Niche
PATIENT SAFETY

An independent investigation into the care and treatment of P in Hertfordshire

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Niche Patient Safety are an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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1. EXECUTIVE SUMMARY

1.1 NHS England Midlands and East commissioned Niche Patient Safety, a consultancy company specialising in patient safety investigations and reviews, to undertake an independent investigation into the care and treatment of a mental health service-user (P). The terms of reference are at Appendix A

1.2 The independent investigation follows guidance published by the Department of Health in HSG (94) 27, on the discharge of mentally disordered people, their continuing care in the community and the updated paragraphs 33-36 issued in June 2005.

1.3 The main purpose of an independent investigation is to identify whether there were any aspects of the care which could have altered or prevented the incident. The investigation process will also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

1.4 In this instance, the incident has been thoroughly investigated by the Trust, and the police. As a result of the prosecution of the Trust by the Health & Safety Executive, the systems and process to govern discharges and placements in community care by the Trust have been thoroughly examined. It is also more than 7 years after the tragic event.

1.5 Therefore the focus of this investigation is to assess the extent and reasonableness of changes made to practice, policy and governance arrangements to prevent, or at least minimise the likelihood, of such a tragic incident happening again.

1.6 We would like to express our condolences to the family of G. It is our sincere wish that this report does not add to their pain and distress, and goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of P up to the point of the offence.

The Incident

1.7 P was a well-known user of mental health services provided by Hertfordshire Partnership University NHS Foundation Trust (HPFT). His first contact with the service had been in the late 1970s. Since then he had had a long and complex history of a psychotic mental disorder.

1.8 He was admitted under Section 3 of the Mental Health Act[1] to Albany Lodge, an acute in patient unit, on 1 January 2007. He was then transferred to a Psychiatric Intensive Care Unit (PICU) as his behaviour was difficult to manage in a less secure environment.

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[1] This section allows for a person to be admitted to hospital for treatment if their mental disorder is of a nature and/or degree that requires treatment in hospital. In addition, it must be necessary for their health, their safety or for the protection of other people that they receive treatment in hospital. Section 3 is used where the person is already well known to psychiatric services or following an initial assessment under Section 2. Under a Section 3 you can be detained for up to six months in the first instance.

1.9 It was originally planned that once his condition had stabilised, P should undergo a longer period of rehabilitation in a locked or low secure unit (Deacon Ward) although this didn't happen for a range of reasons, including a shortage of available beds and a change in P's condition.

1.10 P returned to Albany Lodge on 1 March 2007. Later that month and in April he had treatment for physical complaints at Hemel Hempstead Hospital on three occasions, two of which resulted in short admissions to the hospital.

1.11 In May he had a short trial period in open rehabilitation unit, 75 Hill End Lane. During this time both of his parents also died, three weeks apart. The trial was unsuccessful as it was difficult manage his risk of absconding in an open unit, and he returned to Albany Lodge.

1.12 His mental health condition fluctuated, including episodes of delusions, mild sexual disinhibition, low mood and hopelessness. He was noted to require more help with many aspects of his care. He was referred to the Bed Management & Placement Team (BMPT) to find a suitable residential care home.

1.13 On the 18 July 2007 P was transferred from Albany Lodge to Abacus House, a residential care home in Dunstable, Bedfordshire for a 4 – 6 week trial period. The care home had been identified as a suitable placement by the Trust's Bed Management and Placement Team and P was on an initial trial period: technically he was 'on leave' from the Trusts inpatient unit. A care plan was developed which included regular follow-up by a Community Mental Health Nurse who was his Care Co-ordinator, and P's Consultant Psychiatrist.

1.14 He was visited on 27 July 2007 by his CPN and his Consultant Psychiatrist to give him his depot medication.[2]

1.15 He was again visited by his CPN on 10 August to give him his depot medication. He was noted to appear mentally well, and was enjoying some activities and social contact at Abacus House. He was reported to have made a female friend, and was agreeable to becoming involved in voluntary work. It was also noted he had some concerns about his money.

1.16 The planned visit by his CPN and Consultant Psychiatrist for 17 August was cancelled as the Consultant Psychiatrist was off sick. The visit was re-arranged for a week later. His depot medication was to be given by another CPN as his regular CPN would be on leave.

1.17 On the 24 August 2007 P had been visited by the new Community Psychiatric Nurse (CPN) earlier that day to give him his depot medication. This new CPN also undertook

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[2] Antipsychotics can also be given by an injection that has long-lasting effects. These are called 'depot' antipsychotics and are given by injecting the drug into muscle every two to four weeks. Taking antipsychotics this way means people are less likely to forget to take their medication. Sometimes depot injections are given to people who are very unwell and may not want to take tablets regularly.
http://www.mentalhealthcare.org.uk/antipsychotic_medication#Depot_injections

monitoring of his mental state and confirmed with staff that he was taking all of his oral medication. P expressed concern again about accessing his money from the Post Office in St Albans. He had no complaints about the staff and when asked said he was getting on “Okay, I suppose”.

1.18 Later that day P fatally stabbed a female care worker who was employed by Abacus House and assaulted another female member of staff at the care home. It is not known why this happened or what, if any, events preceded this attack. It appears to have been spontaneous. He was arrested and charged with murder. P was subsequently found to be unfit to enter a plea and a trial of facts was held in April 2009 at Luton Crown Court and jurors ruled that P killed G. On the 22 April 2009 P was ordered to be detained indefinitely in a secure mental health unit.

1.19 There was then a significant delay in the Trust being able to complete an internal investigation into the care and treatment of P as they were then charged by the Health & Safety Executive for contravening a health and safety regulation. The protracted criminal investigations and legal proceedings involving the police, the Crown Prosecution Service (CPS) and the Health and Safety Executive (HSE) prevented the Trust from properly undertaking its own internal review/investigation until all the legal processes had been completed.

1.20 Both the Trust and Abacus House were convicted by a jury at Crown Court in June 2012 and fined. The Trust was found guilty of contravening a health and safety regulation by failing to make a suitable assessment of the risk the patient posed. It was also convicted of a second charge of failing to discharge a duty to ensure persons not in its employment were not exposed to risks to their health and safety. In both instances, key to this was a failure by the Trust to ensure that Abacus House was able to fully provide the care that P required

1.21 At the end of these legal proceedings the Trust was finally able to complete the internal Panel Review of the care and treatment of P. This was finally completed in August 2013 and made ten recommendations.

1.22 Following the prosecution, the Trust also asked Mental Health Strategies, a specialist management consultancy, to review whether the current processes, procedures and practices for the commissioning and placing of patients in independent care were safe. This was completed in October 2012 and this report made 22 recommendations to improve the safety of placements.

1.23 This investigation has therefore reviewed the internal investigation, the action plan arising from it and the Mental Health Strategies review. The investigation has sought evidence and assurance for the changes made to systems and processes following these investigations, action plans and the prosecution of the Trust by the Health & Safety Executive.

Our findings

1.24 P had been in contact with mental health services since 1978. His original diagnosis was that of paranoid schizophrenia. Over the next 25 years this diagnosis changed to personality disorder; schizoaffective disorder - depressive episode; schizophrenic

psychosis - hebephrenic type; and latterly to his current diagnosis, bipolar affective disorder - hypomanic episode.

1.25 P had a lengthy criminal history, having twelve convictions for 17 offences between May 1972 and December 2002. From then on, though he continued to have infrequent contact with the police, it was not of the same nature.

1.26 He had brief periods of stability between 1994 and 2002 when he was able to live independently with some support.

1.27 Between 1981 and 2007 P had fifteen admissions to hospital, seven of which required detention under the Mental Health Act. From 2002 his mental health condition deteriorated and his admissions became more frequent. He had a history of noncompliance with medication, not engaging with services and on occasion's violent or aggressive behaviour when unwell.

1.28 His admission to Albany Lodge in January 2007 was precipitated again by his relapse and non-engagement with services. Because of his deteriorating physical condition and lack of an available bed, the original plan to transfer P from Albany Lodge to low secure rehabilitation was changed, initially to open rehabilitation, which failed, then to residential care. During this time both of his parents died within three weeks of each other.

1.29 It is likely that P was much more unwell than his outward demeanour and behaviour indicated. The decision to transfer him to Abacus House does not seem coherent with the previous plans for rehabilitation, but given the indications of the owner, the Trust team were led to believe that more adequate and skilled mental health care would be provided.

1.30 Because the Trust did not undertake a risk assessment immediately prior to the transfer of P and because it did not undertake more robust due diligence of the selection of the placement, the Trust was prosecuted by the Health & Safety Executive.

