Report of the Independent Inquiry into the Care and Treatment of Patient A

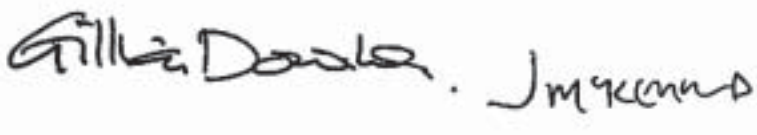
A report commissioned by
Gedling Primary Care Trust, Nottingham

Published November 2005

PREFACE

We were commissioned by Nottingham Health Authority and subsequently by Gedling Primary Care Trust to undertake this Inquiry.

We now present our report, having followed the terms of reference and the procedure which was issued to all witnesses and their representatives.



GILLIAN DOWNHAM
Barrister

JOHN McKENNA
Consultant Forensic Psychiatrist

MOHAMMED JAMIL
Social Worker

ANTHONY DEERY
Registered Mental Nurse
& Senior Manager NHS

ROBERT SOUTHERN
Registered Mental Nurse
& Director of Mental Health
Service Development Consultancy

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Patient A's eldest sister, wife of the homicide victim, who gave evidence on behalf of herself and her family, for her co-operation and forbearance in a process which will have been painful and difficult.

Members of the close family who are now in Pakistan or who found it too difficult to give evidence - they have been the silent witnesses of whom we have been aware throughout the Inquiry process.

All family and friends of the homicide victim who have suffered the trauma of this tragic homicide, for their patience through the long wait for this report.

Professional witnesses who willingly and patiently gave of their time, co-operation and recollections. Such investigations are always stressful.

Staff of AWAAZ and the Zindagi Project, who gave us helpful background information on services for Asian users of mental health services in Nottingham.

Professor Kamlesh Patel OBE, Head of the Centre for Ethnicity and Health at the University of Central Lancashire, National Director of the Department of Health Black and Ethnic Minority Mental Health Programme, Chair of the Department of Health Black and Ethnic Minority Mental Health Programme Board, Chair of the Mental Health Act Commission, Commissioner of the Healthcare Commission and co-author of *Engaging and Changing,* for his expertise and sound advice on the subject of policy development, culture and diversity.

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Lynne Winstanley, Lynn Robinson, Kath Anderson and Gill Blain from Gedling PCT, for providing the link between the Inquiry and the Commissioning body.

The Chief Executive of Nottinghamshire Healthcare NHS Trust, the Director of Social Services, Nottingham City, representatives of Nottinghamshire Probation Service and the Homicide Unit, Nottinghamshire Police and the Clinical Lead, Trent Strategic Health Authority, for their assistance at the final stage of drafting, ensuring that our Inquiry recommendations are directed to the appropriate bodies.

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Chapter 1

Background to the Inquiry

1.1 Introduction

1.1.1 On 27 July 2001 Nottingham Crown Court sentenced Patient A, following his plea of guilty on the grounds of diminished responsibility, for the manslaughter of his brother in law on 29 December 2000. The homicide victim was his wife's brother and his sister's husband. Patient A was made subject to a hospital order under s37 of the Mental Health Act 1983 and a Home Office restriction under s41 of the same Act.

1.1.2 Upon his arrest for the offence Patient A was initially kept in Police custody and then held on remand at HMP Nottingham hospital wing. On 15 February 2001 he was transferred to Arnold Lodge Regional Secure Unit in Leicestershire under s48/49 of the Mental Health Act (MHA), and remained there following the hospital order made by the Court.

1.1.3 Patient A had been in receipt of mental health services during a period of only 24 hours prior to the homicide. Nottingham Health Authority commissioned this Independent Inquiry to examine the care and treatment Patient A received in order to learn lessons from the history and improve services.

1.1.4 Health Circular HSG (94)27 at the time required that an independent inquiry be held where an individual had been in receipt of psychiatric services prior to a homicide. In June 2005 the Department of Health issued new guidance. This now replaces the relevant paragraphs of HSG (94)27 with criteria which require that an independent investigation take place when a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.

1.1.5 In this case there had been two separate and unconnected homicides in the same month within the same Trust in Nottingham. The Inquiry was asked to examine the care and treatment of both men because it was envisaged that there might be features in common concerning the provision of mental health services in Nottingham. It was considered that these would receive greater emphasis from combining the two investigations, with findings and recommendations contained in one report. Management of the two inquiries together also had costs benefits.

1.1.6 In the event, each inquiry involved a very different set of circumstances and a decision was made, after hearing the bulk of the evidence together, that the two inquiry reports should be published separately. This report follows the publication last year of the Independent Inquiry report into the Care and Treatment of Mr Sarwat Al-Assaf.

1.2 The Inquiry Process

1.2.1 The Inquiry team was appointed by Nottingham Health Authority in October 2001. Some delay arose out of Patient A's initial refusal to give consent to release

of his confidential documents. Counsel's advice was sought by the Health Authority but in the event Patient A gave his permission for the Inquiry to use his confidential material on 27 June 2002.

1.2.2 At the same time changes in the structure of local health services meant that the original commissioning body, Nottingham Health Authority, ceased to exist and for a while the Inquiry was in limbo. Delay also arose because of the unavoidable withdrawal through serious illness of the medical member of the panel. A replacement had to be appointed and we also chose to appoint an additional panel member in order to provide essential support on ethnicity issues.

1.2.3 By September 2002 Gedling Primary Care Trust (PCT) had become the commissioning body, the Inquiry panel and clerical support were in a position to proceed and the consent of both men had been obtained. Over the next five months confidential documentation concerning both individuals was obtained, written evidence sought and witness statements received. Terms of Reference and Procedure for the Inquiry are at Appendices A & B.

1.2.4 Written evidence concerning the care and treatment of Patient A was received from 22 individuals and we heard oral evidence from 28 people. Most of this was heard over a period of 13 days between 3 March and 9 April 2003. Evidence was heard from AWAAZ and the Zindagi Project on 22 July 2003 and 2 September 2003, and from more professional witnesses on 1 December 2004 and 17 December 2004. Some witnesses who had not originally agreed to give evidence did so eventually. Witnesses are listed at Appendix C.

1.2.5 One nurse declined to give any evidence or written comment to the Inquiry although he was provided with a draft extract of the report as it concerned him. Fortunately we have been able to use the retrospective notes he made the day after the homicide and his Police statement for the criminal proceedings.

1.2.6 We record our grateful thanks to family witnesses. Some members of the family felt unable to give evidence or were in Pakistan. We have decided to not to name those who did not give evidence. We recognise that this process has been lengthy and unsettling for all relatives, who need to feel that the matter reaches a conclusion.

1.2.7 We are thankful to all the professional witnesses who gave so willingly of their time. For some this will be the second inquiry report and therefore a very protracted process. Our thanks go to them for their tolerance under these circumstances.

1.2.8 Our condolences go to the family of the Consultant Psychiatrist who was Patient A's Responsible Medical Officer (RMO) prior to the homicide and who sadly died before this report was published.

1.2.9 We are grateful to Professor Kamlesh Patel OBE, Head of the Centre for Ethnicity and Health at the University of Central Lancashire, National Director of the Department of Health Black and Ethnic Minority Mental Health Programme, Chair of the Department of Health Black and Ethnic Minority Mental Health Programme Board, Chair of the Mental Health Act Commission and

Commissioner of the Healthcare Commission, who was able to offer his expert advice to us on matters of ethnicity and policy in mental health services.

1.2.10 In the latter stages of drafting this report the present Trust, Nottingham City Social Services, Nottinghamshire Probation Service and Nottinghamshire Police provided us with helpful information on current services, thus ensuring that our recommendations are up-to-date and directed towards the appropriate organisations.

1.2.11 We have asked the commissioning body to ensure that counselling and support is available to the family. It is inevitable that publication of the report will revive painful memories. The Inquiry Panel offers its condolences to all the family of the deceased both here and in Pakistan. We have been assured that the report will available in English and Urdu on Gedling Primary Care Trust's website.

1.2.12 The Inquiry has been asked to anonymise this report in its entirety as far as all witnesses of fact are concerned.

1.3 Summary

1.3.1 Patient A was born and grew up in Nottingham, although he also spent considerable amounts of time with his family in Pakistan. Over a period of about two years in his late teens he began to develop what was later realised to be a psychotic disorder. Uncharacteristically he assaulted a member of the public and was made subject to a Probation Order. Patient A's young wife and their baby, aged seven months, arrived in Nottingham at the beginning of December 2000. She was 17 and he was 19 at the time. The family became increasingly fearful of Patient A, finding him aggressive and threatening in the home. When they discovered him in possession of a knife on 28 December 2000 they sought help from Probation and Police. Patient A was seen by his GP and admitted to the Queen's Medical Centre (QMC) in Nottingham; firstly to the Accident and Emergency Department (AED) and, following his detention under s2 MHA 1983 later that night, to Ward A42 - a psychiatric ward on the QMC site - where he remained subject to nursing observation every ten minutes. The following day he was visited by his family and also by two friends. Patient A left the ward with his friends, parted from them and went on to kill his wife's brother who was also his sister's husband.

1.3.2 We find that although it could not have been predicted that Patient A would kill his brother in law, it was foreseeable from the history that if he left the hospital he might harm someone. It was less than 24 hours after he had been diagnosed with a first onset psychosis, he was acutely ill and had not yet been comprehensively assessed. This homicide could have been prevented by ensuring Patient A remained in hospital. We conclude that there was a failure to keep Patient A on the ward where he should have been detained.

1.3.3 Our task is not to apportion blame but to establish how, in a complex organisation designed to care for mentally ill individuals, this came to happen. This is a wide-ranging report. We find that there were fault-lines at different levels of the structure, which came together on that day permitting Patient A the opportunity to walk out of hospital and carry out the homicide.

1.3.4 As with many other mental health investigations of both homicide and suicide, there was a question over the degree to which the family's concerns had been heard. However, here there was an added component. Some of Patient A's family spoke no English, and there were a number of carers in this complex family. In order to ensure equal access to mental health services for this British-South Asian family, a special effort needed to be made to listen. We find that this did not always happen.

1.3.5 Most striking of all is that Patient A was not unusual amongst individuals admitted to psychiatric hospital. As with many others, the MHA was relied upon to ensure that he received the care he needed. Detention under the MHA has been described as the most serious interference with human rights available to the State under civil powers[1]. It should provide complete and effective control over a patient's care and movements.[2]

1.3.6 This report outlines a number of ways in which Patient A's detention under the Act did not provide him with protection from the consequences of his mental illness. It is the main theme of this Inquiry. It will be repeated throughout.

1.3.7 During a reading of this report it should be remembered that there has been a reconfiguration of NHS organisations since the homicide. Whereas in December 2000 Ward A42 at the Queens Medical Centre was managed by the Nottingham Healthcare NHS Trust, following a review of mental health and learning disability services in Nottinghamshire a new Trust - Nottinghamshire Healthcare NHS Trust - was formed in April 2001. For the purposes of differentiation when it is not clear from the text, the Nottingham Healthcare NHS Trust is referred to as 'The Trust' and the Nottinghamshire Healthcare NHS Trust is referred to as 'the present Trust'.

