ward areas were small with limited communal and outside space. The CQC team were told that a move to a new site was planned for spring 2024; however, this has not yet happened. Not all wards had consistent multi-disciplinary teams to support the care and treatment of patients. Ward managers were relatively new in post, and support for the development of these roles had been slow.

Section 17: Duty of Candour

17.1 Duty of Candour (Regulation 20 under the Health and Social Care Act 2008 (Regulated Activities [amended regulations 2015]), is a general duty to be open and transparent with people who receive care from healthcare provider organisations qualified with the Care Quality Commission. This statutory duty of candour was brought into law for NHS trusts in 2014 following the Francis enquiry into the failings at Mid-Staffordshire NHS Foundation Trust, 2013.

17.2 The overarching duty for NHS trusts to comply with this requirement always applies when an incident has occurred that has resulted or might result in death, or a severe or moderated harm to a person receiving care. This is known as a notifiable incident.

17.3 The duty requires NHS trusts (and other non-NHS providers), to do the following:

- Notify in person the relevant person(s) about the circumstances of the incident followed by a written notification given or sent to the relevant person(s)
- Provide reasonable support to those affected
- Provide an account of what happened
- Advise on what further enquiries will take place

- Include an apology
- Maintain a written record of all correspondence with the relevant person(s), to be held securely

17.4 The trust has provided evidence of contact with Charles's mother (the primary point of contact for his family) from the date of the incident through to the end of the year, with a total of ten calls, and outlined that further contact continued until approximately August 2023. The family, however, have advised the FM review team that they do not recall receiving contact from the trust during this period, stating that communication came primarily from Victim Support and the police. The day after Charles's death, a senior manager and a clinical manager from the trust met with Charles's mother and brother to offer their condolences and an apology on behalf of the trust. They also supported arrangements for their journey home.

17.5 There is no evidence to indicate that Charles' family or George's family were informed about the completion of the trust's 72-hour report or the subsequent desktop review. The trust stated that they would not '*routinely inform families of the conducting of 72 hour reports'.*

17.6 Charles' family informed the FM review team that they were not made aware of the independent investigation, nor were they offered counselling, advocacy, or bereavement support following Charles' death. However, the trust stated that they informed the family of the need for a *'homicide review'* and advised them to contact their GP for support. The review team has not been able to reconcile this information.

17.7 As required by Regulation 20 of the Health and Social Care Act 2008 (set out above) and detailed in the trust's policy and guidance on being open 'Both verbal and written apologies should be given' and 'A written apology, which clearly states the healthcare organisation is sorry for the suffering and distress resulting from the incident, must also be given'. The trust has not provided evidence that these aspects of the Duty of Candour arrangements have been fulfilled. The Facere Melius review team also understand in their communication arrangement with Charles's mother that she preferred written (hard copy) communication. It might have been helpful for the trust to have established with Charles's mother her preferred manner of communication.

17.8 Given that the police investigation subsequently became a homicide enquiry, and as there was an embargo on the trust carrying out its own internal investigation, it would have been difficult for the trust to provide a full account of the incident to the families of Charles or George.

17.9 The police had also allocated a family liaison officer (FLO), whose role is to support a family through a police investigation, to answer their questions and to gather important information about the person who has died. They act as a single point of contact between the investigation team and the families to keep them up to date on its progress.

17.10 George's mother was also contacted by the trust and offered support. She was wanting to raise a complaint with the trust, although the details of this are not known to the Facere Melius review team. A number of further attempts were made by the trust to contact George's mother but they went unanswered. The local police FLO was also in contact with George's family.

17.11 Not all aspects of Duty of Candour have been met at this stage for those families involved in this incident.

Section 18: Conclusion

18.1 This was a tragic and distressing incident that has had a profound effect on those involved. Charles was the unfortunate victim of a seemingly unprovoked attack.

18.2 Charles's inpatient care was carried out in consistent compliance with national and local guidance and policies, and he was making good progress towards rehabilitation. He stopped taking his antipsychotic medication in 2017, however. Although this period of his care is beyond the scope of this investigation, consideration might be given to why this happened, and to understand if this might provide useful insight to inform service improvement for community or primary care services.