1.31 The ensuing Trust internal investigation and then subsequent independent review have made wide sweeping recommendations to improve practice, commissioning of care placements and governance. The Trust has implemented many of these and is addressing those few outstanding recommendations. Given the scale of the changes, the impact the incident has had on the organisation and the continued vigilance and attention of the organisation we believe that it is extremely unlikely that this incident would happen now.

Recommendations

This independent investigation has made six recommendations for the Trust to address in order to further improve practice and governance.

Recommendation 1: The Trust should complete its review of Rehabilitation Services within 3 months of the publication of this report, and be able to demonstrate a clear plan, agreed by commissioners, for providing increased local capacity based upon current needs assessment.

Recommendation 2: The Trust should assure itself that all staff are aware of what constitutes abuse, including unlawful detention, and are able to take appropriate actions to take to protect all vulnerable adults.

Recommendation 3: The Trust should review the risk register thoroughly to assure itself that the identified risks, risk scores and therefore the mitigation are correct, with particular attention to risks where staffing and recruitment are the underlying factors.

Recommendation 4: The Trust should assure itself that Care Coordinators have the necessary skills and qualities to deliver the requirements of the role.

Recommendation 5: The Trust needs to demonstrate that quality also drives the requirement to review placements, and should consider alternative quality based criteria for review of some placements, such as reviewing a suitable number of the placements furthest away, or the patients who have spent the longest time in a placement, or other criteria linked to quality.

Recommendation 6: The Trust should rapidly develop a robust and routine performance management system and Board report for the secondary care placement budget and Bed Management & Placement Team.

2. INDEPENDENT INVESTIGATION

Approach to the investigation

2.1 The independent investigation follows the Department of Health guidance (94) 27,[3] on the discharge of mentally disordered people and their continuing care in the community, and updated paragraphs 33-36 issued in June 2005. The terms of reference for this investigation are given in full in Appendix A.

2.2 The main purpose of an independent investigation is to discover whether there were any aspects of the care which could have altered or prevented the incident. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

2.3 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations about organisational and system learning.

2.4 In this case it is more than seven years after the tragic event. The incident has been thoroughly investigated by the Trust, and the police. Also, as a result of the prosecution of the Trust by the Health & Safety Executive, the systems and process to govern discharges and placements in community care by the Trust have also been thoroughly examined.

[3] *Department of Health (HSG (94)27. Guidance on the Discharge of Mentally Disordered People and their Continuing Care, 1994, amended by Department of Health Independent Investigation of Adverse Events in Mental Health Services. 2005*

2.5 Therefore the focus of this investigation is to assess the extent and reasonableness of changes made since the incident to practice, policy and governance arrangements to prevent, or at least minimise the likelihood, of such a tragic incident happening again.

2.6 The investigation was carried out by Nick Moor, Director of Niche Patient Safety

2.7 The report was peer reviewed by Carol Rooney, Senior Investigations Manager, Niche Patient Safety

2.8 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[4]

2.9 We have been unable to meet with the family of G, the victim in this case, but want to express our sincere condolences to her family. We know that this tragic event will have profoundly affected her family and we have no wish to cause them further hurt.

2.10 We have met with the care assistant who was also involved in the incident at Abacus House and explained the purpose and outcome of this investigation.

2.11 We have been unable to meet with the family of P, although they have been kept informed of the outcome of this investigation.

2.12 We have met with P himself and explained the outcome of the investigation and our findings.

[4] National Patient Safety Agency. Independent Investigations of Serious Patient Safety Incidents in Mental Health Services. 2008

3. THE CARE AND TREATMENT OF P

Personal history

3.1 P was the second of seven children, born in St Albans. He maintained regular contact with his parents until their deaths in 2007, and appears to have been close to them throughout his life.

3.2 Brought up in St Albans, he achieved all normal developmental milestones. He attended local schools, and left at age fifteen. He later attended evening classes, and obtained a Diploma in Agriculture in 1972. He worked as a farm worker until he was twenty three when he broke both of his legs in a road traffic accident. This left him unable to work to on a farm. He then went on to work in the local Hill End hospital in the gardens and the laundry, and later as a volunteer for the Red Cross.

3.3 P is unmarried, and as far as is known has had no significant relationships. He lived with his parents until he was thirty two. Following his second admission to hospital he stayed in The Causeway, a social rehabilitation hostel in St Albans. He was able to stay there until 1998 when his application for housing was successful. He then moved to his own flat where he stayed until December 2006.

Psychiatric history

3.4 P had been in contact with mental health services since 1978. His original diagnosis was that of paranoid schizophrenia. Over the next 25 years this diagnosis changed to personality disorder; schizoaffective disorder - depressive episode; schizophrenic psychosis - hebephrenic type; and latterly to bipolar affective disorder-hypomanic episode. This is his current diagnosis.

3.5 Following his second admission which was under Section 37 in 1987, P was placed under Guardianship.[5] He was initially discharged to The Causeway, a social rehabilitation unit with an emphasis on residential care with a therapeutic social care approach. This appears to have led to a longer settled period. By 1998 he was able to live independently in his own flat until 2006.

3.6 Between 1993 and 2002 P was supported in the community with regular depot medication and visits by his Community Psychiatric Nurse (CPN) every six weeks. Between his admissions he would be supported by out-patient appointments and contact with his CPN to give him his depot medication. More latterly this role was fulfilled by his Care Coordinator.

3.7 In July 2005 P was discharged from Albany Lodge and placed under a Mental Health Act Section 25 Supervised Discharge order, with twice weekly visits from the Home Support Team (HST), a weekly depot injection given at Edinburgh House and fortnightly visits from his Care Co-ordinator. On this occasion community supervision was less successful and he was readmitted to Albany Lodge in January 2006. His

[5] *Guardianship was a community based order under Section 7 of the Mental Health Act 1983, which Social Services had responsibility for. The order had the power to require a person to live at a specified place, attend appointment and allow a doctor or Approved Social Worker to attend their residence, although they had no power to force entry. Section 25 Supervised Discharge was added to the Act in 1995 under the Mental Health (Patients in the Community) Act 1995. Similar in power to Guardianship, it placed the responsibility upon the NHS for implementation and monitoring.*

Supervised Discharge order was allowed to lapse, and on his discharge, a more intensive support plan was implemented by the HST.

3.8 He was admitted on two further occasions in 2006; in May under Section 3 after a period of non-cooperation, and in September. On this occasion he was admitted informally but later detained under Section 5(2) and then Section 3 as he left the ward frequently, being brought back by the police. He became aggressive and abusive, refusing to cooperate. He was discharged by Hospital Managers against clinical advice in October and went home with support from the HST, though Supervised Discharge was considered.

3.9 Between October and December, he was reluctant to engage with services (his Care Coordinator reported not seeing him for six weeks), had not taken his medication (his GP reported he had not collected his prescription) and had missed his Care Programme Approach (CPA) review on 20 December. Concerns were also expressed about his physical health, as when he was seen he became breathless on exertion, complained of dizziness and reported epileptic type seizures.

3.10 On 28 December 2006 he was taken to A&E for smoke inhalation following a fire at his flat. He had fallen asleep and been woken by a neighbour banging on the door when he had heard the smoke alarm. According to the Fire Brigade, the fire had been caused by P starting cooking under the influence of alcohol, before falling to sleep. A Mental Health Act assessment was undertaken, during which it was reported that P attempted to hit the assessor. It was not possible to complete the admission that day and P took his own discharge from A&E.

3.11 P was taken to A&E on 1 January 2007 by the police, and from there he was admitted to Albany Lodge.

Contact with criminal justice system

3.12 P had a lengthy criminal history, having twelve convictions for 17 offences between May 1972 and December 2002. From then on, though he continued to have infrequent contact with the police, it was not of the same nature.

3.13 According to psychiatric reports, P ‘s offences included two offences against the person, one sexual offence of indecent exposure with intent to insult a female, two offences against property, four offences of theft and associated offences, two offences relating to police/courts/prisons, three offences relating to firearms and offensive weapons and three miscellaneous offences. On at least five occasions he assaulted someone, and twice was convicted of Actual Bodily Harm (once on his father). The table below, taken from the internal investigation, provides an incomplete chronology of his offences.