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[1] Mental Health Act Commission Tenth Biennial Report 2001-2003 *Placed amongst strangers; Twenty years of the Mental Health Act 1983 and future prospects for psychiatric compulsion;* TSO 2003. The full quote from paragraph 1.3 page 23 is *"The removal of a mentally disordered person who is in crisis from their situation to a place of care and treatment is no doubt frequently necessary, and often the most beneficent act possible, but it is nevertheless the most serious interference with human rights available to the State under civil powers."*

[2] *Case of HL v United Kingdom* European Court of Human Rights, Application No. 45508/99, 5 October 2004. This Court decided that HL was in fact detained even though not detained under the Mental Health Act because *"the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements…….the concrete situation was that the applicant was under continuous supervision and control and was not free to leave".* (paragraph 91).

Chapter 2

The History

2.1 Understanding the history

2.1.1 Our investigation will reveal that the homicide occurred whilst Patient A was suffering from an acute psychotic illness.

2.1.2 Patient A's family have criticised services for failing to detect his mental illness earlier and to hear their growing fears for their safety. We trace the history leading up to the eventual diagnosis the day before the killing, and take into account the need for this family to feel heard now.

2.2 Family Background

2.2.1 Patient A was born in Nottingham on 1 June 1979. One of four children, he grew up in Nottingham but spent a considerable amount of his life in Pakistan, travelling there on approximately five occasions and marrying in Pakistan when in his late teens.

2.2.2 Patient A's parents come from Kotli, a rural district of Azad Kashmir in Pakistan. Many of the family continue to live there. There is no known family history of mental disorder.

2.2.3 Patient A's father lived in the UK for 30 years, dying here in his eighties, after more than a decade in residential care. His marriage to Patient A's mother was his third marriage, his first wife having died and his second marriage having ended in divorce.

2.2.4 Patient A's immediate family stayed close to each other both physically and emotionally. When the daughters married they stayed in Nottingham, moving to live near their mother and supporting her. Patient A's mother speaks the family language, Mirpuri, which is a dialect of Punjabi, but has very limited spoken English.

2.2.5 Patient A stayed in close touch with his mother and his three sisters. The eldest took on responsibilities as family head when their father was in residential care. An able, articulate and educated woman, she represented the family's views to this Inquiry.

2.3 Family structure

2.3.1 The family structure is complex but an understanding of it is necessary in order to grasp the connection between Patient A and the victim of the homicide.

2.3.2 There are two families connected with each other through two half-sisters who married into each family. Each half-sister bore a son and a daughter. Each son and daughter married their first cousin from the other family.

2.3.3 Patient A's eldest sister was married the victim of the homicide, whose sister was married to Patient A.

2.3.4 Patient A's brother in law ran a busy local grocery in Nottingham. We heard he was a popular local figure. He and his wife, Patient A's eldest sister, had three children. It appears to have been a happy and stable marriage.

2.3.5 Within the family Patient A's brother in law was referred to as Bhapa – meaning elder brother. We heard that he treated Patient A like a son.

2.3.6 Patient A was married in Pakistan in 1999 and their child was born in Pakistan in May 2000. His wife first came to this country on 2 December 2000, only three weeks before the homicide. At that time she was 17 years old and her baby was aged 7 months. She spoke almost no English. She returned to Pakistan in May 2002 and now lives there.

2.4 Patient A up to the age of 18

2.4.1 Patient A went to school in Nottingham but often did not attend, choosing instead to spend time with friends. After leaving school aged 15 he spent six months in Pakistan with his family. There had been no disciplinary problems and he was at least average academically. He sat no exams and therefore gained no qualifications.

2.4.2 Attendance in Nottingham on a kit-car mechanics course was short-lived and he left after six months without completing it. His work record was erratic, with various semi-skilled and labouring jobs. For around a year he was a restaurant worker and shop assistant, working in the same shop as his future brother in law in West Bridgford. We heard that they got on reasonably well, though rarely spoke to each other.

2.4.3 Patient A appeared in Court in August 1998 charged with an offence of burglary. He was convicted and sentence was deferred for six months, but by that time Patient A was in Pakistan visiting his family.

2.5 1998 to October 1999: First signs of psychosis in Pakistan

2.5.1 Patient A told the Inquiry that it was during a period of about a year in Pakistan, when he was 18 to 19 years old, that he began hearing voices. He said they were constant and at the time he attributed them to family members, thinking they were natural. He believed that people knew what was happening to him because they could read his mind.

2.5.2 At first the voices spoke in Punjabi and he acted on them, following people, and at one point punching his uncle. His sister confirmed that he had become aggressive towards members of the family at this time.

2.5.3 Patient A recalled that whilst in Pakistan he had consulted someone in connection with these voices, though he could remember no details and did not know whether this person was a doctor. Although he now realises it was paranoia, he thought at the time that others might have been responsible for 'jadu' on him. This, we heard in evidence, is the word for black magic in Pakistan.

2.5.4 Patient A married at the age of 19 while staying in Pakistan with his future wife's family. This had been planned by his parents since he was very young. The marriage was not favoured by Patient A's eldest sister, who was very close to her brother and who felt concern at the possible effect on her own marriage if the relationship went badly.

2.5.5 Patient A returned to the UK three months after the wedding, leaving his wife there until legal arrangements could be made for her arrival. By that time she was pregnant.

Onset of psychosis
It appears that Patient A was probably suffering from symptoms of psychosis whilst in Pakistan. It is unclear what treatment he received there.

2.6 1999 to December 2000: Continued signs of psychosis in the UK

2.6.1 Patient A returned to the UK in October 1999 and lived with his mother and father. His wife joined him fourteen months later on 2 December 2000, when their daughter was aged 7 months.

2.6.2 The fourteen months before his wife arrived were marked by a number of difficulties and Patient A told us he experienced voices during the whole of that time.

2.6.3 In early 2000 his brother in law helped Patient A set up his own shop in Sandiacre, but this was not successful and it closed after two months. During that time, in March 2000, Patient A was convicted of the 1998 burglary and was fined £500.

2.6.4 In the same month he assaulted a store worker in an electrical retailer's shop in Nottingham following a dispute with the manager. In her Police statement after the homicide one of Patient A's younger sisters recalled "*I was about to leave when quite unexpectedly (my brother) punched the manager in the face with his fist*". Patient A told us that he was hearing voices at the time but could not remember what they said.

2.7 Probation Report

2.7.1 Patient A pleaded guilty to common assault in April 2000. A Probation Officer then interviewed him and prepared a report for the Court. Patient A's offending was thought to be related to the pressure he was under looking after his elderly parents and attempting to manage his new shop. The Probation Officer reported *"I consider that his offending was related to the stress he was experiencing at the time and his inability to cope with a difficult situation. He expressed much regret for his offending and seemed to appreciate that he must learn to manage and control his temper".*

2.7.2 The Probation Officer recalled that Patient A seemed to be rather withdrawn at the time. The Magistrates Court's sentence was one of 12 months Probation Order with a condition that he attend an anger management course called the Street Violence Programme.

2.8 Probation Order and Street Violence Programme

2.8.1 Weekly Probation appointments began and the Probation Officer worked with Patient A on *"managing his anger, frustrations and temper and I was trying to motivate him to see the benefits of attending the street violence course".* At this stage he was assessed as not representing a risk of serious harm either to himself or anyone else, being considered a low-risk offender in terms of re-offending and harm.

2.8.2 Nor was there any concern over his mental state. When he attended the Street Violence Programme sessions he reportedly sat very quietly and those running the course were not sure whether he was taking in any of the information. The Probation Officer had wondered whether his education was disrupted by his numerous visits to Pakistan.

2.9 Breach of the Probation Order

2.9.1 Patient A soon began to default from Probation appointments. He reported disagreements at home and in June 2000 left temporarily to stay at the YMCA, helped by his Probation Officer who put him in touch with a project worker from a community group called Reachout.

2.9.2 In August 2000 the Probation Service started breach proceedings, an automatic procedure because Patient A had attended only four out of six Street Violence Programme sessions.

2.9.3 In October 2000 Patient A appeared in the Magistrates' Court in connection with this breach and was given a chance to start re-attending on the street violence programme. This he did, and the Probation Service produced a positive recommendation for the Court in a report dated 2 November 2000.

2.10 Patient A's account of the year to December 2000

2.10.1 Patient A told the Inquiry panel that throughout the year after his return from Pakistan he had heard voices, which appeared to come from outside him. He had once chased someone to check this out, but not caught them. Voices sometimes told him what cassettes to listen to and he felt as if he was being watched. None of this was known to Probation or his family.

2.11 Family accounts of the year to December 2000

2.11.1 Giving evidence to the Inquiry Patient A's eldest sister recalled that during that same year Patient A's violence within the home had gradually grown. *"He would become verbally abusive, but then at times….he would tip into smashing pieces of furniture or slamming doors or kicking doors and punching, which was alarming, but we didn't know what the cause was for it."*

2.11.2 After the homicide one of Patient A's sisters told the Police:
"(My brother) often spoke of leaving home saying he wasn't happy…. he left home for approx 3 weeks … He never gave a specific reason …He returned home daily. He looked rough and would smell … After a while he clearly wanted to

return home. He spoke of taking an overdose and committing suicide……. He was very distressed when he moved back, crying uncontrollably and unable to speak."

Gradual onset of psychosis
It is not uncommon for the onset of psychotic disorders to be insidious and gradual so that the nature of the illness is not apparent to professionals and family in the early stages. Other, very plausible, explanations are often initially sought. With hindsight Patient A's increasing withdrawal, distress and difficulty coping were likely to have been associated with his developing mental illness.

2.12 Patient A's wife arrives in the UK

2.12.1 On 2 December 2000 Patient A's wife and their daughter aged 7 months arrived in the UK for the first time, coming to live with Patient A and his mother. By this time Patient A's father had suffered a stroke and been admitted from residential care to a nursing home.

2.12.2 Within a week or so, the date being unclear from the evidence, there was an incident in which Patient A reportedly hit his wife. One of his sisters told Police after the homicide that, following a telephone call from her mother she and another sister arrived at the house to find Patient A's wife crying and saying that he had hit her that day and the day before. Patient A's brother in law arrived shortly afterwards and, although accounts differ, it seems that Patient A was restrained quite forcibly by him, following which Patient A became upset and started crying. The Police were not called.

2.12.3 Still distressed, Patient A's wife was adamant that she would not remain in the house with her husband, and we were told that it was considered safest for her to stay with her brother and his wife (Patient A's eldest sister) until things improved.

2.12.4 Patient A's eldest sister told the Inquiry that it was when Patient A assaulted his wife that *"fear was then put into family members".*

2.13 Withdrawal of Probation Order Breach Proceedings

2.13.1 The Probation Officer told the Inquiry that on 11 December 2000 he discussed with Patient A his missed appointments and noted that his wife and child were in England.