18.3 George's care in the community was diligent and mostly successful. There was a long period, after much work by his care team, when his mental health improved to the extent that he was able to get on with his former life.

18.4 This review has identified a number of missed opportunities to take prompt action to restart the medication regime for George that would have provided safe and appropriate treatment for him, and to safeguard others. His condition deteriorated sharply after (against professional advice) he stopped taking his prescribed medication, as he disclosed.

18.5 While it is acknowledged that relying on the MHA as a first resort in responding to patients who are resisting taking their medication (while lacking capacity), is necessary, there could have been more emphasis placed on ethically encouraging George to restart his medication as early as possible

once all the necessary tests had been undertaken. It is possible that this could have been done while George was in the ED at the same time as instigating the procedural aspects of the MHA.

18.6 The teams that decided to admit him to the acute admission ward, and those caring for and treating him once he was on this ward, tended to place too much emphasis on the fact that his capacity for violent and aggressive behaviour was a factor that had occurred some years earlier. As a result they underestimated the current risks that he posed while he was still not taking any antipsychotic medication, and they did not devise a timely plan for restarting it or a safety plan in case his behaviour worsened. Warning indicators of his potentially escalating agitation and potential for violence were missed or dismissed.

18.7 The clear warning that was communicated to the medical team treating George about his history of unprovoked and unpredictable violence was not treated with sufficient urgency, and it was not effectively and promptly cascaded to the rest of the team involved in his care.

18.8 Some or all of the factors outlined in this report could have been taken more seriously, with more professional curiosity and alertness being exercised.

Section 19: Recommendations

19.1 The Patient Safety Incident Framework (PSIRF) advocates a variety of system-based approaches to learning from patient safety incidents; it replaced the Serious Incident Framework (2015) in August 2022. PSIRF emphasises quality improvement and the development of meaningful, system-focused safety actions. The recommendations outlined below are the improvement areas identified in this investigation that should be evaluated against existing Patient Safety Improvement Plans and, if necessary, integrated with ongoing work in the trust and the broader system. It is crucial to apply the collaborative approach encouraged by PSIRF in developing safety actions, using tools such as Human Factors Intervention Matrix (HFIX) and iFACES (inequality, feasibility, acceptability, cost/benefit, effectiveness, and sustainability) to assess their potential value and ensure that implementation, monitoring, and tracking processes are effective and manageable.

19.2 The following recommendations focus on the acute admission ward. The trust may wish to consider, however, if there is benefit in considering them across all their acute mental health inpatient units where there is any learning from this investigation that is applicable.

Patient Safety

R1 The trust should work with its health system partners to establish on-site seven-day-a-week senior medical cover for their inpatient acute services. This should include access to associated clinical services such as pharmacy, pathology and ECG. This would ensure that the best possible care and support is provided, and that the safety of other patients and ward staff is not compromised.

Staffing

R2 The trust should assure itself that the level of qualified staff on the ward is sufficient, safe, and meets the needs of the patients. There should be arrangements to ensure that escalation processes function effectively to alert senior staff if qualified nursing levels are compromised because of sickness or vacancies.

Clinical risk management

R3 Risk assessment and risk management is a key aspect of mental health practice. The trust should assure themselves that the systems and arrangements in place on the acute admission ward effectively maintain the trust's approach to risk management, and that the quality of risk assessment and safety management plans is robust and meets the standards required.

Care planning

R4 Effective care planning is a vital process for the wellbeing and care of a patient. The trust should assure themselves that the approach to care planning on the acute admission ward for all patients is robust and carried out in line with the trust policy on care planning. This should include a system to ensure that there are effective arrangements for monitoring compliance with this important aspect of patient care.

Information sharing / communication

R5 Information sharing and communication are essential components in providing safe and effective care for patients. The trust should assure themselves that there are robust systems in place on the acute admission ward to ensure that all relevant staff are provided with important information in a timely manner. This should include establishing effective systems for monitoring such arrangements.