Table 1: Chronology of offences

DATE	OFFENCE/CONVICTIONS	REMEDY
May 1979 Sept 1979	Possession of loaded air weapon in public place. Indecent exposure	Not known, but coincides with onset of mental illness
1980	Actual Bodily Harm	Remanded at Hill End Hospital, then 1 year probation
1981	Taking and driving away. Possession of an offensive weapon – attempted to hit another person with a hammer	Admitted to Hill End Hospital from Brixton Prison
1984	Criminal damage x 2	Fined. Inpatient treatment at Hill End Hospital followed by Day Hospital placement
Dec 1987	Actual Bodily Harm on his father Assault on police officer Possession of an offensive weapon	Section 37 order to Hill End Hospital
Jan1993	Crashed his car outside police station	Voluntary admission to hospital
Feb 2002	Assault of a police officer and public order offence	Section 2 admission to Albany Lodge
2004	Assaulting a police officer and public order offence	Psychiatric admission

4. ARISING ISSUES, COMMENT AND ANALYSIS

4.1 In this section we review the interventions offered to P in his last admission, and the policies and procedures in place when he was sent to Abacus House.

4.2 We also looked at the Trust's current policies and procedures and other documentation to consider any policy changes that have been made since the incident in June 2007 and the prosecution and conviction of the Trust in 2012 for a breach of health and safety regulations. We interviewed seven managers from the Trust, including two executive directors, who all described how policies and procedures have been changed and implemented, and how performance and risks are now monitored. We have also interviewed a Social Worker who was able to describe the changes to practice now in place regarding placements. A full list of the documents reviewed can be found in the appendices.

4.3 We have focussed on the points identified in the terms of reference and further areas that have emerged during our investigation. The Trust has provided a significant amount of evidence for the implementation of the action plans arising from this case and we have reviewed this.

The terms of reference for this investigation relevant to this section required that we review:

- the existing chronology of events leading up to the homicide;
- the care, treatment and services provided by the NHS for the service user's latter episode of care up to the time of their offence;
- assess compliance with local policies, national guidance and relevant statutory obligations; and

- the adequacy of risk assessments and risk management, including specifically the risk of the service user harming himself or others.

Care and treatment

4.4 In this section we review the interventions offered to P in his last admission, and policies and procedures in place when he was sent to Abacus House.

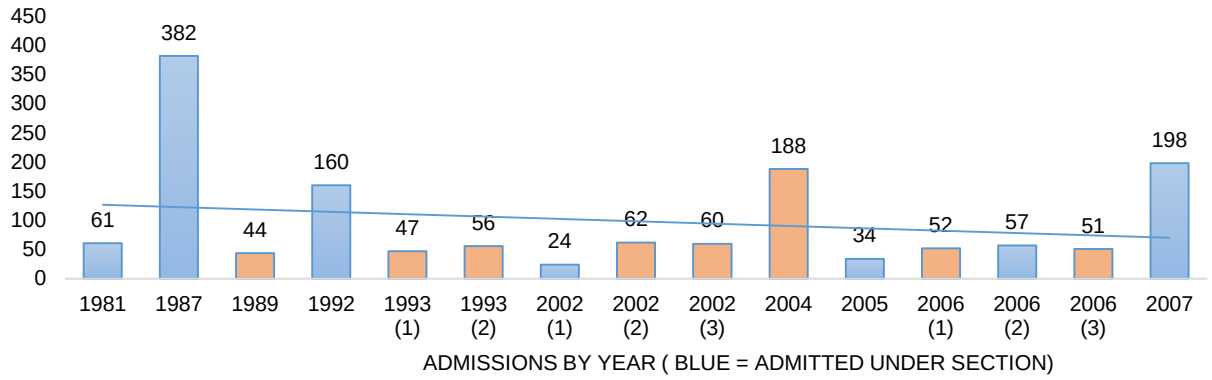
4.5 We have noted the increasing frequency of P's admissions to hospital since 2002.

4.6 Between 1981 and 2007 he was admitted to hospital on 15 occasions. Of these, there were eight informal admissions, and 7 when he was admitted under section (including two hospital orders from court).[6] Of the eight informal admissions, these led to detention under the Mental Health Act 1983 (MHA) on four occasions. It is also noted that on two occasions when he was regraded to informal from a section he continued to stay in hospital as an informal patient. From the clinical notes and the comprehensive history provided it is clear his illness was of a relapsing nature.

Prior to his last admission and the homicide of G, it can be seen that there was an increase in the frequency of admissions, and a decrease in the length of time between admissions. Between 1981 and 2002 he had six admissions in 21 years, and from 2002 to 2007 he had nine admissions over five years. In total he had four admissions lasting more than five months, and the rest (eleven) lasted between one and two months. The median length of stay was 57 days.

4.7 He had two periods without admission to hospital; a long settled period between 1994 and 2002, during which he was removed from the provisions of Section 117 aftercare[7], and again in 2003. In 2002 and 2006 he had three admissions per year, and in 2004 and 2007 one much longer stay in hospital. Figure 1 below highlights his admissions to hospital and their lengths of stay between 1981 and 2007.

Fig 1: Length of admission in days



[6] 'Admitted under section' is professional shorthand for sections of the Mental Health Act 1983 used to compulsorily detain people who are unwilling to stay in hospital for assessment or treatment. Informal status means that a person is not unwilling to receive treatment in hospital.

[7] Section 117 imposes a duty upon health and social services to provide aftercare. It states that aftercare services must be provided to patients who have been detained in hospital:

- *For treatment under Section 3;*
- *Under a hospital order pursuant to Section 37 (with or without a restriction order); or*
- *Following transfer from prison under Section 47 or 48.*

4.8 We note the changing nature of his diagnosis, and the time required to come to a settled view. Since 2004 P has been treated under the diagnosis of Bipolar Affective disorder. That diagnoses can change over time can be difficult to understand for those outside of mental health, but is typical of the difficulties sometimes found when treating and managing the consequences of a complex and severe mental health disorder.

4.9 Whilst the correct diagnosis is important, it is just as important to ensure that the correct treatment is given. As P had episodes of hypomania and psychosis, his treatment with both mood stabilisers and antipsychotic medication was entirely appropriate.

4.10 P was increasingly less able to care for himself in his own flat, causing the housing agency and his care team concern. The increasing relapses over 2006 and the period of disengagement in the autumn, leading to the fire in his flat and subsequent admission all paint a picture of increased deterioration that was never fully in remission prior to his trial at Abacus House. Following his admission to Albany Lodge in 2007 the original intention to provide a longer period of psychiatric rehabilitation in a low secure environment appears entirely appropriate. Lack of availability at the right time prevented this happening.

4.11 Two possible placements were found for P by the Bed Management & Placement officer in late June 2007. The first was in St Neots, which had been previously declined by P because of the distance. The second was Abacus House in Dunstable, Bedfordshire.

4.12 P was assessed by Abacus House staff at Albany Lodge on 2 July 2007 and concluded that he was suitable to become a resident at Abacus House for a four to six week trial period. The Trust staff would continue to administer his depot injections as Abacus House 'staff were not allowed to administer depot'.

4.13 On 3 July 2007 P told his Named Nurse on Albany Lodge that he was not ready to go to Abacus House. He felt physically unwell and expressed thoughts of throwing himself on a motorway but denied intent as he described himself as a coward. This was reiterated the next day when P told the ward round he was not ready to go to Abacus House as he was having difficulty getting out of bed. He was, however, encouraged to visit and a visit was arranged for the 9 July 2007.

4.14 On 5 July 2007 the Bed Management and Placement Officer recorded that the owner of Abacus House said that although P was challenging, Abacus House would take him but needed to have a CPA care and risk management plan before he was transferred from Albany Lodge. Arrangements put in place to support the transfer to Abacus House included:

- depot injections to be given by CMHT as Abacus House did not have any medical staff or people trained to give it;
- CPA review planned for 13 July 2007; and
- additional funding provided to Abacus House to ensure sufficient staffing to manage risk of absconding.

4.15 On 5 July 2007 P is recorded as saying he "felt he could not see any way forward with his future but has agreed to give Abacus a try and hopes it works out".

4.16 P was escorted to view Abacus House on 9 July 2007. He stated he had not made up his mind whether he would go there or not, despite his previous agreement. A report from the manager of Abacus House described P's visit to Abacus House. It was noted he arrived at 10.00 and was shown the available room and "he said he liked it". The activities were explained and he apparently expressed an interest in gardening and cooking. The visit was reported as having lasted twenty minutes as they had to return to Albany Lodge 'due to transport arrangements'. P later stated (presumably after visiting Abacus House) that Abacus House was alright but not "his cup of tea" but did not give any reason why he should not be transferred there.

4.17 It was noted on several occasions over the next few days that he was disinhibited, and had approached staff for sex. He left the ward for four hours on 11 July and returned accompanied by the Police. According to the notes he appeared dishevelled, smelly and elated in mood – described as grinning inappropriately. However he also reaffirmed that he was willing to "give going to stay at Abacus House a trial for 28 days".

4.18 P continued to exhibit unusual or bizarre behaviour on occasions over the next few days but did not appear to be distressed. On one occasion he fell out of bed and sustained a bruise on the side of his head. He expressed some concern about leaving Albany Lodge.