2.13.2 On 20 December 2000 Patient A attended Nottingham Magistrate's Court where proceedings for breach of probation were withdrawn because he was, on the basis of Probation evidence dated 2 November 2000, then complying with the terms of the Probation Order.

Probation and the family

We note the marked discrepancy between Patient A's presentation as an offender within the criminal justice system and his behaviour at home. The Probation Service knew nothing of the family's anxieties. We were told that a Probation Order is an order of the Court intended to prevent re-offending and it would not have been routine for any contact to take place with the family. Indeed, in the absence of Patient A's consent it would have been a breach of confidentiality to make contact with the family. However, his consent for such contact was not sought although by that time Patient A had been described as withdrawn, under stress because of family pressures, and had been unhappy enough to leave home for a period.

2.14 Thursday 21 December 2000: Police attend at the house

2.14.1 We heard from Patient A's eldest sister that it was when Patient A's wife left to stay with her and her husband for a while that Patient A began to damage furniture and doors in the house, becoming violent towards his mother.

2.14.2 Patient A's wife returned and, feeling worried about the situation, Patient A's eldest sister told us she decided to speak to the Police, asking them to ensure that if they got a call from that address they should *"take it seriously and if it is somebody that they can't understand properly that's because she can't speak English and not to dismiss it".*

2.14.3 On 21 December 2000 Patient A's mother, who speaks almost no English, dialled '999' and called the Police. His eldest sister told the Inquiry what a huge step this was for her.

2.14.4 The Police Command and Control Log recorded *'caller can not speak much English – she is having a problem with her son – he is still on the premises'.*

2.14.5 A Chief Inspector from the Nottinghamshire Police Professional Standards Unit, giving evidence on behalf of the Police, informed us that two Police Officers (Police Officers A and B) attended at the house at the house at 13.02 hours. He could not tell us what information, if any, about Patient A's mother and wife's ability to speak English would have been known to the Officers prior to their visit.

2.14.6 He said that statements made by these Police Officers after the homicide reported that on arrival there had been *"no problems and that a sliding door had simply fallen off its runners".* Patient A, his wife and his mother were said to have been present at the time. The Police Officers spoke to Patient A who told them his mother was ill and in need of counselling. They judged that no crime had been committed, that this was therefore not a Police matter, and left. The visit lasted about 20 minutes.

2.14.7 In a written joint statement to the Inquiry, the Chief Inspector and a Detective Superintendent from Nottinghamshire Police stated on behalf of the Police that there was confusion for both control room operators and Officers over what had been going on at the house, adding *"it is not clear whether Patient A's [mother or wife], neither of whom speak fluent English, made any serious efforts to tell them".*

2.14.8 One of the Police Officers in attendance, Police Officer A, in written evidence given through her senior officers, informed the Inquiry that if a crime had occurred she would have obtained a statement using an interpreter if necessary. She added that she would not have accepted the story of one person if another person was clearly distressed, and would not leave anyone in a vulnerable position in need of her assistance without taking positive action. The other Police Officer in attendance, Police Officer B, gave written evidence that he would *"under no circumstances attend an incident of any nature and not take any steps to determine whether or not Police assistance is required".*

2.14.9 We heard that Police standing instructions did not explicitly require Officers to seek some form of interpreter. However, they would be expected to get a good understanding of what had happened. The Chief Inspector told us that there was no provision for an interpreter to attend a home visit with Police Officers, but a new system called 'Language Line' had just been introduced in 2000. This would have enabled Police Officers to telephone a number from the home and obtain a telephone interpreter. It would then have been a case of *"passing the receiver between ourselves and the person who we're speaking to".*

No use of Language Line interpreter

All the evidence we have received confirms that Patient A's wife and mother could speak virtually no English. The only English-speaking individual present at the Police visit was therefore Patient A. We have no reason to doubt the evidence of either Police Officer and we take into account that the situation may have calmed down by the time they arrived. However we now know that Patient A was mentally ill and had been, so we are told, damaging the furniture and threatening his mother. If the Officers had accessed the new Language Line facility from the home it seems probable that they would have heard an entirely different account from Patient A's wife and mother. We conclude that the Police Officers' understanding of the situation was limited by the absence of an independent interpreter and that as a result they did not obtain a full account from the complainant.

Recommendations 1.1, 1.2 and 1.3

2.15 Anonymous contact with Probation

2.15.1 By this time Patient A's eldest sister, who was at work, had been informed of events. Feeling dissatisfied with the situation she reasoned that since her brother was subject to a Probation Order his behaviour would amount to a breach of the order. Anonymously, and without identifying Patient A directly, she telephoned a Senior Probation Officer. The Senior Probation Officer told us "*…she said he'd assaulted his wife the previous Saturday and he was now causing trouble in the house, breaking items of furniture … the family had called the Police that day but her mother had not conveyed how serious the situation was and they had left. The caller went on to say he had threatened his mother and threatened to burn down the house and car".*

2.15.2 The Senior Probation Officer told us the information Patient A's sister gave was *"very articulate and very measured and I formed the impression this was clearly someone who was very concerned about what was happening in the family and had, perhaps for the first time, actually made contact outside the family".* She was anxious to know if there was a way of ensuring that the Police would

recognise the potential seriousness of the situation should the family telephone them again. In her evidence the Senior Probation Officer said, *"I got the impression that the family had been trying to deal with this alone. That may well have been because of the family, they were unclear what avenues they could actually use for supporting and resolving the issue. It may have been lack of knowledge about what agencies were available and a lack of confidence in them in terms of whether or not they would support the family……I was concerned about the isolation the family were experiencing…… I received two further phone calls that day from (Patient A's sister) and it was clear that (his) behaviour that day continued to be a source of concern".* It was only on the second or third occasion that the Senior Probation Officer was able to be sure who they were talking about.

2.15.3 She added *"Although I couldn't put my finger on, or identify, what was wrong, there had been nothing in our records that suggested (Patient A) was problematic or a drug user, so something unusual was happening".* She said it was not normal for them to search through all the records to try and identify who an anonymous call was from.

The eldest sister's fears

Patient A's eldest sister's desire for anonymity was, she told us, connected with her fear for herself and her husband. The family had always looked to them to manage any family issues, in particular in relation to Patient A. In her evidence to the Inquiry she said "No other family member wanted to deal with him, as they feared a violent reaction….. I believed there was a real risk of him hurting a family member. He had already assaulted his wife and (brother in law), and therefore his violent behaviour had crossed the threshold from being outside the home to now being directed towards family members. That is why I took the step I did of contacting various agencies, in order to protect the family and indeed him……myself and (my husband) were responsible for contacting various agencies and subsequent actions taken. I therefore considered myself and (my husband) to be at greatest risk."

2.15.4 It is clear from the evidence that there was a discussion on the telephone about how to protect Patient A's wife and the baby. The senior Probation Officer recalls that Patient A's eldest sister was *"very concerned for reassurance that (Patient A's) wife wouldn't be forced out of the home".* Although the Senior Probation Officer could not remember exactly what was said, her standard advice in connection with domestic violence would have been that she see a solicitor and seek an injunction to get her husband out of the house; *"sadly both the behaviour and the description of the events in that house, as you'll appreciate, are not unusual situations for us in the profession that we work in".* Patient A's eldest sister remembers the conversation differently, believing she was told that Probation could obtain an emergency injunction with a power of arrest and if necessary remove Patient A from the house and put him before the Court for breach of probation. She told us she felt let down that this was not done.

Dissatisfaction

Patient A's eldest sister expressed to us her dissatisfaction with the advice and actions of the Probation Officers that day. She understood that they had powers to bring Patient A before the Court for breach, remove him from the home and obtain an injunction. In fact the only legal power available to the Probation Service was to instigate breach proceedings, and this was a slow process involving a repeat of the procedure Patient A had already been through earlier in the year. Probation had a responsibility to be clear about exactly what they could and could not do for the family. This was not connected with mental health. It was plain communication of their powers.

2.16 Probation Officers speak to the Police

2.16.1 Continuing to feel concerned about the situation, the Senior Probation Officer told us that she and the Probation Officer *"debated at some length…..whether it would be helpful or unhelpful for us to go and make a home visit to the family…..it's not normal practice to make regular home visits and it's certainly not practice at all to make unscheduled home visits."* In the end a decision was taken not to make a home visit. The Senior Probation Officer explained *"I didn't know what was wrong – I was concerned that we might actually exacerbate the situation, but what we did decide to do…..was to make a phone call and see if that gave us any other information".*

2.16.2 The Probation Officer therefore telephoned and spoke to Patient A's eldest sister and then to Patient A. He recalls that she described her brother as *"difficult….slamming doors and shouting at everyone"* but when he engaged Patient A in conversation *"he didn't actually let on anything I could use to talk to him".*

2.16.3 Given the limited information they still had, the Senior Probation Officer wrote in her statement for the Inquiry *"I was not able to form a view about the cause of (Patient A's) behaviour. However, I was concerned that (he) posed a risk to his family members and consequentially (sic) to his child".*

2.16.4 The Senior Probation Officer told us she believed she had a *"first responsibility"* to ensure the safety of the family by reporting to the Police allegations *"that were clearly criminal in nature".* She therefore decided to telephone the Police. But they were, she said, reluctant to return to the house. So, during the early evening, the Probation Officers took the unusual step of calling at the Police Station to express their concerns.

2.16.5 At the Police station it was, we were told, a "*fairly uphill battle*" to convince the Police that there was a reason for them to go back to the family but *"it seemed to me that the Police, if you like, had a more obvious reason to go back than (we) did for suddenly appearing on the door step*".

2.16.6 The Probation Officers' efforts were successful. It was agreed the Police would go out a second time and reassure the family that if they made contact again their call would be given priority.

2.17 Second Police attendance at the house

2.17.1 During that evening at 19.05 hours, therefore, two different Police Officers (Police Officers C and D) attended at the address. The Police account is that they spoke with Patient A's wife, mother and one of the younger sisters, who told them there had been no further problems since that morning but they were concerned about his behaviour and suspected that he may be taking drugs. In fact their conversation was largely with Patient A's sister since, apart from Patient A, she was the only English speaking person present.

2.17.2 The Police Officers spoke to Patient A in a private room separate from the rest of the family and *"tried to impress upon Patient A the seriousness of the situation".* Patient A was reported to have been grinning continuously throughout and did not appear to be taking in what they were saying.

2.17.3 Following their visit the Police passed this information by telephone to the Social Services Emergency Duty Team (EDT). This was not, we were told, a referral. Quite often a call would be made to the EDT because the Police *"just had concerns…..it's for their information….they may be able to put it with other information…..and… build a better picture".*

2.17.4 The Chief Inspector pointed out that the matter had been recorded in the Police log as a domestic violence incident. No criminal activity had been reported and there was no disorder, so there was little that Officers could do at the scene on either occasion; they had gone further than was strictly necessary by contacting Social Services EDT.