Record keeping

R6 The trust should assure themselves that the staff on the acute admission ward follow professional standards and good practice in relation to the documentation of clinical records. This should include systems to monitor

robustly and regularly the effectiveness of record keeping to ensure that clinical records both electronically and paper-based provide timely and accurate information to support clinical oversight

Section 17 leave arrangements

R7 The trust should review all Mental Health Act section 17 leave policies, procedures, assessments and good practice guidance to assure themselves that the requirements are scrupulously carried out. Systems need to be in place to provide evidence-based assurance that all section 17 leave on the acute admission ward conforms to and is carried out in line with those policies and requirements.

Medicines management/optimisation

R8 The trust should review its approach to medicines management/optimisation, particularly for those patients who are non-compliant with their atypical antipsychotic medication. This should include working towards a system of reinitiating atypical antipsychotics (such as clozapine) in the community, with 24-7 access to rapid screening tests and results.

The trust should assure themselves that there is a strong emphasis and focus on a proactive and timely approach to ethically encouraging and supporting patients to restart their medication regime as soon as is practical.

Critical incident memorandum of understanding (MOU)

R9 The trust and the police should work collaboratively to develop a critical incident MOU. This should include arrangements for establishing key roles and responsibilities for the management of the immediate response to an incident. This would enable the trust managers and the police to have a clear understanding of what to expect from each agency and what the requirements would be to safeguard staff and patient welfare, address any public safety issues, and arrangements for services to return to normal functioning as soon as is practicable.

Operational procedures for responding to alarms and calls for assistance on other wards

R10 The trust board should assure themselves that the systems that have been put in place in on how staff respond to alarms and calls for assistance on other wards have been implemented. They should also assure themselves that these arrangements do not compromise patient safety, and that there is an effective system in place to monitor its implementation and if necessary to escalate any concerns.

Duty of Candour

R11 The trust should assure itself that all aspects of Regulation 20 of the Health and Social Care Act 2008 are fully understood and implemented, with particular attention paid to paragraphs 3 and 4, which relate to the requirement for written notification to the relevant person(s) of the requirements set out in paragraph 2(a).

Supplementary recommendation

In addition there is a supplementary recommendation for NHS England regional team and the local NHS Integrated Care Board.

These organisations may wish to consider a review of the period of time between when Charles last took his antipsychotic medication in 2017 to when he was sectioned in under the Mental Health Act (2015). The purpose of such a review would be to establish why he stopped taking his medication and whether there is any learning to inform improvements for social services, the community or primary care services.

Section 20: Appendices

- Appendix one: Terms of reference
- Appendix two: SEIPS map

Appendix one – Investigation Terms of Reference (ToR)

Terms of Reference for Independent Investigations in accordance with Appendix 1 of NHS England's Serious Incident Framework 2015

The following Terms of Reference for Independent Investigation 2022/7648 have been drafted by the relevant NHS England regional team, in consultation with the relevant ICB.

The Terms of Reference will be developed further in collaboration with the Investigative Supplier and the affected families.

Purpose of the investigation/commission

To establish the facts that led to the incident in spring 2022, and whether there are any lessons to be learned from the case in relation to provision of mental health inpatient care and treatment to George and Charles.

To identify any areas of best practice, opportunities for sustainable system learning and areas where improvements are required, with a focus on the period leading to admission of both patients to the ward to the date of the incident.

Involvement of the affected family members, professionals, and George

- Ensure that members of both George and Charles's families, and relevant staff are fully informed of the investigation, the investigative process, and understand how they can contribute.

- Involve both families as fully as is considered appropriate, in liaison with Victim Support, Police and other support or advocacy organisations.

- Ensure that staff contributing to the investigation process understand how their information will be used and processed and are aware of organisational support.

- In collaboration with George's current clinical team, offer a minimum of two meetings to George so that he may contribute to the investigation process by providing his experience of his care and treatment, and to receive the findings of the investigation (as appropriate).

Serious Incident Response

- Consider and assess the Trust's response following the incident, to identify and implement any immediate learning.

Care and treatment /Contact with services

- Compile a detailed chronology of contacts and service access for Charles and George focussed on the period leading to their admissions to the ward to the date of the homicide.

- Undertake a critical review and analysis of the healthcare and support needs of Charles and George; assessing whether these were fully recognised and understood by professionals, commenting on whether appropriate care, treatment and support services were offered, identifying both areas of good practice and areas of learning.

- Consider and outline whether there were any organisational or operational barriers to the effective support of George and/or Charles and how services should respond effectively if similar circumstances occur.

- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time, including a focus on interconnecting, and influencing factors, making use of relevant research and case evidence to inform the findings.

Risk Assessment and Care Planning

- Consider the quality of health care assessments on which decisions were based and actions were taken, specifically in relation to the appropriateness of admission to the ward for both George and Charles.

- Examine the effectiveness of care planning, including whether George and Charles, and their families were sufficiently and appropriately involved.

- Review the adequacy of risk assessments and risk management for George, specifically in relation to risk of violence to others.

- Consider how George's risk of violence to others was understood by professionals from a Safeguarding perspective, and the understanding of staff in relation to the implications and risk towards fellow patients.

- Identify whether professionals had the relevant training or knowledge to understand health and social needs and risks identified, including those relating to learning disability and safeguarding vulnerabilities in respect of Charles.

- Consider medication management and regime following admission, whether this was risk assessed and managed appropriately.

- Review and assess compliance with local policies, national guidance and relevant statutory obligations.

Deliverables

- To ensure continuous learning, promptly communicate opportunities for early learning identified throughout investigative activity, through regular touch point meetings.

- Provide NHS England with a monthly update on progress (template to be provided by NHS England) detailing actions taken, actions planned, family contact and any barriers/risks to investigation progress.

- Based on investigative findings, make system, organisational or service specific, outcome-focused recommendations, with a focus on sustainable system improvement, and priority rating.

- Provide a final written report and a separate, anonymised and publishable Executive Summary to NHS England (that is easy to read and meets NHS England accessible information standards) within six months of receipt of all clinical records.

- Provide a concise, anonymised, case study which clearly outlines the learning points and opportunities for improvement, to enable wider sharing of learning across the NHS.

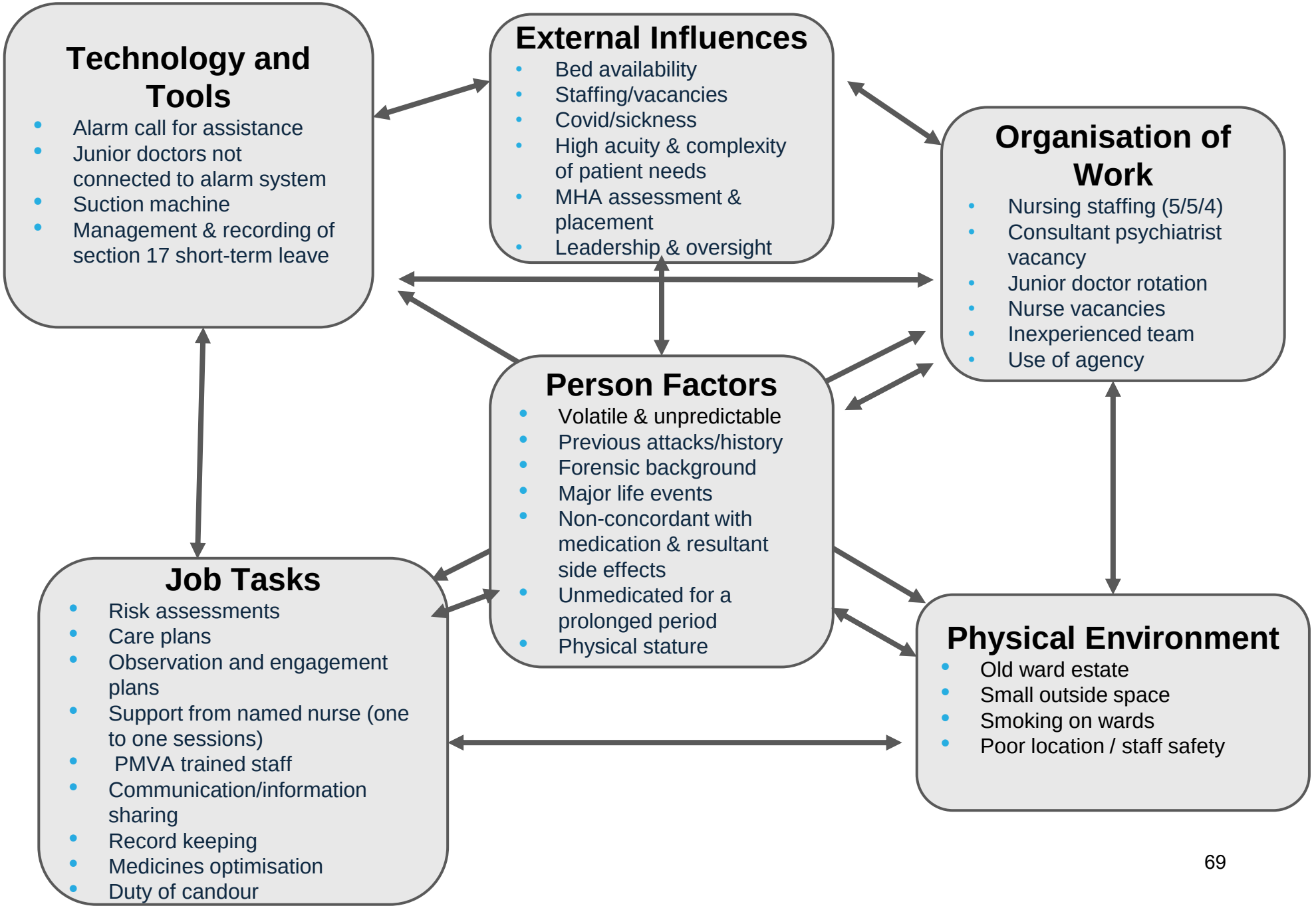
- Share the findings of the report in an agreed format, with both affected families and George, seek their comments and ensure appropriate support is in place for receiving the findings, ahead of publication by NHS England.