4.19 The following points were recorded at the last CPA meeting about P on 16 July:

- P was going to Abacus House to begin his trial period on the 18 July 2007 – he was not keen and seemed nervous and withdrawn.
- The previous week had seen a continued pattern of poor hygiene, low mood, isolation and complaints of poor physical health.
- P still had psychomotor retardation, with negative feelings about himself and prognosis.
- He wandered around the unit and had walked into a live ward round claiming that he wanted sex through the NHS.

4.20 On the 18 July 2007 P was transferred from Albany Lodge to Abacus House, a residential care home in Dunstable, Bedfordshire for a 4 – 6 week trial period. Technically he was 'on leave' from the Trusts inpatient unit. A care plan was developed which included regular follow-up by P's Consultant Psychiatrist and visits from a Community Psychiatric Nurse who was his Care Co-ordinator. This included two weekly visits to give him his depot medication.

4.21 He was visited on 27 July 2007 by his Care Coordinator and his Consultant Psychiatrist to give him his depot medication.[8]

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[8] *Antipsychotics can also be given by an injection that has long-lasting effects. These are called 'depot' antipsychotics and are given by injecting the drug into muscle every two to four weeks. Taking antipsychotics this way means people are less likely to forget to take their medication. Sometimes depot injections are given to people who are very unwell and may not want to take tablets regularly.*
http://www.mentalhealthcare.org.uk/antipsychotic_medication#Depot_injections

4.22 He was again visited by his Care Coordinator on 10 August to give him his depot medication. He was noted to appear mentally well, and was enjoying some activities and social contact at Abacus House. He was reported to have made a female friend, and was agreeable to becoming involved in voluntary work. It was also noted he had some concerns about his money.

4.23 The planned visit by his Care Coordinator and Consultant Psychiatrist for 17 August was cancelled as the Consultant Psychiatrist was off sick. The visit was re-arranged for a week later. His depot medication was to be given by another CPN as his Care Coordinator would be on leave.

On the 24 August 2007 P had been visited by the new Community Psychiatric Nurse (CPN) earlier that day to give him his depot medication. This new CPN had known P for many years through his contact with other mental health services. The CPN also undertook monitoring of his mental state and confirmed with staff that he was taking all of his oral medication. P expressed concern again about accessing his money from the Post Office in St Albans. When asked how he was getting on said "*Okay, I su*ppose". He did say he was unhappy at Abacus House, especially at being locked in, and wanted to return to the St Albans area. He also said that he felt bullied by a member of staff. The CPN was with him for approximately thirty minutes and described him as calm, lucid and very polite. No aggression or agitation was observed at all, and the CPN was very shocked when later told of the attack.

4.25 **Comment**

The Trust has acknowledged that access to a suitable number of appropriate beds for psychiatric rehabilitation is an issue. We note the internal investigation recommendation to review the availability of non-forensic, low secure rehabilitation beds to ensure there are sufficient to meet local needs. Whilst this may have happened immediately after the prosecution by the HSE, we have seen no evidence that this has been completed or that the Trust has sufficient low secure rehabilitation beds. However, we acknowledge that demand for mental health services is continually changing, and there are multiple factors that can impact upon this. Such factors are not limited to the number of rehabilitation beds, but could include, for example, wider access to acute inpatient beds; the number of care coordinators in the community; financial pressures elsewhere in the Trust or health system, and access to step down and supported living care in the community.

Recommendation 1:
The Trust should complete its review of Rehabilitation Services within 3 months of the publication of this report, and be able to demonstrate a clear plan, agreed by commissioners, for providing increased local capacity based upon current needs assessment.

4.26 The clinical history shows that P had responded well when given tight boundaries. This could be seen following his Guardianship orders, and on one occasion when he was given a Section 25 Supervised Discharge order. His failure to respond positively to the more open environment at 75 Hill End Lane may have been that he responded better

with tighter boundaries. But the death of his mother coincided with this period and must have had an impact. The death of his father following his return to Albany Lodge must equally have impacted upon his mood and thought processes. After the death of his parents there are comments in the notes regarding P feeling hopeless, suicidal and wanting to kill himself, though it is noted he felt safe in Albany Lodge. Despite a history of going AWOL he chose to stay in Albany Lodge after being discharged from his Section 3.

4.27 It is possible that P's manifestation of grief at the loss of his parents appeared outwardly as low mood, but may also have masked a deeper psychosis. Even though he may have appeared outwardly improved and discharged from Section 3, his underlying illness was still present, with elements of persecution and paranoia. What is clear is that the care team were aware of the deaths of P's parents and considered how this might affect him. The care plan included comments on 'allowing P time to grieve'. What this means in actual practice is not clear. Despite this, in a few short months, P lost both of his parents, gave up his flat (significant as a marker of independence), suffered two episodes of physical ill health requiring treatment in an acute hospital, failed a trial in open rehabilitation unit and was then found a place in residential care. These are all significant factors that must have had some impact on his already fragile mental state.

4.28 The internal investigation expressed concern that the need for low secure rehabilitation was swiftly changed due to lack of local availability, and that the overall plan whilst in Albany Lodge lacked coherence and consistency. The investigation concurs with this finding. However, we also agree that based upon P's increased deterioration in self-care and inability to live safely and independently that the decision to place him in more supportive residential care would have been appropriate at the time. What is clear is that, as the ensuing events showed, Abacus House was not appropriate and supportive residential care. We do agree with the internal investigation that the arrangements made for follow up whilst at Abacus House were appropriate, though with the benefit of hindsight, were based on flawed assumptions about P's mental health and the ability of Abacus House to adequately care for him.

Compliance with policies, national guidance and relevant statutory obligations

4.29 Key local policies in force at the time of the homicide includes:

- Acute Ward Operational Policy: June 2005
- Bed Management Policy: November 2005
- Clinical Risk Assessment and Management for Individual Service Users, Policy and Procedures, Assessment and Recording Tools: October 2005
- Integrated Care Programme Approach and Care Management Policy: July 2007

4.30 There are key areas of non-compliance identified by the internal investigation. These include:

- failure to undertake pre-discharge CPA and risk assessment review;
- failure to share a copy of the care plan with P;
- not fully engaging the 'carer' in the care planning arrangements.

Acute Ward Operational Policy: June 2005

- risk assessments not reviewed when there were changes that caused concern;
- not sharing information when there has been an increase in risk.

Clinical Risk Assessment and Management for Individual Service Users, Policy and Procedures, Assessment and Recording Tools: October 2005

- risk assessment;
- implementation of the role of the Care Co-ordinator;
- the requirements of the Care Plan – with particular reference to the need of a contingency plan.

Integrated Care Programme Approach and Care Management Policy: 2004 and 2007

4.31 This investigation concurs with these findings. However, we were also concerned to note that P reported to the CPN giving him his depot injection in Abacus House that a member of staff bullied and was horrible to him. The CPN also noted that P (and presumably other residents) was locked in the home and could not leave at will even though he was not detained. The allegation of bullying should have been escalated according to the local policy on safeguarding. [9] P being locked in the home was unlawful detention. This too should have been escalated by the CPN but was not.

4.32 **Comment**

In the light of the investigation into care at Winterbourne View we are all much more concerned with abuse of vulnerable adults. Adult safeguarding is now on a statutory footing alongside safeguarding children. Organisations must ensure that all staff are aware of what constitutes abuse and are able to act upon concerns of abuse appropriately. That P was locked in was unlawful detention. Although there is no indication that P lacked capacity, there will also be increasing attention paid to deprivation of liberty following the judgement of P v Cheshire West[10].

[9] *Hertfordshire Safeguarding Adults from Abuse Procedure Issue 4, July 2007*

[10] *P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council & Anon [2014] UKSC 19 (19 March 2014) URL: http://www.bailii.org/uk/cases/UKSC/2014/19.html*

Recommendation 2

The Trust should assure itself that all staff are aware of what constitutes abuse, including unlawful detention, and are able to take appropriate actions to protect all vulnerable adults.

The adequacy of risk assessments

4.33 Risk assessment is one of the central tenets of mental health care. Between 2 January 2007 and his transfer to Abacus House, P had six separate documented risk assessments.

These were recorded on the following dates:

- 2 January 2007
- 2 March 2007
- 27 April 2007
- 11 May 2007
- 22 May 2007
- 25 June 2007

4.34 The risk assessments all noted his history of violence towards staff, that he had carried a knife and a hammer in the past, that his compliance with medication was poor, and that he had been paranoid when unwell.

4.35 The last risk assessment on 25 June 2007 also mentioned that his parents had both died very recently, and as special risk factors that he had been physically aggressive towards a Social Worker in response to being sectioned, and he had become verbally abusive and attempted to grab a member of staff.