2.17.5 The next day, Saturday 22 December 2000, given concern for the safety of Patient A's child, a referral was made by Probation to the local Social Services Department.

First signs of professional concern

It had now become apparent to Probation and Police Officers that something was amiss, but they found it difficult to identify precisely what that was. Probation Officers believed "something unusual was happening" though they located their concern within the framework of domestic violence/Police/solicitors rather than mental health/GP/Social Services. The family's belief that Patient A might be taking drugs was a plausible explanation for his behaviour. Indeed he did later refer to smoking £5-10 of cannabis daily for the last 5 years or more. Patient A's eldest sister was understandably frustrated with the situation, but there is evidence that both the Probation Service and the Police took the situation very seriously, each going beyond their usual remit to respond to the family's needs. Probation Officers would not usually call at a Police station in the evening to express their concerns or make a referral to EDT on a Saturday, and Police Officers would not generally attend at an address twice in a day without some immediately urgent reason. Police telephone contact with Social Services EDT was appropriate and indicated they were beginning to grasp that this was not a simple matter of law enforcement.

Mental health training for Probation Officers

Although a first episode of psychosis would have been difficult to detect, we were concerned to hear that neither Probation Officer had received any in-

service training in mental health. The Probation Officer explained "Whether a person is or not mentally ill is really not my area of expertise or domain". Probation Officers, we were told, do not come across mental health problems because individuals sentenced to Probation orders are within the criminal justice system. We think this is surprising because figures indicate that the prison population has a very high incidence of mental ill-health[3]. The Senior Probation Officer was nevertheless clear that Probation Officers are expected to know enough to raise a question mark about mental health issues, and we think that this should have been high on their list of possible concerns when confronted with Patient A's situation, which they regarded as very unusual. We recommend that Probation Officers receive post-qualifying training on the identification and management of mentally disordered individuals and the Mental Health Act.

Recommendation 2.2

Police and Probation roles in mental health investigation

Anxious not to exacerbate the situation the Probation Officers decided against a home visit, instead asking Police to do this. They describe Police as reluctant to go a second time, though after a visit to the Police station from the Probation Officers they agreed to do so. This was an extremely unsatisfactory situation. Something needed to be done but it did not seem clear who should respond. In fact either agency had a reason to visit the home; Probation because Patient A was subject to a Probation Order, and Police because there might have been some risk to the family. Moreover, either agency could have telephoned the GP and initiated a MHA assessment, and either agency could have telephoned Social Services with concerns over the safety of the baby. We recommend that Nottinghamshire Probation Area and Nottinghamshire Police jointly consider how to manage Probation mental health emergencies, including those that take place out of hours.

Recommendation 2.1

2.18 28 December 2000: Urgent call to the GP

2.18.1 Patient A's eldest sister recalls that on Thursday 28 December 2000 she was called to her mother's house where she found Patient A in the house, angry and agitated, with a large knife; *"he was only inches away from my children, his child, his wife and our mother. I moved from the doorway towards him, talking gently to him at the same time, he was still waving the knife from side to side. I genuinely feared he was going to hurt somebody any moment so I stood in front of him to protect my children who were nearest to him. After managing to get the knife off him I telephoned the doctor from another room since I did not want him to overhear".* Having had the knife taken from him Patient A started crying.

2.18.2 Patient A told the Inquiry that at the time he believed everyone could mind read. He was hearing voices on the television telling him that his brother in law was coming with some friends to get him and had picked up the knife to defend himself.

[3] The Office for National Statistics in 1997 found that nine out of ten prisoners have at least one of five disorders (Neurosis, psychosis, personality disorder, alcohol abuse or drug dependence). Between 12% and 15% of sentenced prisoners have four of the five.

2.18.3 Upon hearing Patient A's eldest sister's whispered telephone call, the family's GP immediately dialled '999' and asked the Police to attend at the house; *"As far as I was concerned this gentleman had no psychiatric history……I am aware that the Police have Police surgeons who can deal with somebody who subsequently turns out to have a mental illness and I felt that was the appropriate thing to do".* She added that this was not a common occurrence. In fact she had never called '999' before and had not done so since. The GP did not consider taking any action under the MHA since the overriding impression she had was that there was the potential for violence.

Good practice
This immediate response by the GP was good practice and it led to swift attendance at the house by the Police.

2.19 Third Police attendance at the house

2.19.1 Two Police Officers arrived to the house at 16.36 hours, one of them Police Officer B who had attended at the house on the first occasion on 21 December 2000, and the other Police Officer E. The Chief Inspector said they described Patient A as quiet and agreeable. Patient A's sister recalled that she told the Police Officers her brother had been muttering to himself, throwing paper on the gas fire. His eye movements were not right and it appeared he was talking to somebody who was not there.

2.19.2 Giving her statement to Police after the homicide Patient A's eldest sister remembered Patient A had been *"asking me not to go to Pakistan as he felt (my husband) was going to marry someone else. He also asked me if (my husband) hit me".* This had reminded her of an occasion some months before when her brother had suddenly said *"don't worry about yourself because if (your husband) ever does anything to you I'll kill him".* She tried to reason with him, explaining that her husband had never hit her and would not do so.

2.19.3 Patient A's eldest sister described Patient A as waving the knife at the family. However, the Chief Inspector, giving evidence for the Police, pointed out that the Police Officers said in their witness statements for the criminal proceedings *"There were no threats to the family with or without a knife".* Nor was there any sign of a breach of the peace since he was calm by the time the Police arrived. No offence had been committed and therefore no arrest was possible.

2.19.4 Patient A's eldest sister described to us her feelings when the Police Officer told her there was nothing he could do. She said *"At this point, through a mixture of anger, fear and frustration that my repeated pleas for help were being ignored, I said to the Officer 'are you going to wait until he kills someone before you do anything?' His reply still echoes in my mind, 'don't get shirty with me love' ".* Police Officer B told us *"I did not make or hear from any other Officer the comment 'Don't get shirty with me love' ".*

2.19.5 Patient A's sister expressed her view to the Inquiry that *"the Police were in a position to do something, they didn't, they didn't take it seriously".* She felt the initiative to take any action was left with her.

Different understandings of 'threat'

*'Threat' seems to have been understood very differently by the family and by the Police. The family **felt** threatened, but the Police understood that Patient A had not **made threats** to anyone, with the result that no offence had been committed. Unsurprisingly, such distinctions were unhelpful for Patient A's eldest sister, who felt upset and angry that nothing was being done.*

Unacceptable comment

The phrase "Don't get shirty with me love", if made, would have been unacceptable from the Police. The Chief Inspector, giving evidence on behalf of the Police, was absolutely clear about this. Without hearing evidence from everyone present we cannot reach any conclusion as to whether the disputed phrase was actually used, and the remit of the Inquiry would preclude such an extensive investigation. However, we welcome Police acknowledgement that a comment like this should never be made by a Police Officer. Where gender and ethnicity are issues this kind of comment is particularly inappropriate and insensitive. Police training should make it absolutely clear that statements of this kind must not be made.

Recommendation 1.4

2.20 Patient A taken to his GP

2.20.1 In the event the Police did take action, escorting Patient A to the GP's surgery, though there are different versions of how that came to happen.

2.20.2 Police Officer B, in his evidence to the Inquiry, stated *"No criminal offences had occurred and due to the concern of the family for the welfare of (Patient A's) mental health I used my practical Police experience and arranged for (him) to visit his doctor and be examined from a medical point of view".*

2.20.3 Patient A's eldest sister recalls pleading with the Police not to leave the family alone in the house with her brother, and then telephoning the GP saying that she feared he would seriously hurt someone that night if he were left there. Her recollection was that she had been asked to bring him along to the surgery, with someone who could give a history of events in the past couple of days.

2.20.4 This does not accord with the evidence of the GP who remembers Patient A's eldest sister telling her that the Police were bringing him to see her. The GP was, she told us, *"absolutely furious".* She explained *"I could not believe that the Police would without my consent…..have just brought somebody who had burst into the living room of his house wielding a knife, down to see me, a female GP, without my consent, when there is a mechanism for dealing with potentially violent patients who may have a mental illness via the Police surgeons in custody".* The GP felt it was completely clinically inappropriate to see Patient A at the surgery, and potentially risky.

The legal powers of the police

Patient A had not, the Police concluded, made any threats. He was calm whilst they were there and so there was no breach of the peace and therefore no power to arrest him. On the evidence, we cannot find fault with this. Section 135 MHA upon issue of a warrant permits Police, a social worker and a doctor to enter and remove to a place of safety someone "believed to be suffering from mental disorder" if there is reasonable cause to suspect that they are being "ill-treated, neglected or kept otherwise than under proper control". But this would not have applied either. The consequence was that Patient A could not have been forced to attend a Police station, and the option of being seen by a Police surgeon as suggested by the GP was never a possibility. Without any legal powers to do otherwise the Police could legitimately have left the house at this point.

Non-legal options for Police action

The Police did not leave the house; they decided instead to escort Patient A voluntarily to the GP's surgery. However, this was not the best action they could have taken. The Police should by this time have identified that there might be a need for a formal assessment under the MHA. They should have explained to Patient A's eldest sister that the family could telephone the Social Services Department and/or ask the GP to visit and carry out an assessment. Patient A's wife, as the nearest relative was legally entitled to request an assessment under the Act, yet it does not appear that the Police informed her or Patient A's sister of this right. The Police could also have followed the most obvious course of action and simply telephoned the GP themselves. The GP had, after all, been responsible for calling 999 because she understood that the situation involved some risk. She told the Inquiry that if they had phoned her back she would have gone to the house and seen Patient A there, with the Police present. She could then have initiated a MHA assessment if necessary.

Need for improved mental health training for Police

The Police were criticised by Patient A's eldest sister for their inaction and criticised by the GP for their action. They should have been clearer about the action they could have taken. Training in mental health for beat Officers was, we were told by the Chief Inspector, limited. We strongly recommend that Police training include information about mental health legislation and guidance on how to deal with mentally disordered individuals.

Recommendation 1.5

2.21 Assessment of Patient A at the GP surgery

2.21.1 Whatever the exact sequence of events and conversations, Patient A went with the two Police Officers to the Surgery and his eldest sister took her mother by car. Once there, the Police left. It was around 17.00 hours.

2.21.2 The family waited to be seen, with Patient A *"sitting very calmly".* The GP saw Patient A with his mother and sister at 17.30 - 18.00 hours. The atmosphere was *"completely calm".*

2.21.3 The GP's notes included *"not sleeping, not eating, yesterday asked if cameras were being fitted to the house by workmen. Today came into living room brandishing a knife…… appears to be listening to someone/something else.,,,*

says he has a headache and 'funny stuff coming out of head'. Denies hallucinations. Says he wouldn't harm anyone".

2.21.4 The GP quickly realised she needed to speak to the hospital. She telephoned and spoke to a Psychiatrist, the Specialist Registrar (SpR) on-call, who arranged for Patient A to be assessed in AED at QMC. Patient A agreed to go to hospital voluntarily, but the GP considered he was detainable if he refused admission. She offered to provide a medical recommendation for a S2 MHA admission, indicating that she was prepared to come out in the evening and giving her home telephone number.