- Where recommendations are made:

    - contribute to a stakeholder meeting hosted by NHS England prior to publication, to provide an opportunity for organisations to explore and fully understand the intention behind all recommendations, to assist effective action planning and make any appropriate revisions to the recommendations based upon discussion.

    - conduct an evidence-based Assurance Review with key stakeholders, in conjunction with the relevant commissioner, 6-12 months following publication of the report, to assess implementation and monitoring of associated action plans. Provide a short-written report, for NHS England, outlining the findings of the Assurance Review, that will be shared with families and stakeholders, and which will be made public.

Appendix two: SEIPS System explorer


Technology and Tools
Alarm call for assistance
Junior doctors not connected to alarm system
Suction machine
Management & recording of section 17 short-term leave
External Influences
Bed availability
Staffing/vacancies
Covid/sickness
High acuity & complexity of patient needs
MHA assessment & placement
Leadership & oversight
Organisation of Work
Nursing staffing (5/5/4)
Consultant psychiatrist vacancy
Junior doctor rotation
Nurse vacancies
Inexperienced team
Use of agency
Person Factors
Volatile & unpredictable
Previous attacks/history
Forensic background
Major life events
Non-concordant with medication & resultant side effects
Unmedicated for a prolonged period
Physical stature
Job Tasks
Risk assessments
Care plans
Observation and engagement plans
Support from named nurse (one to one sessions)
PMVA trained staff
Communication/information sharing
Record keeping
Medicines optimisation
Duty of candour
Physical Environment
Old ward estate
Small outside space
Smoking on wards
Poor location / staff safety

Section 21: Glossary

Aripiprazole

Antipsychotic medication which helps with conditions such as schizophrenia and bi polar, and is available only on prescription

Clonazepam

Is a benzodiazepine, it's used to control seizures or fits due to epilepsy, involuntary muscle spasms panic disorder and sometimes restless legs syndrome.

Clozapine

Anti-psychotic medication for schizophrenia, often used for patients who are unresponsive to or intolerant of conventional antipsychotic drugs.

Community Treatment Order

Introduced in 2018 a CTO provides supervised treatment in the community, and provides conditions that must be complied with, which may include where someone lives and when and where treatment will be provided. If the conditions are broken or an individual becomes too unwell to be supported in the community they may be admitted to hospital.

Community Psychiatric Nurse (CPN)

This is a specialised mental health professional who provides care and support to individuals with mental health conditions in community settings, rather than in hospital settings. They are trained registered nurses with additional education and expertise in mental health nursing. The primary responsibilities of a Community Psychiatric Nurse include assessing individuals' mental health needs, providing therapeutic interventions, administering medications, offering counselling and support, and assisting in the development and implementation of care plans to promote recovery and well-being. CPNs play a crucial role in delivering mental health care in the community, helping individuals manage their conditions and improve their quality of life.