4.36 Policy in force at that time required a new risk assessment to be undertaken where these was any significant change of circumstances. There was no risk assessment after 25 June 2007 to support his trial leave at Abacus House, which is identified as a change in circumstances. However, we have been told that the risk assessment of 25 June was shared fully with the staff at Abacus House, and they had been informed that P had been physically aggressive and that he had tried to hit an Approved Mental Health Act Practitioners (AMHP)[11] in the process of a MHA assessment with a view to him being sectioned.

4.37 The Trust internal investigation made three recommendations regarding risk assessment:

[11] *AMHPs are responsible for organising, co-ordinating and contributing to Mental Health Act assessments. It is the AMHP's duty, when two medical recommendations have been made, to decide whether or not to make an application to a named hospital for the detention of the person who has been assessed. To be detained under the Mental Health Act individuals need to be suffering from a mental disorder, the nature or degree of which warrants detention in hospital on the grounds of their health and/or the risk they present to themselves and/or the risk they present to others.[1] The AMHP's role includes arranging for the assessment of the person concerned by two medical practitioners who must be independent of each other and at least one of whom should be a specialist in mental health*

- The Trust should demonstrate that all service users moving into a funded placement in the community have a risk assessment during the forty-eight hours before the placement begins
- The Trust should demonstrate that risk assessments are accurate and thorough, envisaging the scenario when the individual service user begins this particular placement.
- The Trust should initiate a regular audit of pre-discharge risk assessments, to provide assurance that the forty-eight hour pre-discharge standard is being met consistently.

Predictability and Preventability

4.38 The Terms of Reference for this investigation require us to consider if this incident was either predictable or preventable.

4.39 Predictability is '*the quality of being regarded as likely to happen, as behaviour or an event*'.[12] An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.[13]

Prevention means to '*stop or hinder something from happening, especially by advance planning or action*' and implies '*anticipatory counteraction*'; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

4.40 In the following section we will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome.

4.41 As discussed earlier P had a long history of aggressive behaviour and violent offences. On at least five occasions he assaulted someone, and twice was convicted of Actual Bodily Harm (once on his father). In December 2006 he assaulted the Approved Mental Health Act Practitioner whilst being assessed for detention under the Mental Health Act.

4.42 Between 2 January 2007 and his transfer to Abacus House in July, P was assessed for risk of harm to himself or others on six occasions. Prior to this, between 2004 and 2006 he was assessed on five occasions. These assessments all identified his propensity for violence, his history of carrying a weapon and his criminal charges. They also identified that his risk of relapse and that alcohol often precipitated violent outbursts when unwell. Despite it being predictable that in the future P may be violent, there was no indication that P had ever threatened or attempted to kill somebody. Therefore this investigation believes that the killing of G was not predictable.

4.43 P was not risk assessed as he should have been prior to transfer to Abacus House. Had this happened there may have been a change to the plan. Whilst this most likely would have led to a delay rather than a significant change of plan, it is likely this would

[12] http://dictionary.reference.com/browse/predictability

[13] Munro E, Rumgay J. *Role of risk assessment in reducing homicides by people with mental illness.* The British Journal of Psychiatry (2000)176: 116-120

not have significantly altered events. P was recently bereaved. He was not well despite being taken off section 3. But we acknowledge there was no anticipation that P could ever kill somebody, and given his outward demeanour when seen by the CPN hours before the incident there was no indication that he had become so unwell as to be such a danger to other people.

This investigation therefore concludes that the incident was not preventable.

5. THE TRUST INTERNAL INVESTIGATION

5.1 In this section we examine whether the Trust's investigation into the care and treatment of P met its requirements.

5.2 The NPSA's good practice guidance states that in the event of a homicide the trust must carry out an investigation to establish a chronology and identify underlying causes and any further action that needs to be taken.[14] The Trust commenced its internal investigation, a desk top review of all documents, immediately after the incident in August 2007. The police did not permit interviews for fear of compromising the criminal investigation. The investigation was undertaken by a Consultant Psychiatrist, together with a Senior Service Manager in the Trust, neither of whom had been involved in providing care and treatment to P. Their report was submitted to the Trust in April 2008.

5.3 **Comment**

The Memorandum of Understanding between the Association of Chief Police Officers and the Department of Health (the MoU)[15] is intended to promote collaboration between agencies, and to allow each agency to undertake it duties to promote safety. The guidelines supporting the MoU state that *"the primary concern of all agencies is that of public safety. While there is nothing in law that says the police's duty to investigate ranks higher than the NHS's duty to ensure patient safety, interference with a police investigation could undermine potential legal proceedings. However, where the NHS considers its own investigation to be particularly important, it should not be slow to challenge any decisions or requests by the police that an investigation should not be undertaken by the NHS*".[16]

The investigation team acknowledge that the incident was in 2007. We understand the Trust now has a much more robust approach to managing internal investigations

[14] National Patient Safety Agency *(2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

[15] *Memorandum of Understanding: Investigating Patient Safety Incidents Involving Unexpected Death or Serious Untoward Harm*
A Protocol for Liaison and Effective Communications between the National Health Service, Association of Chief Police Officers and Health and Safety Executive.
http://webarchive.nationalarchives.gov.uk/20130107105354/http://dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4129919.pdf

[16] Department of Health. "*Guidelines for the NHS: In Support of the Memorandum of Understanding - Investigating Patient Safety Incidents Involving Unexpected Death or Serious Untoward Harm*
http://webarchive.nationalarchives.gov.uk/20130107105354/http://dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_063043.pdf

where there is police involvement that is fully supportive of the MoU.

5.4 On conclusion of the criminal proceedings against P, the Crown Prosecution Service, the Health & Safety Executive, the police and Bedfordshire Local Authority initiated further investigations into possible breaches of Health & Safety legislation by the parties involved in the care of P. At that time the police made it clear that the Trust was not permitted to pursue and complete its internal Panel Review, as required by prudent governance and what was then the Strategic Health Authority (SHA) at the time.

5.5 Eventually the Trust was permitted to commence its more detailed internal investigation within certain parameters. Since it was still unable to interview witnesses the internal review was suspended until the outcome of any prosecution of the Trust was known. The Trust was charged with a breach of Health & Safety legislation and fined in July 2012. The Trust then completed its internal investigation though five years had passed since the incident. At the same time, the Trust initiated an independent review of care placement procedures.

5.6 The Trust internal investigation is an extensive document, 94 pages long. The Trust convened an investigation panel consisting of:

- Trust Non-Executive Director (as Panel Chair)
- Nurse Consultant
- Executive Director of Quality & Safety
- Consultant Psychiatrist
- Head of Practice Governance
- An independent consultant as report author

5.7 The Trust involved P's family in the investigation and interviewed P. They were advised against contacting the family of G because of the possibility of litigation.

5.8 **Comment**

Best practice guidance now advises that NHS organisations communicate discuss openly with victims of serious incidents in healthcare.[17] This guidance states that being open about what happened and discussing incidents promptly, fully and compassionately can help families to cope better with the after effects and reduce claims and litigation. The guidance states that '*It is important to remember that saying sorry is not an admission of liability and is the right thing to do'*.

There is a new culture within the NHS and a statutory duty on organisations to operate a duty of candour. The Trust policy has changed significantly since 2007 and the Trust now has new policy and guidance "*Learning from Incidents; Reporting, Managing and Investigating*" and "*Being Open*" which stresses the importance of engaging openly and honestly with families where there has been a serious incident.

[17] National Patient Safety Agency. *Being Open Framework: Communicating Patient Safety Incidents with Patients, Their Families and Carers*. http://www.nrls.npsa.nhs.uk/easysiteweb/getresource.axd?assetid=65172&type=full&servicetype=attachment

5.9 The internal investigation reviewed a significant amount of documentation and interviewed nine staff, including the Care Coordinator, CPN who last saw P and the Consultant Psychiatrists responsible for P in 75 Hill End Lane and also Albany Lodge.

5.10 The outcome of both the internal investigation and the independent review of care placement procedures led to a comprehensive and wide ranging action plan. The following section reviews the progress the Trust has made in implementing these changes.

6. ACTION PLANS AND CHANGES MADE

6.1 The internal investigation of the incident made ten recommendations and the independent review of care placement procedures made 22 recommendations to improve practice, safety and governance. These both resulted in extensive action plans with significant Board ownership and oversight of implementation. These recommendations are included in the appendices.

6.2 From interviews we have noted how seriously the Trust took, and still takes, this incident. One of our interviewees pointed out that the P investigation permeated everything the Trust did in some way, and we found evidence of ongoing commitment to change.