2.21.5 The GP gave evidence that she told the SpR what had happened and that an assessment of risk was implicit in this. She said to us that she considered Patient A *"of potentially being quite a high risk to others particularly his family members".* This does not fit with the recollection of the SpR, who told the Inquiry *"we agreed that he posed no obvious risk to other people and could be assessed in the Accident and Emergency Department".*

2.21.6 The GP wrote a referral letter for the family to take with them to the hospital saying *"Thank you for seeing this 21 yr old man who appears to be suffering from acute psychosis. His behaviour changed abruptly 2 weeks ago. He has become volatile and bad tempered and is not sleeping, eating or communicating with his family. On 16th Dec he attacked his wife out of the blue and then ran downstairs with his 7/12 old daughter. Today (Patient A) walked into the living room (where family including young children were gathered) brandishing a knife. It took a while to persuade him to relinquish this. O/E Tired, distracted and worried, denies hallucinations but appeared to be hallucinating in surgery. Slow to answer questions, laughed inappropriately at one point. Accepts he needs help".*

2.21.7 Her notes record almost exactly the same information, adding *"Spoke to on-call psychiatrist, they will see him this evening".*

GP assessment

The GP was the first person to make a diagnosis of probable mental illness. This was a comprehensive assessment that led to appropriate action, which led to an admission and an offer to complete forms for detention under the MHA. The GP went out of her way. This was a good standard of care.

Communication of risk information from GP to AED

We accept the GP's evidence that a risk assessment was implicit in her description of events on the telephone to the SpR. The events were fresh that day and her referral letter was unambiguous as to the dangers of the situation. Equally, the GP was content to allow the family to take Patient A to hospital and be seen in AED. This indicated that she did not consider the risk was then an immediate one and the SpR was entitled to interpret it in this way.

2.22 Assessment at AED

2.22.1 Patient A's eldest sister took her mother and Patient A by car to the AED of QMC, Nottingham, although this was not without incident. Patient A had been given the GP's letter and once in the car he opened and read it. Deciding that he was not going to go to hospital he at one point got out whilst the car was at traffic lights, needing considerable persuasion to carry on.

2.22.2 They arrived at AED at 18.15 hours. Security was called and attended. One of the Senior House Officers working in the Department assessed Patient A at 18.45 and then arranged for a Senior House Officer (SHO) Psychiatry, to attend AED.

2.22.3 The SHO (SHO A)assessed Patient A and took a history from his mother and sister at 20.30 hours, telling us it was very difficult: *"The mother did not speak English, or very good English. Sister was tense, emotional, and (Patient A) himself was crying, and at times staring into cubicles. I think he was responding to hallucinations….at times he would just lie down in the cubicle with no expression of emotion at all…..at times he was giving me very intense eye contact. So I think it was difficult for all of us, because his mother just didn't come to terms with all these changes in him, and his sister was trying as much as possible to communicate with me what the problem was as well".*

2.22.4 We heard from SHO A that he was the only SHO covering the whole of the QMC and outlying units that night. He recalls having six other patients to assess and had to attend to an elderly patient who was physically unwell in one of the outlying facilities. His priority was to ensure that Patient A went to a ward as soon as possible because his presence in casualty would put others at risk.

2.22.5 SHO A told us he was aware that trying to acquire interpreter services might take some time, thereby increasing the time Patient A was in casualty. He was worried that the longer he stayed there the more likely he was to abscond.

No independent interpreter

The circumstances were undoubtedly pressured, but it remains the case that no independent interpreter was considered to assist with this difficult situation. Although Patient A's eldest sister was willing to interpret for her mother and for Patient A's wife, she was emotional, tense and very involved in the situation through marriage and family. We comment later on the poor facilities for psychiatric interview at QMC AED at the time. There is also a need for improved guidance to nursing and medical staff on obtaining an interpreter, especially when they are under pressure and out of hours.

Recommendation 4.1

2.22.6 SHO A was told about the incident with the knife and the assault on Patient A's wife, when he was said to have hit her on the face and then taken the baby and *"held her possessively"*. Patient A's eldest sister said that over the last three weeks her brother had become low and tearful, had not eaten for four days and not slept for three days. He would put pillows around his head saying that his head hurt badly. SHO A recorded:

"Summary:- 3 week history of low mood, behavioural changes i.e. more irritable, bizarre. Angry towards his wife and hit her, brandished a knife recently. He was

noticed to be responding to hallucinations. There is a history of cannabis use. Unclear what other drugs.

Plan:-
1. Needs MHA
2. SpR contacted
3. Needs admission to an acute ward
→ urine drug screening
→ Droperidol + Lorazepam PRN
→ level of obs:- medium 10 minute checks

2.22.7 SHO A told us he thought Patient A was probably acutely psychotic; *"I felt that it was a first onset psychosis and that probably with medication and containment on an open ward, all this sort of risky behaviour might be contained by treatment".* He therefore telephoned Ward A42.

2.22.8 The Nurse in Charge of QMC Psychiatric Ward A42 that evening (Nurse in Charge A) disagreed with the suggestion of an open ward, favouring admission to the forensic ward at the Trent Unit, Wells Road Centre in Nottingham. Having heard detail of aggressive, violent behaviour she told us *"that just highlights forensic immediately".* SHO A recalled that Nurse in Charge A was uneasy about managing Patient A on Ward A42 because of a shortage of nursing staff, though the nurse told us she could not remember a discussion about observation level at that stage.

2.22.9 However, the telephone discussion between them was cut short because at this point Patient A tried to leave AED. A QMC Security Guard arrived quickly and prevented Patient A leaving, whereupon the SHO decided that an assessment under the MHA was needed. He bleeped the SpR on-call, who attended very promptly and SHO A passed on to her the detail of his discussion with Nurse in Charge A.

Poor psychiatric assessment facilities in AED
SHO A's assessment was comprehensive under difficult circumstances. It was a busy evening and he had four or five patients waiting to be assessed after Patient A. Although it was normal practice at QMC for psychiatric assessments to take place in AED, this was not a satisfactory setting. We were informed that QMC AED is the largest and busiest casualty department in England. The SpR told us "Casualty was not an ideal environment for him to be assessed in at all because it was quite noisy, and I had complained to the social worker that it was an inappropriate place. There was no privacy and there were six or seven of us crammed into this little cubicle." This was basic and inadequate for the assessment of a disturbed individual. We are pleased to hear that the recently completed new AED at QMC now provides good facilities for psychiatric assessment.

2.23 Assessment and detention under s2 MHA

2.23.1 The SpR arranged for an Approved Social Worker (ASW) to be present and then assessed Patient A in AED at 20.00 hours. In her witness statement she said

"*… he seemed very frightened, agitated and was mute. He sat motionless and tense on a stool and did not respond to any questions that I put to him …* "

2.23.2 Her entry in the medical notes stated "*… rocking head – sunken face and slumped posture … Tearful… possibly hallucinations (auditory). Probable first episode psychosis… Plan: Section 2 MHA as withdrawn consent to admission on three occasions … ward advise med 10 obs – can be increased to constant. Given 2 mg lorazepam prior to transfer. For meds prn. Physical. Bloods and urine. Possible suicide risk due to obvious distress, low mood and lack of other history from patient"*

2.23.3 Although the GP had offered to provide a medical recommendation, it was considered to be quickest to get this done through AED, and a Doctor from AED therefore provided the second joint medical recommendation for s2 MHA. The reasons for admission were given as *"He is agitated, tearful, mute and unable to consent to admission. He seems to be distractible and absconded from hospital. He has a short history of paranoid ideas, violence and low mood."*

2.23.4 An Approved Social Worker (ASW), completed the S2 application for assessment form. On the accompanying ASW report he noted Patient A's recent conviction for assault, the Probation Order and that his wife was '*frightened of his behaviour'*. The application was made to the appropriate hospital but the wrong Trust was identified. The nearest relative, Patient A's wife, was mistakenly given the baby's name and the form confusingly indicated that she both was and was not informed of the s2 application and her power to order his discharge. The section papers were nevertheless accepted by the hospital and this was a legal admission under the Act. If events had not intervened the papers would have been subject to a formal scrutiny process and errors rectifiable under the Act could have been dealt with by returning the papers to the social worker for amendment.

2.23.5 The ASW Report, written to accompany the s2 papers, referred to a discussion with the nearest relative, but Patient A's wife was the nearest relative as defined in the MHA. She was at home with the baby and did not speak English. The ASW accepts that he did not actually speak to her and thinks that his report may have been a précis of what the family felt. His notes again confuse Patient A's wife's name with that of the baby.

Errors on the application form

Under pressure in AED, this was a hurried assessment resulting in mistakes on the application form. The MHA provides for rectification of certain errors because they are inevitable occasionally. However, where complex family structures and unfamiliar names cause confusion in the context of cultural difference there is a particular need for concentration on the accuracy of obtaining correct information. ASW cultural awareness training should emphasise this point.

Recommendation 5.1

The nearest relative

The ASW indicated on the section 2 application that he had consulted with the nearest relative but in fact he cannot recall doing so. Arrangements should have been made to inform Patient A's wife of her legal rights as his nearest relative, using an interpreter if necessary.

Recommendation 5.1

2.23.6 In the same ASW Report, written to accompany the Section 2 papers, the ASW comprehensively covered all the points already raised, recording under the heading *'Discussion with GP + Psychiatrist'…."assault on wife: threats to her with a knife"* and assessing under the heading *'Protection of Others'*

"1. Has threatened wife
2. Has assaulted wife
3. Young child in the house
4. Has a recent conviction for ABH (on probation)."

2.23.7 During the assessment under the MHA, Patient A's eldest sister told us she repeatedly voiced her fears, both for her own safety and that of her family if her brother were allowed to leave. *"I spoke to (the SpR) and the social worker individually in depth regarding events leading up to that time. I kept telling them that he would be very angry at me for bringing him here and that if he left I fear he would harm me or my family. They assured me that he couldn't just get up and go now and that he had been sectioned and that they had the power to keep him there".*

2.23.8 Patient A's evidence to the Inquiry indicated that his delusional thinking involved paranoid ideas about his brother in law. He told the Inquiry that at the time he continued to believe everyone could read each others minds and he thought his brother in law was responsible for getting him into hospital.

Documented risk information

By this time a range of information concerning risk was available on the medical file. There was documentation of a conviction for ABH, at least one recent assault on his wife, the brandishing of a knife in the presence of a child and low mood suggesting suicide risk. One of the s2 medical recommendations stated that he had absconded from hospital.

Patient A's eldest sister's concerns

During the s2 assessment Patient A's eldest sister expressed an anxiety that if Patient A left the hospital he might harm her or her family. She was reassured that he "couldn't just get up and go now" because of the MHA section. Having used the powers of the MHA we think the professionals involved were entitled to this belief. It was for that very reason the Act had been used. However, her concerns were quite specific and, in addition to reassurance, a careful note should have been kept of her comments for the purpose of later risk assessment.