Lorazepam

It is a benzodiazepine; it's used to treat anxiety and sleeping problems.

Mental Health Assessment and sections

The mental health action (1983) is legislation which allows medical professionals to ensure that individuals who require assessment or treatment to be admitted to hospital. This can be achieved as:

- Detention or involuntary detention
- Compulsory admission to hospital
- Being sectioned
- Being a formal patient

There are a number of sections available to be used:

- Section 5(2) - patient already in hospital
- Section 2 - admission for assessment
- Section 3 - admission for treatment

Mental Health Act (MHA) 1983, Section 17 leave

A leave of absence from hospital when detained, this can be leaving the ward or the hospital for short periods of time, but may involve certain conditions, such as returning to the ward at a certain time.

Mental Health Act (MHA) 1983, Section 45A

Section 45A of the Mental Health Act (MHA) 1983 allows higher courts to order hospital admission for convicted offenders who have a mental disorder. This section is also known as a hybrid order, as it allows a judge to sentence an offender to prison while also mandating hospital treatment.

Mental Health Act (MHA) 1983, Section 135

Section 135 of the Mental Health Act 1983 provides for a magistrate to issue a warrant authorising a constable to enter premises, using force if necessary, for the purpose of either removing a mentally disordered person to a place of safety, or if the premises specified in the warrant are a place of safety, keep the person in the premises for the permitted period of detention which is usually 24 hours but can be extended for a further 12 hours under section 136(B).

Mental Health Act (MHA) 1983, Section 136

Section 136 of the MHA 1983 gives the police power to remove someone from a public place to then be formally placed in a place of safety; this can be for example a hospital unit (mental health unit or A&E department), a police station, this generally changes according to the person's presentation. This section of the Act aims to facilitate a clinical assessment of the health and wellbeing of an individual as well as the safety of other people around them. An individual can be held under Section 136 for a maximum of 24 hours, with the possibility of extending this period by up to 12 hours if a clinical assessment cannot be conducted. This clinical assessment involves the Approved Mental Health Practitioner and an approved Doctor.

136 suite

The purpose of a Section 136 suite, sometimes known as a 'mental health suite' or space is to serve as a place of safety for individuals who are detained under Section 136 of the Mental Health Act 1983 in England and Wales. A person can be detained under Section 136 if they have a mental illness and there is an immediate need for 'care or control**'.**

Multi Agency Public Protection Arrangements (MAPPA).

The Criminal Justice Act, 2003, requires the establishment of Multi Agency Public Protection Arrangements in each of the 42 Local Criminal Justice areas in England and Wales. Whilst not a statutory body, MAPPA requires the Local Criminal Justice Agencies to work together to manage the risk posed by relevant offenders and therefore better protect the public from harm. The Responsible Authority for MAPPA are the police, prison and probation services, other agencies have a duty to co-operate with the Responsible Authority. The Responsible Authority for specified sexual and violent offenders have a duty to ensure that the risk posed by that offender are appropriately assessed and managed *(see references).*

NHS Banding

Agenda for Change banding, adopted in 2004. The NHS uses a banding system to structure its staff and pay scales, with each role assigned to a band. The bands represent different levels of experience, education, and responsibilities, and staff can move up the bands by applying for different roles where they would need to have gain experience or studying further. Banding levels go from more junior posts (Band 1 and 2) to more senior roles (Band 8D and 9).

Olanzapine

Helps manage symptoms of schizophrenia and bi-polar disorder.

Section 12 Doctor (S12)

This is a registered medical practitioner who has been approved under Section 12(2) of the Mental Health Act 1983. This section of the law allows certain qualified medical professionals, including psychiatrists and other doctors with relevant experience and expertise, to recommend the detention and assessment of individuals under the Mental Health Act.

Zopiclone

A sleeping tablet, only available on prescription, used for short-term insomnia.

Zuclopenthixol decanoate

Deep muscular injection for maintenance in schizophrenia and paranoid psychoses

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