6.3 Our judgement on the implementation of actions and changes made is based on a series of probing interviews with key Trust staff (including 2 executive Directors responsible for quality and safety and the Trust Head of Practice Governance) and the rigorous scrutiny and analysis of documents. The documents were all assessed for evidence of completion of actions, 'follow through' from previous minutes or triangulation with the points raised at interview. The documents reviewed included:[18]

- Policies on Bed Management, Clinical Risk, Learning Lessons and Safeguarding Adults
- Reports to Integrated Governance Committee on Bed Management and Care Placement (January 2013, October 2013 and July 2014)
- Audit Committee reports
- Report on Clinical Effectiveness to Audit Committee
- Integrated Governance Committee minutes and agenda for February, April, and November 2014
- Quality & Risk Management Committee minutes
- Trust Risk Log
- Trust Risk Register
- Quality & Risk Reports for October 2013 and April 2014 which detail evidence of implementation of actions (through audit), changes made and lessons learnt.

[18] For a comprehensive list of all documents reviewed please see Appendix C: references, bibliography and documents reviewed

Notable good practice

6.4 Considerable change has happened in the organisation since the incident. Key elements of notable good practice that stand out, building on the recommendations, include:

- policy template with clear **Rules** (internally agreed things that must be done) and **Standards** (national standards that must be followed);
- carer practice policy;
- risk register that contains all risks to the Trust, including risks to quality of clinical care, linked to CQC standards, that is regularly reviewed;
- learning lessons policy to share and embed learning following incidents;
- regular audit of pre-placement checks;
- ongoing development of Bed Management and Placement Team to provide a central focus for managing secondary commissioning of care;
- recruitment of contracts manager for secondary commissioning;
- development of formal commissioning and contracting functions
- the Bed Management & Placement Team undertakes quality based due diligence assessments of placements
- successful bid for Health Foundation money to lead the Safer Care Pathways in Mental Health project for the East of England;
- development of an internal Business Intelligence System to help the Trust and managers track quality performance;
- Secondary Commissioning / Bed Placement service remains on Trust risk register;
- renewed quality governance process and Integrated Governance Structure within the organisation to assure the organisation of quality;
- risk management panels including rehabilitation consultants, for staff to take difficult and complex cases to when concerned with care; and
- evidence of having acted and removed patients when concerned about the quality of a care provider.

6.5 The Trust routinely reviews progress against the action plans for this and all other Serious Incidents. The integrated governance structure provides a vehicle to capture and share learning whilst assuring the Trust of progress against the actions and recommendations

6.6 All the ten recommendations from the internal investigation have been implemented. The audit of clinical risk assessments is part of everyday practice monitoring, with oversight through performance reports, individual supervision, local clinical audits and the full use of a pre-discharge checklist completed by Care Coordinators for all service users who are going into placements. The Rehabilitation service review recommended further analysis and development of a business case for an increased in the capacity and availability of low secure rehabilitation beds. This is currently being dealt with and will be taken through the Service Innovation Board for approval. The Strategic Business Unit is working on a proposal to develop a Rehabilitation high dependency service in order to reduce the requirement and use of external providers.

Outstanding actions and further recommendations

6.7 The Trust has made progress against most of the recommendations from the independent review. However, there are some recommendations from the independent review that are not completed, and some the Trust has chosen not to pursue. At June 2014 progress was as follows:

- four recommendations have been completed;
- twelve recommendations remain in progress. Ten of these recommendations relate directly to the Placement Development Project;
- four recommendations have not been met and work is required to progress them. Three of these relate directly to the Placement Development Project; and
- two recommendations have not been taken forward by the Trust.

6.8 Since 2012 the Trust has been through massive and wholesale restructuring to provide more effective use of resources. This has not been without consequences since we have been told that the restructuring meant that many community staff took the opportunity to retire or 'vote with their feet'. This has left the Trust short of community staff and unable to progress two key recommendations – having sufficient skilled care coordinators and also sufficient Social Workers embedded within community teams.

6.9 **Comment**
Recruitment of key staff is a key risk to achievement of the recommendations, and quality overall. It will impact upon service capacity, and affect many other areas such as staff sickness, complaints, and incidents. The Trust has staffing as a risk on the risk register. However the score on the register we reviewed (dated 9 July 2014) was a score of 8. Given the evidence of widespread staff shortages and the reported difficulties in recruitment along with the obvious impact on quality the investigation wonders whether this risk score is in fact appropriate.

Recommendation 3.
The Trust should review the risk register thoroughly to assure itself that the identified risks, risk scores and therefore the mitigation are correct, with particular attention to risks where staffing and recruitment are the underlying factors.

6.10 The Trust has not been able to deliver Care Coordinator training. Whilst delivering training may not be the only way to achieve the same outcome of the recommendation (skilled and competent Care Coordinators), the Trust could seek alternative ways of commissioning the training (possibly through the Safer Care Pathways project or fellow organisations in the region) and also make efforts to assure itself that its Care Coordinators have the requisite defined skills set and experience.

Recommendation 4.
The Trust should assure itself that Care Coordinators have the necessary skills and qualities to deliver the requirements of the role.

6.11 The Trust has embedded routine audits of the pre-placement checklist to ensure that Care Coordinators are reviewing placements and risk assessing the patients before placement. However it has not been able to ensure that routine reviews of the placement take place after placement. Because of ongoing financial pressures on secondary commissioning budget the Bed Placement and Management Team have been tasked with reviewing the 'top 40' most expensive placements.

6.12 **Comment**

Whilst this is understandable, given the scale of the cost improvements required of the Trust and the potential overspend for the secondary commissioning budget, it could be perceived that finances were driving the review, and that quality was a secondary issue.

Recommendation 5.

The Trust needs to demonstrate that quality also drives the requirement to review placements, and should consider alternative quality based criteria for review of some placements, such as reviewing a suitable number of the placements furthest away, or the patients who have spent the longest time in a placement, or other criteria linked to quality.

6.13 Although the Board does receive a frequent report on the Care Placement procedures (three in the last year), this does not appear to be a routine report. Also these tend to be feedback of audit results for pre-placement checks and risk assessment completion. There were recommendations in the independent review around developing robust contract and financial management systems for the budget and service and development of a routine performance dashboard report for the Board. This hasn't happened yet, but with further service developments and the employment of the contracts manager there is an opportunity to rapidly achieve all these recommendations.

Recommendation 6.

The Trust should rapidly develop a robust and routine performance management system and Board report for the secondary care placement budget and Bed Management & Placement Team.

7. CONCLUSIONS

7.1 The Terms of Reference require that we conclude by considering if a similar incident/circumstances occurred today whether the current Trust policies and procedures prevent a similar placement and incident.

7.2 The killing of G and the stabbing of her colleague in Abacus House was an extremely tragic and traumatic event. No investigation can ever truly demonstrate the grief and loss the victims' families experience in these events.

7.3 However we hope it is some consolation that this incident and the subsequent prosecution of the Trust for a breach of the Health & Safety at Work Act has had an extremely significant impact on the organisation. We have heard that this incident, above all others, now permeates everything the Trust does and affects how many of its staff, and the Board, think about the delivery of all care.

7.4 The Trust internal investigation and the subsequent independent review have made wide sweeping recommendations. The Trust has implemented many of these and is addressing those few outstanding recommendations.

7.5 Given the scale of the changes, the impact the incident has had on the organisation and the continued vigilance and attention of the organisation we believe that it is extremely unlikely that this incident would happen now.

7.6 This independent investigation has made six recommendations for the Trust to address in order to further improve practice and governance.

Recommendation 1:
The Trust should complete its review of Rehabilitation Services within 3 months of the publication of this report, and be able to demonstrate a clear plan, agreed by commissioners, for providing increased local capacity based upon current needs assessment.

Recommendation 2

The Trust should assure itself that all staff are aware of what constitutes abuse, including unlawful detention, and are able to take appropriate actions to protect all vulnerable adults.

Recommendation 3.
The Trust should review the risk register thoroughly to assure itself that the identified risks, risk scores and therefore the mitigation are correct, with particular attention to risks where staffing and recruitment are the underlying factors.

Recommendation 4.
The Trust should assure itself that Care Coordinators have the necessary skills and qualities to deliver the requirements of the role.

Recommendation 5.
The Trust needs to demonstrate that quality also drives the requirement to review placements, and should consider alternative quality based criteria for review of some placements, such as reviewing a suitable number of the placements furthest away, or the patients who have spent the longest time in a placement, or other criteria linked to quality.

Recommendation 6.
The Trust should rapidly develop a robust and routine performance management system and Board report for the secondary care placement budget and Bed Management & Placement Team.