Recommendation 5.2

The family in crisis

Patient A's family were distressed and there was an urgent need for them to receive support. This could have been provided immediately by a referral to AWAAZ, a local South Asian community organisation providing help to those

suffering the effects of mental ill-health in their family. Information on the support available to minority ethnic groups should be made available to clinicians and social workers in AED and the acute admission wards at QMC.
Recommendation 4.2

2.24 Making the admission and observation decision

2.24.1 Taking into account information from the GP, and following discussion with SHO A and with Nurse in Charge A, the SpR decided to admit Patient A to Ward A42 at QMC with 10 minute nursing observation.

2.24.2 The process by which this decision was made was not straightforward. The SpR requested high observation for Patient A, but Nurse in Charge A did not have sufficient staff immediately available to provide that. Again she suggested Patient A be admitted to the Trent Unit forensic ward. Discussions bordered on open disagreement and reached a rather uneasy resolution with a decision that there would be admission to A42, 10 minute observation and PRN medication (medication given when required).

The observation compromise
The SpR felt that she had reached a compromise on observation, but a safe compromise with a reassurance that observation could be increased once Patient A was on the ward and would, in any event, be reviewed by the SHO within an hour or two.

No agreed reason for observation
We discovered there had been different understandings of the risk posed by Patient A. The Nurse in Charge A of Ward A42 expressed anxiety about the potential risk to others including her nursing staff. The SpR felt that risk of self harm was the dominant concern because of his distress. Neither The SpR nor Nurse in Charge A referred to any risk that Patient A might abscond. Nurses who gave evidence did not know why observation was necessary and were unaware that Patient A had attempted to abscond from AED. There should have been clear and agreed documentation of the reasons for observation. It was most unsatisfactory that, when Patient A was admitted to A42 and nursing observation began, there was no agreed understanding of the risks he posed. The reason for observation should be agreed between the psychiatrist and nurse in charge of the ward, or disagreement recorded. The reason should be expressed clearly in terms of assessed risk to self and/or others, and for detained patients the risk of absconding should be recorded.
Recommendations 6.2.2(b), (c) and (g)

2.25 Evening Admission to Ward A42

2.25.1 Once the decision to admit had been made, the ASW went with Patient A, his sister and mother to Ward A42. Patient A was formally admitted on 28 December 2000 at 21.20 hours.

2.25.2 Upon her arrival at the ward, Patient A's eldest sister remembers noticing that the doors were not locked but being reassured by a nurse that *"he could not just leave and that they have to check on him every 10 minutes or so".* She told us that after several expressions of anxiety about the possibility that he might leave

the ward and *"do something to me or my family"* a nurse took her hand and said *"we guarantee he won't leave, don't worry he won't just turn up in the middle of the night or anything like that. Go home and get a good night's sleep".*

Appropriate reassurance
Again, this was appropriate reassurance. At the time the unnamed nurse was expressing the reasonable belief that Patient A would not be permitted to leave the ward and revealing a confidence that the ward could contain him there. A note should have been made of her concerns. This was the second time that Patient A's eldest sister had expressed these fears. This information should have been available for risk assessment.

2.25.3 Staff Nurse A, Patient A's keyworker, recorded that Patient A was given 10 mg Droperidol quite soon after his arrival because he appeared *"quite incongruent and preoccupied and seemed agitated".* It seems that he then settled and made himself a cup of tea, responding appropriately to others on the ward.

2.25.4 Staff Nurse A then commenced completion of 18 separate items of nursing documentation. These are detailed in Chapter 3.

2.25.5 Within this extensive documentation Staff Nurse A recorded: Patient A's diagnosis; that he had hit his wife and threatened her with a knife; that he had a conviction for ABH and was on probation; that he was smoking £5-10 cannabis a day; and that he could present a risk of physical aggression. No mention was made of absconding. The 10 minute observation level was recorded and there was a plan to use a personal alarm, medication and involve the Police if the situation warranted it.

2.26 29 December 2000: Assessment during the night and morning

2.26.1 SHO A assessed Patient A on ward A42 at 01.30 hours on 29 December 2000 after he had slept. He found Patient A more talkative than when he had seen him in AED, quite calm and collected; *"he complied quite easily with all the procedures of the physical examination….and was completely different to when I saw him in Casualty…It was a dramatic change".* SHO A wrote in the medical notes *"astonishingly settled"*. He did not discuss observation levels with the Nurse on the Ward. In evidence he added *"I felt relieved that he is in hospital….and quite satisfied with the way things are going, because I felt that he responded to the medication. I felt that probably, with treatment with an atypical, he will settle down. So I wasn't really particularly worried about him at that time".*

No change to observation level
The SpR had expected that the observation level would be reviewed by SHO A. Although no formal review took place it is evident that Patient A seemed much calmer. It would have been difficult to justify any increase in observation level.

2.26.2 At 06.45 hours it was noted that Patient A's breathing was from his diaphragm. The count was recorded as 22 and the duty doctor was consulted. It was decided not to give any further PRN medication without consulting a doctor first. Patient A could not be woken and remained deeply asleep until around noon. His sister telephoned on one occasion during this time.

2.26.3 There were no entries in the nursing notes between 06.45 and 16.00 hours.

2.27 Patient A's wife, mother and youngest sister visit him at lunch time

2.27.1 Patient A's wife, mother and sister gave statements to the Police recalling that they had been shopping for Patient A in the morning and then visited him on the ward with a change of clothes, pyjamas, toiletries, Get Well cards and some money. Their recollection of the exact time varies slightly but it was around 12.30 to 1.00pm. Patient A's sister recalled that they had woken him up. After about half an hour his sister and mother had left, leaving his wife and baby on the ward with him.

2.27.2 The family's arrival was not recorded on the ward at the time, although the day after the homicide Staff Nurse B completed a retrospective account in which he confirmed that Patient A's relatives visited at lunch time that day. He also wrote *"Whilst in the company of his wife and daughter he appeared settled. He was being comforted by his wife and was playing with his daughter".* That was confirmed in his statement to the Police after the homicide.

2.27.3 Patient A's wife later told the Police *"He played with the child..... he appeared all right to me".* She added that her husband had asked her who had called the Police and the GP.

No record of Patient A's first family visitors

There was no contemporaneous record of these visitors or any evidence of communication with them. Had a note been taken of their names and relationship to Patient A the name of the nearest relative, wrongly recorded by the ASW and entered in the nursing records, could have been corrected. There should be guidelines for busy nursing and medical staff on the management of visitors to psychiatric wards. A note should be made of visitors to detained patients.

Recommendations 6.6.2 and 6.6.2(c)

No record that Patient A's wife remained on the ward

From the sworn statements of Patient A's wife, mother and younger sisters given to the Police after the homicide, and from the retrospective note provided by Staff Nurse B and his Police statement, it is apparent that Patient A's wife and the baby remained on the ward with Patient A from about 1.30pm to 4.00pm when her family returned to collect her. There was no note that risk to her or the baby had been considered. In his Police statement Staff Nurse B said he checked on them every 10 minutes but did not say that he had introduced himself or spoken to them. Patent A's wife gave no account to Police of any conversation with nursing staff during the 1-2 hours she was there. Risk to her and the baby should have been assessed and recorded.

Recommendation 6.6.2(b)

2.28 2pm: Psychiatric Review

2.28.1 At 14.00 hours Patient A was reviewed by his Consultant Psychiatrist, who was also Patient A's Responsible Medical Officer (RMO) under the MHA. Staff Nurse B, Patient A and the SHO B, working under the supervision of the Consultant

Psychiatrist, were also present. Staff Nurse B said in his Police statement *"This lasted around ½ an hour during which time his wife wasn't present".*

2.28.2 SHO B took notes for the medical records, recording *"Thought somebody was coming to beat him up. Hence for self-defence he was brandishing a knife…..hearing voices….more than one person. Couldn't tell I/II person. Has been happening 7 months…feeling depressed, crying bouts…..Cannabis £5-10 a day, smoking skunk – 3-7 times a day. Does not think he is unwell….had cut himself on the arm 3 weeks ago….no suicidal thoughts".*

2.28.3 Staff Nurse B recorded much the same information on the nursing form 'Weekly Summary and Evaluation Ward A42' adding *"Denied any ideas of self harm or harm towards others – doesn't think he is ill. Is willing to stay and take medication…..obs level to remain the same (Med 10)".* There was to be no leave at present. 'Action to be Taken Before Next Review' was given as *"Invite family to obtain further history –(Staff Nurse B); Continue to assess mental state – Ward Team; Monitor effects and/or side effects of medication – Ward team".*

2.28.4 In his report for the Trust's internal review after the homicide the Consultant Psychiatrist recalled that Patient A had been calm, settled, tearful at times, co-operative, with no anger or hostility, giving answers which were sometimes limited to two words *"I just …".* Nevertheless, until his psychosis was fully controlled there was still felt to be the potential for further violence. The risk factors identified were a history of acute psychosis, especially with paranoid experiences, substance abuse, a history of disturbed, aggressive behaviour and a previous episode of violence in a young male. In view of these factors it was agreed that he should be kept on the ward under *"close observation"* until such time as he was adequately treated.

2.28.5 Giving evidence to the Inquiry the Consultant Psychiatrist added that Patient A had been brandishing a knife the night before, and had told him he had the knife on his person all day at home and for two weeks before that. He was emotionally unstable, admitted hearing voices and kept the knife because he thought somebody was going to come and get him or beat him up.

2.28.6 Medium ten observation was intended, the Consultant Psychiatrist said, to address the risk of possible harm to others and, since he had cut his arm a few days previously, the risk of self-harm. In the ward review Patient A was seen as a '*potential risk*' rather than an '*immediate risk*'.

2.28.7 The Consultant Psychiatrist knew Patient A had tried to leave AED, this being the reason he was detained under s2 MHA. However, he did not feel that Patient A was at either immediate or high risk of absconsion.

2.28.8 The Consultant Psychiatrist believed the requirement of *'close observation'* would be met by medium ten minute observation, since a patient would not be permitted to leave the ward unless escorted by a nurse, and even then it would need agreement with the RMO under s17 MHA. In between 10 minute checks the patient would be on general observation, meaning that *"staff ought to know who goes or comes".*

Observation level consistent with presentation at review
The case was reviewed within a short time of admission. Comprehensive discussion of the issues was recorded in the notes. Bearing in mind the circumstances of Patient A's presentation in the review it would have been hard to justify going up to high observation at that time. Given Patient A's calm and settled state, and that he had not shown signs of wanting to leave the ward, it was reasonable to consider any risk to others 'potential' and that he was not at either immediate or high risk of absconsion.

Delusional thoughts not revealed at review
Patient A told us he had believed that because the Consultant Psychiatrist was Asian, his brother-in-law was paying him money. He thought there was a connection between the two of them and he had felt scared at the review. He said nothing to the Consultant Psychiatrist about these delusional ideas.