Appendix A: Terms of reference for the investigation

Independent investigations should increase public confidence in statutory mental health service providers. Unlike many independent investigations following serious incidents in mental health, because this tragic incident has been further followed by a prosecution under the Health and Safety at Work Act, and has therefore had both a significant internal investigation and an external investigation by the Health & Safety Executive, the focus of this investigation is to:

- Review the existing chronology of events leading up to the homicide.
- Review the care, treatment and services provided by the NHS for the service user's latter episode of care up to the time of their offence.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming themselves or others.
- Review the trust's internal investigation and other investigation recommendations and action plan.
- Consider if this incident was either predictable or preventable.
- Focus the investigation on the present day services and current processes.
- Review the progress that the trust has made in implementing the recommendations and the learning from their internal investigation and other investigations.
- Consider if a similar incident/circumstances occurred today would the current Trust policies and procedures prevent a similar placement
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations
- Provide a written report to NHS England that, if necessary, includes measurable and sustainable recommendations.
- Assist NHS England in undertaking a brief post investigation evaluation.

APPENDIX B: Terms of reference for the Trust internal investigation

The revised terms of reference agreed by the Executive Team in September 2012 were as follows.

Care and Treatment Provided to P

1. *The Review Panel will undertake a review of the clinical records, other documentary evidence and witness statements previously made by staff for the purpose of previous police and Health and Safety Executive investigations.*

2. *Consider any additional information or interviews with staff that are essential for the purpose of completing the review of the care and treatment of P, avoiding if possible any unnecessary duplication.*

3. *Provide an overview of the care and treatment provided to P from his first contact with mental health services.*

4. *Review in more detail the care and treatment provided to P during the last inpatient episode of care beginning 2 January 2007, with his admission to Albany Lodge, and the events leading to the death of Kathleen Bainbridge. This will include the services provided by the NHS, the Local Authority and other relevant agencies.*

5. *Compile a summary chronology of P's care from his first contact with mental health services followed by a detailed chronology of events during the six months leading up to the incident in August 2007 and establish the detailed facts relating to the incident itself.*

6. *Review the appropriateness of the treatment, care and supervision of P in the light of any identified health and social care needs. This exercise will include (but will not be restricted to) consideration of the following:*
    - Diagnosis
    - Medication
    - Assessment of decisions taken and their validity
    - Any cultural factors which affected the needs of the service user
    - Staff responses to P's concerns
    - Range of treatments/interventions considered
    - Social care

- Reliability of the case notes and other documentation

7. *Review the adequacy of risk assessments, including specifically the risk of P harming himself or others.*

8. *Comment on the adequacy of the communication between the various agencies involved with P.*

9. *Examine the effectiveness of the care plan for P including consideration of the extent of involvement of P and P's family.*

10. *Review and assess compliance with local policies (including the handling of complaints), national guidance and statutory obligations including the appropriate use of the Mental Health Act regarding admission, discharge and the granting of leave.*

Actions taken by the Trust following the incident

11. *Review actions and associated action plans put in place by the Trust since the incident and report on their implementation, progress and effectiveness to date.*

12. *Consider the findings and recommendations of the review of secondary commissioning undertaken by the Trust since the incident and its outcomes, in the context of systems in place at the time of the incident and currently in relation to social care placements.*

Other Relevant Issues

13. *Consider any other matters arising during the course of the investigation which are relevant to the occurrence of the incident or might prevent a recurrence*

The Report

14. *Provide a written report to the Trust and Commissioners that includes measurable and sustainable recommendations. The report should be completed by the end of January 2013 (subsequently amended to May 2013).*

Good Practice Guidance

15. *The above review will take place in accordance with Department of Health Guidance June 2005 and National Patient Safety Agency, Independent Investigation of Serious Patient Safety Incidents in Mental Health Services* ***Good Practice Guidance February 2008***

Appendix C: References, bibliography and documents reviewed

National Policy and literature

Department of Health, Association of Chief Police Officers and the Home Office. *"Memorandum of Understanding: Investigating Patient Safety Incidents Involving Unexpected Death or Serious Untoward Harm: A Protocol for Liaison and Effective Communications between the National Health Service, Association of Chief Police Officers and Health and Safety Executive"*. 2006

Department of Health. "*Guidelines for the NHS: In support of the Memorandum of Understanding - Investigating patient safety incidents involving unexpected death or serious untoward harm".* 2006

Department of Health HSG (94)27: "*Guidance on the Discharge of Mentally Disordered People and their Continuing Car*e", 1994, amended in 2005 by Department of Health; "*Independent Investigation of Adverse Events in Mental Health Services"*. 2005

Department of Health. *"Refocusing the Care Programme Approach Policy and Positive Practice Guidance"*. March 2008

Department of Health. *"Code of Practice; Mental Health Act 1983 (revised)".* 2008

Department of Health. "*Refocusing the Care Programme Approach: Policy and Positive Practice Guidance*". 2008

Home Office and Department of Health. *"No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse".* 2000

Mental Health Act (1983)

Munro, E; Rumgay, J. "Role of risk assessment in reducing homicides by people with mental illness". The British Journal of Psychiatry (2000)176: 116-120

National Patient Safety Agency. "*Independent Investigations of Serious Patient Safety Incidents in Mental Health".* 2008

National Patient Safety Agency; "*Root Cause Analysis Investigation Tools: Investigation interview guidance"* 2008

National Patient Safety Agency; "*RCA Investigation: Evaluation, checklist, tracking and learning log".* 2008

National Patient Safety Agency; "*Being Open".* 2004 (Updated Nov 2009)

National Patient Safety Agency, *"Independent Investigations of Serious Patient Safety Incidents in Mental Health"*. 2008

Current Policies
Bed Management Secondary Commissioning Policy
Carer Practice Policy
Clinical Risk Policy
Continuing Care and Placement Team Operational Policy Draft (V1)
Learning from Incidents Policy
Social Care Funded Placements Policy
Hertfordshire Safeguarding Adults from Abuse Procedure April 2011 Issue 5

Old Policies
Bed Management within Mental Health Services for Older People Oct 2004
Bed Management Policy V1 March 2008 Review Date Extended July 2009
Bed Management Policy Adult Mental Health Acute In-Patient Beds V2 Nov 05
Bed Management Policy Nov 09 V2.1
CPA and Care Management V 3 Oct 2004
Care Coordination Policy V4.4
Clinical Risk Assessment and Management for Individual Service Users V4 2005 Oct
Integrated Care Programme Approach and Care Management Policy V4july 2007
Hertfordshire Safeguarding Adults from Abuse Procedure June 2007 Issue 4

Minutes, agenda and other documents
Bed Placement Service Report Integrated Governance Committee 5 February 2013
Board Report on Care Placement January 2013
Board Report on Care Placement July 2014
Board Report on Care Placement October 2013
Clinical Effectiveness Programme 2014/2015 Mid-Year Report for Audit Committee September 2014
Copy of West Herts Strategic Business Unit Risk Register 29 09 2014
Draft minutes of Quality and Risk Management Meeting 2 October 2013
Draft minutes of Quality and Risk Management Meeting 3 April 2014
Integrated Governance Committee Agenda 9 July 2014
Integrated Governance and Risk Management Structure
Integrated Governance Committee Agenda 5 February 2014
Integrated Governance Committee 20 November Final Minutes
Integrated Governance Committee 30 April 2014 Final Minutes
Integrated Governance Committee 5 Feb 2014 Final Minutes
Integrated Governance Committee Action Plan Report 9 July 2014 Final
Integrated Governance Committee Agenda 30 April 2014
Intellectual Property Agreement HPFT Final Draft 8 October 2014
Integrated Governance Committee Placement Report October 14
Options Appraisal for High Dependency Rehabilitation to Transformation Board
Performance Report Board Final Q4 2013/ 2014
Placements Steering Group Minutes 11 September 2014
Project Board Agenda 17 October 2014
Project Board Minutes 16July 2014
Quality & Risk Management Committee Minutes 2 October 2013
Quality Impact Assessment Form June 14
Quality Visit Report Q2 July Sept 14
Risk Log and Timetable 17 October 2014
Risk Log Revised 8 October 2014
Risk Management Panel Guidance
Secondary Commissioning Feasibility Study Oct 2014 V3

Trust Risk Register July 2014
West Herts Strategic Business Unit Quality and Risk Report Oct 2013
West Herts Strategic Business Unit Quality and Risk Report April 2014

Safer Care Pathways in Mental Health Project information
Eastern Academic Health Science Network “Plan on a Page”
Letter to XXXX, Health Foundation, 8 August 2014
Health Foundation Safer Care Pathways in Mental Health Project Risk Log
Safer Care Pathways in Mental Health Outline Project Timetable Revised 8 October 2014
Safer Care Pathways in Mental Health Patient Safety Champion Role Information 29 September 2014
Project Update for Board 17 October 2014

Clinical Notes and records
Clinical Notes for P from 2007

Investigation and action plans
Report of the internal review of the care and treatment of service user P from December 2006 and the events leading to the death of care worker G on the 24th August 2007
Action Plan P CCG Amendments 26 September 2013
Review of Progress: Mental Health Strategies Recommendations

APPENDIX D: Trust internal investigation action plan

Recommendation 1
The Review Panel is very conscious that this incident occurred over five years ago, since when many changes have occurred in the Trust and in the statutory and national policy framework within which the Trust now operates. As would be expected, most of the actions arising directly from the event have been carried out a long time ago. Thus the recommendations now focus on ensuring that all that needs to be done has been done to ensure such an incident does not happen again.

Recommendation 2
The Trust should demonstrate that all service users moving into a funded placement in the community have a risk assessment during the forty-eight hours before the placement begins.

Recommendation 3
The Trust should demonstrate that risk assessments are accurate and thorough, envisaging the scenario when the individual service user begins this particular placement.

Recommendation 4
The Trust should initiate a regular audit of pre-discharge risk assessments, to provide assurance that the forty-eight hour pre-discharge standard is being met consistently.

Recommendation 5
The Trust should demonstrate that the placement check list, which has been introduced since these events, is completed in all cases – thus evidencing that the roles of the care co-ordinator and placement service are clearly understood and that the placement is carefully assessed as suitable for the individual.

Recommendation 6
The Trust should ensure that the review of the placement service is fully implemented by 1st October 2013.

Recommendation 7
The Trust should review the availability of non-forensic, low secure rehabilitation beds to ensure they are sufficient to meet local needs.

Recommendation 8
The Trust should provide guidance to clinicians and clarify the circumstances in which a case review or second opinion is sought in the management of complex cases that may, in addition, have a long history of care within the Trust. Case review may be via peer review, CPA review or other appropriate process.

Recommendation 9
The policies and strategies within the Trust related to the involvement of Carers should be reviewed in the light of this case and the experience of P's brother as a 'carer'. Guidance should be strengthened to assist staff in engaging with concerned or significant others, who may not always meet the strict definition of a carer, but are concerned for, or supportive of the wellbeing of the service user. Such guidance should help staff achieve a balance between engaging with the carer whilst not compromising their duty of confidentiality towards the service user.

Recommendation 10
The Trust's new electronic patient record, PARIS, which is replacing CareNotes in the Trust during 2013/2014 does not allow unconfirmed entries to be made, which occurred in P's episode of care. The unconfirmed entries identified in this report indicate the need to strengthen the importance of timely and, where practicable, the contemporaneous entry of records. Staff training in record keeping and particularly in preparation for using PARIS must emphasise the importance of making clinical entries to the record as soon after the intervention as is practically possible for the health and social care practitioners across the Trust.

APPENDIX E: Independent review of care placements and procedures recommendations

People

1. The Trust should assure itself it has sufficient skilled Care Co-ordinators to carry out the required functions of Care Coordination within its Community Mental Health Teams. This should include modelling the functions against the demands being placed upon Care Co-ordinators.

2. The Trust should assure itself it has sufficient Social Workers within Community Mental Health Teams so that service users and other staff have adequate access to social work expertise to help navigate through the social care and personalisation agenda, and so that the local authority recognises that robust attention is being placed on delivering the new social care agenda, and social care is not simply seen as an alternative funding source for aftercare.

Process

3. The Trust should develop an enhanced Bed Management & Placement Service, to provide access to support and resources to guide Care Co-ordinators through the application process, including screening of paperwork for 'completeness' prior to referral and consistency of the application of FACS criteria, and advising Care Co-ordinators on the availability and suitability of placements.

4. The Trust should ensure all Care Co-ordinators are trained in the key aspects of their role, with full consideration of the statutory requirements under S47 of the NHS & Community Care Act.

5. All Care Co-ordinators making a referral for health or social care funding should attend the panel to request the funding and be available for questioning by the panel.

6. Referrals should include an application for a fully worked up care package, with a thorough assessment of need and current risk assessment, and clear evidence as to why the placement has been considered, alternatives and prior experience in other care settings. Referrals must include the intended benefit intended and demonstrate consideration of needs, rather than a general request for help, and also document consultation with the service user and their family/ carers.

7. The separation of social care and health funded panels has not reduced expenditure, and in some cases increases it by delaying discharge. The Trust should return to a single, joint Placement Panel. The role and responsibility for this panel should be to provide assurance to the Trust Board (and commissioners) that:

    - all placements have been made with robust scrutiny of the referral by a suitably skilled and informed panel membership

- the referral has been based on a thorough assessment of need and consideration of the suitability of the placement to meet the needs
- the placement meets the Trusts minimum standards of quality, informed by a robust contract and quality review process, including CQC inspection

8. This panel needs to be supported by a service which has an understanding of the quality, suitability and availability of resources and placement to meet individual needs. This should include understanding of the specialist skills and qualities of each resource, recent contract and quality reviews, and the availability of spaces. This should be undertaken by an enhanced Bed Management & Placement Service.

9. The Trust should design new documentation which more properly assesses need for further treatment and rehabilitation, and stops using the current assessment (NHS Checklist and NOA) documentation for referral to other hospitals for treatment.

10. For longer term, out of area placements, there is a need for a Trust service to case manage the care, drive and attend the CPA review process in the placement, and oversee the contracts and quality reviews of service provision in an active process. Where the patient is unlikely to return to Hertfordshire for some years, this should be a function of the Bed Management and Placement Service.

11. For shorter term placements and placements within Hertfordshire, the Trust must ensure local Care Co-ordinators, Responsible Clinicians and other members of CMHTs retain involvement and attend CPA review meetings. The Trust should develop a protocol to establish how long local Care Co-ordinators, clinicians and teams should retain involvement, and at what anticipated period or circumstance they should hand over case management functions to the Bed Management and Placement Service.

Policy

12. The Trust should clarify how disputes over funding sources and decisions on joint funding for after care are escalated, managed and resolved with particular regard to Section 117 aftercare.

Performance

13. The Trust should audit at least twice a year, all referrals for placement in supported living, residential care, nursing care and other hospitals for completion of up to date Risk Assessments prior to transfer to the new service from HPFT, whether family members and the service user were consulted in the placement process, and to assess if and when placements have their care needs assessed within the timescale agreed at panel. This should be reported to services and the Trust board.

14. There should be a twice yearly audit of people placed in care homes and other care treatment services, to assess whether they have a recent Risk Assessment and CPA Review (in the last 6 months), and if family and carers have been contacted to receive their views on the suitability and quality of the placement.

15. Assessing risk and care needs is a core function of all Care Co-ordinators and Responsible Clinicians. The Trust should assure themselves it is part of the team case management system and staff appraisal system.

16. All placements must be reviewed in line with policy (initially within first 7 days, then within 6 weeks) and then at 6 monthly intervals as a minimum. Care Co-ordinators must consider not just whether the placement is able to meet the patient/ service user needs, but what would be required to increase the person's independence, how this could be delivered and if necessary/ appropriate how the service user could be returned to Hertfordshire.

17. The Bed Management & Placement and Service Team Leaders should be custodians of an information system to record the dates of reviews, and remind Care Co-ordinators when the next review is due.

18. Team Managers, Service managers and the Panel members should receive a monthly 'at a glance dashboard' of placements and run rates/ projected costs of all placements to support the monitoring and placement decisions, including anticipated discharge dates by month.

19. Current financial management and reporting systems are not fit for the purpose of robust commissioning and performance management of the care placement process and the Trust needs develop new robust systems and metrics.

20. The Trust Board needs to develop a distinct aggregated Board Performance report for all care placements, including the quality of services commissioned alongside the number of placements and financial costs.

Procurement

21. As an urgent priority, the Trust needs to demonstrate it has carried out the full function of commissioning all services (health & social care) as if it were the primary commissioner. This should include: Needs assessment, market assessment of provision, procurement and development of framework contracts, quality and performance metrics, and contract and performance reviews. There needs to be sufficient resource available to undertake these tasks, and a regular contract monitoring and review process built in which informs the services, Bed Management & Placement Service and the Trust Board of the capacity and quality of local provision (and also out of area treatment places), and this should assist the Trust in proactively developing a market and range of provision rather than being a passive and reactive recipient of other organisations activities.

22. The Trust needs to develop procurement, contracting and invoice validation capacity to ensure that services invoiced are services required. This must provide strong linkages between the finance department, Bed Management & Placement Service and Community Teams.