Family not invited to the review
The missing piece of the jigsaw was the absence of family at the review. There is no evidence that they were invited even though Patient A's mother and sister had visited the ward an hour or so before the review, and Patient A's wife was actually there whilst it was taking place. She was Patient A's wife and nearest relative, there was the possibility she might have been at risk from him and the baby was with her. Without family involvement a comprehensive risk assessment could not take place. Had she been asked, Patient A's wife would have been able to report that Patient A had asked questions concerning family responsibility for his hospital admission. This may have caused the RMO to consider whether a higher level of observation was needed. Arrangements should have been made for her to attend the review, with an interpreter if necessary. Arrangements for family attendance at reviews need to be clearer.
Recommendation 6.6.1

No consideration of fitness to receive visitors
There is no evidence that there had been any clinical consideration of Patient A's fitness to receive visitors and, if he were to receive visitors, what they should be told about his mental state or whether there was any risk to them. This was a first episode of psychosis and he was acutely unwell when admitted less than 24 hours previously. During the afternoon he received eight visitors. Guidelines on visiting should include reference to the need for an assessment of a patient's fitness to receive visitors and any risk involved to the patient or visitor, especially during the first 24 hours after admission.
Recommendation 6.6.2(a)

2.28.9 In his retrospective note the day after the homicide, Staff Nurse B stated that after the ward review he informed Patient A that he remained on 10 minute observation and would have to stay on the ward. He added in his Police statement *"After the assessment (Patient A) was not considered to be a risk either to himself or to others…. He was then rejoined by his wife and they remained together until she left roughly at 4pm".*

2.28.10 After a nursing handover to the late shift, at around 14.30 hours, Nurse in Charge B introduced herself to the new patients on the ward. Although she could not remember specifically how it happened on that day, she explained it would be

usual practice to ensure that new patients are orientated to the ward, introduced to staff and other patients, and had the observation policy explained to them.

2.28.11 The late shift was fully staffed with four nurses. Nurse in Charge B, an E Grade nurse, was clinically responsible for the shift. Staff Nurse B and Staff Nurse C were E Grades and there was also a healthcare assistant. This was a very busy acute admission ward on a Friday afternoon. Staff would have been arranging patients' New Year leave and medication, but there were no other particular pressures that day.

2.28.12 Retrospective notes of Nurse in Charge B indicate that Patient A was settled on each check during the afternoon.

2.29 Another sister visits to collect Patient A's wife and baby

2.29.1 Patient A's middle sister told the Police in her statement that she arrived on the ward at around 3.30pm to collect his wife and the baby. She thought they had been there long enough and the baby needed feeding. On the way to the hospital she bought a pizza and a fruit drink. When she arrived on the ward Patient A, his wife and the baby were on the bed. Patient A's sister offered her brother some pizza but he appeared *"vacant and distant".* In her Police statement Patient A's wife said that he came to the main entrance of the hospital to see them off, and that nobody stopped him from leaving the ward. His sister told Police *"(my brother) walked us off the ward".* She planned to drive his wife and the baby home then return later to see her brother again.

No record of the arrival of Patient A's other sister on the ward
No mention is made in any of the contemporaneous notes of the arrival of this sister on the ward. Staff Nurse B, who was carrying out observations of Patient A between 15.00 and 16.00, made no reference to her in his Police statement.

No record of conversation with any of the relatives
Staff Nurse C and Nurse in Charge B had the impression that Staff Nurse B spoke to the relatives, though none of the relatives make any mention of any conversation. Nor does Staff Nurse B say anything about communication with the family in any contemporaneous notes, his retrospective account or his Police statement. Without any evidence from Staff Nurse B we are unable to establish whether he had any language in common with Patient A's wife and mother, or whether he considered the use of an interpreter. It appears from the information available that the family were not informed of Patient A's continued detention under the MHA or that he was not to leave the ward either alone or with them.

Recommendation 6.6.2(d)

Delusional thoughts unknown to family or professionals
Patient A told the Inquiry of the delusional thinking which occurred during his sister's visit. When he had been brought some Mango and Guava drinks he had believed there was some special message and meaning to this. He believed Mango meant "(Patent A)" and Guava meant "go and do it". He then felt he "had to do it", that he was under pressure from "everyone", inside and outside his family, to kill his brother-in-law. He told no-one of these thoughts. The delusional re-interpretation of an ordinary event as a special message that contains an instruction for action is a recognised psychotic phenomenon.

It is common for such thoughts to be concealed. The family could not have been expected to know about them and certainly should not feel they could have detected them.

2.30 4.00pm: Patient A missing from the Ward

2.30.1 At just before 16.00 hours, when Staff Nurse C took over observation from Staff Nurse B, he was told that Patient A was not on the ward. It is not clear how long he had been missing. Nothing was noted in any of the contemporaneous records and the Inquiry received no evidence from Staff Nurse B. In his Police statement Staff Nurse B said that at 4pm Patient A *"went missing from the ward and I started a search of the ward and the surrounding areas. He could not be found. I returned to the ward and within a couple of minutes he was back himself".*

2.30.2 Staff Nurse B's retrospective notes say that on his way back he found Patient A returning to the ward with a bar of chocolate; "*He had been to the shop on B floor and also seen off members of his family. I again reiterated his sectioned status and that he was on medium obs and couldn't leave the ward. He accepted this, changed into his pyjamas and settled on to his bed".*

2.30.3 Patient A told us he could not remember being given any information about his stay in hospital. Nor could he recall when he had put on his pyjamas, saying he hadn't got changed from the night before and also that he'd put them on that morning. But he must have changed into his day clothes in the afternoon. It was not suggested he went off the ward wearing pyjamas.

Poor recollection of events
It is not unusual for people to have little recollection of events which took place when they were acutely mentally ill, particularly those surrounding a hospital admission. Patient A was able to remember the content of his delusional thinking most clearly. At the time this would probably have been uppermost in his mind.

2.30.4 Nurse in Charge B and Staff Nurse B discussed Patient A's observation level but high observations did not seem appropriate because, Nurse in Charge B told us, he had returned independently to the ward, had bought items from the shop to ensure his stay was comfortable, appeared settled, put on his pyjamas and was not expressing any wish to leave.

2.30.5 Nurse in Charge B stressed that Patient A put on his pyjamas of his own volition and that the practice of putting patients in pyjamas to prevent them absconding would not have been tolerated on the ward. This latter point is at odds with the evidence of the Consultant Psychiatrist, who told us that patients were asked to put on pyjamas if there was a risk of absconding as it *"helps to observe people and stop them leaving if they're in pyjamas".*

2.30.6 Nurse in Charge B said; *"…people do go off the ward and they do bring themselves back, and it happens quite a lot if some people misunderstand the observation policy, and you do get some people who are confused who just wander out the door, but when they come back it's sort of considered as "Well they didn't run away"……They had the opportunity….the absconsion risk looks slightly less because…they were out….and they still chose to return to the ward. So in that way it looks….in his favour really that he came back".*

2.30.7 Nurse in Charge B confirmed to the Inquiry that following Patient A's return to the ward Staff Nurse B reiterated the observation policy to him and he appeared to understand.

2.30.8 Reflecting upon these events in evidence, Nurse in Charge B wondered whether Patient A might have been 'testing the water', looking for the way out, but at the time it had seemed to her that he had every opportunity to go but did not. The Consultant Psychiatrist, Patient A's RMO, was not informed of this incident of absconding, but having heard that he had been polite, co-operative and willing to change into pyjamas, the Consultant Psychiatrist told us he did not consider that it had been necessary to let him know. He trusted the ward staff; *"We have quite experienced nurses and we have to trust them in some areas".*

2.30.9 Nothing in the nursing notes made any reference to Patient A's absence from the ward. The entry made by Staff Nurse B at 16.00 read; *"Given universal container for urine drug screen. Rights read under s2 which he appeared to understand".* This was the last recorded contact with Patient A.

2.30.10 At the same time Staff Nurse B added a note explaining that he had *"fed back outcome of review to [social worker] who is acting as a Child Social Worker".* We note that the same day there had been a telephone call from Social Services to Patient A's GP seeking information about his medical condition because of concerns about the child's welfare. This was the follow-up to the Social Services referral concerning the welfare of the baby.

No record of Patient A's absence

No contemporaneous record, either in the nursing notes or elsewhere, was made of Patient A's absence, his return to the ward or the reasons for his absconsion. This should have been recorded in Patient A's nursing notes. It would also have been logical for this kind of information to be recorded on the Observation Record but there was no provision for it to be included there. The failure to record Patient A's absence reflects the low degree of importance attached to it at the time. This was poor practice. The observation policy should require that absences be recorded.

Recommendation 6.2.2(d)

Unacceptable nursing practice

Although Nurse in Charge B stressed that Patient A put on his pyjamas of his own volition at 16.00, the note of Staff Nurse B suggests this was in the context of being told he must stay on the ward. We think it would be unusual for a young man to think of changing into his pyjamas at 4pm, particularly since he had slept in that morning and did not arise from his bed until midday. The comment of the Consultant Psychiatrist above indicates he believed patients were asked to change into pyjamas to prevent their absconsion at QMC. This practice, if used in the Trust, deprives patients of dignity and should not be necessary where staffing levels are adequate and observation levels appropriate. The Code of Practice (paragraph 19.32) to the Mental Health Act advises: "Patients should never be deprived of appropriate daytime clothing during the day, with the intention of restricting their freedom of movement." This practice no longer has a place in modern psychiatric care and, for the avoidance of doubt, the present Trust should make it clear to staff that it should not take place at QMC.

Recommendation 6.2.6

The Consultant Psychiatrist should have been informed

Patient A had been able to walk off the ward unobserved. It was clearly believed by the nurses that some more effective method was needed to restrict his potential for further absconding. This should not have been for him to change into pyjamas, whether it was voluntarily or not. Patient A was a new and unknown patient. The Consultant Psychiatrist should have been informed so that he could undertake a review of observation level. He should have been told that nurses could not watch the door constantly. The practical difficulties of medium observation should have been made known to him. This may have influenced his assessment of risk and observation level.

Recommendations 6.2.2(j) and (l) and 6.2.6

2.31 Patient A's friends arrive on the Ward

2.31.1 No contemporaneous record was kept of the later arrival of the third set of visitors to Patient A. Staff Nurse B's retrospective account states that at 16.40 hours QMC reception telephoned Ward A42 to say that two relatives of Patient A had come to see him. The two men, both Asian, arrived on the ward and were shown to Patient A's room by Staff Nurse B, who said in his Police statement *"I greeted the two men who introduced themselves only as relatives. They asked how (Patient A) was and I generalised but told them that (he) must remain on the ward. I showed them to (his) room and left the three of them together".* According to Staff Nurse C, Staff Nurse B said to him *"I've just let some people on there with him".* Staff Nurse C told us he had the impression they were family. He had thought there was a conversation between Staff Nurse B and the visitors and that Staff Nurse B had been *"quite involved in discussions with the family and friends".*

2.31.2 The two men were, in fact, friends of Patient A's. Patient A told us he phoned them up and asked them to come to the hospital. He said they did not know he was on a section. Giving evidence to the Inquiry, one of them described having known Patient A for 20 years. They had, he said, almost grown up together. He stated that the friends walked in to the ward and told a nurse that they were there to visit Patient A. The female nurse pointed out his room. They were not, he said, asked anything or told anything; *"nobody asked our names*

and who we were and we were not told anything about why he was in hospital and that he could not leave the ward".

No record of visitors to the ward

There are no contemporaneous notes of the visitors' arrival on the ward, and there are differences in the later accounts given by the friends and by Staff Nurse B. Staff Nurse B says that the friends claimed to be relatives and that he "generalised" about how Patient A was but told them he must not leave the ward. The friends say that nobody asked their names and they were not told he must stay on the ward. Whatever the exact nature of the conversation, if the friends had been asked their names and precise relationship to Patient A there would have been less likelihood of misunderstanding. It was not enough to generalise. We bear in mind that the friends, like the family, had no understanding of mental illness or the MHA. Their account has similarities with that of the family who visited earlier and who do not appear to have been informed that Patient A was very mentally unwell, legally detained on the ward and not permitted to leave. This was the third time that day that Patient A had received visitors without any record in the notes that they had arrived or who they were. Patient A was a new patient with a first acute psychotic episode, it was his first admission, he was a detained patient, his family and friends were not familiar with mental illness or psychiatric hospitals and the history indicated there were possible issues of risk to others. The recording of visitors would have been important information for the nursing notes and psychiatrist who was next to review Patient A. Guidelines are needed for busy ward staff who should know what recording is expected of them when visitors arrive.

Recommendation 6.6.2

Confidential information

There is no record that Patient A's consent had been sought for the sharing of confidential information about his mental state with family members or anyone else. It was important to know who his visitors were. Friends would have had no right to receive confidential information. Relatives should usually expect to receive more, and the nearest relative must be informed in certain circumstances. Present Trust guidelines, backed by training, should make it clear what information can and should be shared, and with whom.

Recommendation 6.6.2(d)

2.32 4.45pm: Patient A walks out of the hospital

2.32.1 Patient A's friends later told Police that they had visited the hospital after receiving a mobile phone call from him. Upon their arrival Patient A had said he did not know why he was there. His friends thought he appeared to look lost. He asked them for cigarettes but they had none and so it was decided they would go to a local shop outside the hospital. Patient A put some clothes on over his pyjamas and they walked out of the ward. He told us it was his idea to go. One of his friends explained *"No-one asked us where we were going, we just walked off the ward together".*

2.32.2 In his evidence Patient A revealed that his delusional thinking motivated his actions. He left the ward because of the 'message' he believed he had received and was intending to *"do it",* referring to the homicide.

2.32.3 We asked Patient A whether he knew he was on a section and he replied *"no",* although he confirmed that a nurse had told him he was not allowed to leave the ward. In reply to our question *"how difficult was it to get off the ward?"* Patient A replied *"Walked out"*.

2.32.4 Patient A was captured on a hospital security CCTV camera walking out of the hospital, timed at 16.44 and 20 seconds. The camera was sited near South Entrance Exit.

Patient A walks off the ward

From the accounts given by Patient A and his friends it appears that they all simply walked off the ward unnoticed. Staff Nurse B later told Patient A's eldest sister that her brother had gone to the hospital shop but not returned. That explanation is not repeated in his retrospective account of events or his Police statement and it seems most likely that, at the time, it was a best guess based upon Patient A's previous disappearance, perhaps intended to reassure the relatives.

Failure to prevent Patient A leaving the ward

Whatever the circumstances, it is self evident that there was a failure to contain Patient A on the ward where he was compulsorily detained under the MHA. He should not have been able to walk unnoticed or unchallenged from the ward on two occasions that afternoon. The RMO, was absolutely certain about this. He told us "it shouldn't have happened". From the evidence we have heard we do not find that there was any individual failing. Responsibility must be shared between those charged with Patient A's care on that nursing shift, those responsible for management of the ward, those charged with ensuring adequate staffing of the ward, those responsible for observation and absconding procedures and training, and those ultimately responsible for ensuring that acute psychiatric wards at QMC are secure for detained patients at all times. Subsequent chapters deal further with these interconnected points.

2.33 5.05pm: Patient A again found to be missing from the ward

2.33.1 29 December 2000 at 5pm was, like all other days on the ward, a particularly busy time. Dinner arrived for patients, visiting time began, the medication round was started and observation handover was taking place. We were told that this occupied three nursing staff. Staff Nurse B, according to the *Untoward Incident Report form* completed later, was in the ward office.

2.33.2 Nurse in Charge B took over observation from Staff Nurse C, who signed the Observation Chart to indicate that he had completed his observation hour. In evidence to the Inquiry he stated that at around 16.50 to 16.55 hours he saw Patient A at the top of the ward near or in his room with his two visitors. After handover Staff Nurse C started the medication round.

2.33.3 Between 17.00 – 17.05 hours Nurse in Charge B noted that Patient A was not present on the ward. Along with a certain amount of anxiety *"there was definitely the feeling that 'Oh, he's probably gone and done what he did again', but I mean that doesn't matter, you have to follow the policy, which is that you start to search for them immediately".*

2.33.4 The missing person procedure was started and a search of the immediate area begun.

Patient A unobserved for twenty minutes
If the timing of the CCTV camera was accurate, and we have no reason to question it, Staff Nurse C could not have observed Patient A at 16.50 to 16.55 since the camera recorded that he had already walked out of the building at 16.45. In addition, Staff Nurse B later told the Police that Patient A had been missing since 16.45. We accept that observation was recorded only at the end of each hour and it would have been difficult to remember exactly when and where individuals were last seen. However at the minimum, if Patient A had been observed just before he left the ward at around 16.40 and his absence noticed at 17.00, there was a period of twenty minutes without nursing observation.

No-one watching the open door
No-one was keeping a continuous watch on the open ward door at the time Patient A was found to be missing. Nurse in Charge B had taken over observation. Staff Nurse C was doing the medication round in the Treatment Room. The Health Care Assistant was dealing with dinner. Staff Nurse B was in the ward office, from where it was impossible to see the open door. He could have left the office to watch the door, either on his own initiative or at the request of the Acting Ward manager Nurse in Charge B, but even then a telephone ringing or a patient needing attention would have provided a momentary distraction. A patient intent on going would only have to wait for an opportunity. Observation handover provided such an opportunity on two occasions that afternoon. Patient A was twice found to be missing after observation handover.

Observation handover
It would have been impossible, without additional staff, to keep observation going through the handover period. Observation handover, we heard, usually began about 5-10 minutes before the hour and lasted for 5-10 minutes up to the hour. With a number of patients to observe and check a patient may have been seen 5-10 minutes before handover and their absence not noticed until after handover, possibly 20 minutes later. This problem will not have been unique to the Trust.

2.34 The missing patient checklist

2.34.1 The form entitled *'Checklist for QMC Psychiatric Acute Wards, Missing Patient Considered to be at Risk'* was completed by Staff Nurse B.

2.34.2 It recorded that Patient A was noticed to be missing at 17.05 by Nurse in Charge B. A tick box indicated that other wards were notified by Staff Nurse B and a local search undertaken by Nurse in Charge B. That search included psychiatric ward areas on the same floor, shop and main entrance on B floor, and D floor canteen area.

2.34.3 The form listed eight further people and organisations to be notified with tick boxes which were to be dated and timed. In order these were: the Medical Officer, RMO, Police, Security, A&E, Relatives, DNPS, Senior Manager and Senior Nurse QMC.

2.34.4 Of these only the Police and relatives were entered on the form as having been notified, the Police at 17.35 and the relatives at 18.00 hours.

2.35 Responsible Medical Officer not informed

2.35.1 The Consultant Psychiatrist, who was Patient A's RMO under the MHA, was not informed that Patient A was missing. Indeed he was not contacted from the time of the Ward Review at 14.00 that day until 08.30 the following day. We were told by nursing staff that it was not always routine to contact the RMO.

RMO should have been told

The RMO was very clear in his evidence to the Inquiry that he should have been informed Patient A was missing. "We may not always be available but at least they should attempt". He was surprised that contact was not routine: "for an incident like that, when somebody on section 2 has been said to be higher than average risk for patients who are admitted for the first time and with that kind of history… I am surprised". We recommend it be made clear to nursing staff that in all cases where missing patient documentation is completed the RMO must be informed. The MHA Code of Practice states that the Responsible Medical Officer should be informed immediately when a detained patient is absent without leave.[4]

Recommendation 6.2.2(j)

2.36 Hospital security not informed

2.36.1 Nursing staff made no contact with hospital security even though Nurse in Charge B told us that it was normal procedure to inform the security service that a patient was missing. This, we were told, would generally be done after the local search.

2.36.2 Giving evidence to the Inquiry for the hospital security service, a security guard told us that they are usually informed by telephone when a patient from the psychiatric wards is missing. A detailed description of the individual is taken, how long they have been missing and when last seen on the ward. They then scan their cameras, located all over the hospital, search the grounds and send a security vehicle around the perimeter to search for the missing patient; "*in the meantime the ward has also contacted the Police, so then the Police are involved as well, and nine times out of ten the Police do get them….And sometimes we have got them back, but it's a case of helping each other, with the security and the Police we work together with the ward staff".*

2.36.3 Adding that it was *"quite common"* for people to go missing, he said *"There's nothing stopping him or her walking away……there's nothing stopping them….They can walk out them doors…. they just push 'em open and out they go".*

2.36.4 The Chief Inspector, of Nottinghamshire Police Professional Standards Unit, expressed his view that Hospital Security should be notified in every case *"as early notification could prevent the patient from leaving hospital grounds at all".*

[4] Paragraph 21.6 a. of the Mental Health Act 1983 Code of Practice

Hospital security should have been asked to search

Hospital security should have been informed immediately Patient A was noticed to be missing. Evidence to the Inquiry suggests that the security service would have scanned their cameras and been able to discover that Patient A left the building at 16.44. This was vital information. Internal searches could then have ceased. Patient A could immediately have been treated as absent without leave from the hospital. It was 19.20 before hospital security were informed, and then it was by Police and not by nursing staff.

Recommendation 7.2(c)

2.37 Nursing notes

2.37.1 At 17.35 Staff Nurse B made his first entry in the nursing notes since 16.00 hours. He recorded *"(Patient A) appears not to be on the ward. He was visited by two friends and may have left the ward in their company. Missing patients procedure implemented. Police informed".*

2.38 Untoward Incident Report form

2.38.1 This form was completed by Staff Nurse B. There was no place on the form to record the time at which the form was completed but it recorded the untoward incident as occurring at 17.05.

2.38.2 Under the heading *'Absconsion'* there were three possible boxes to be ticked: absconsion, missing patient and attempted. The box *'missing patient'* was ticked.

2.38.3 Under the heading *'Brief Report of Investigative Findings and Outcomes of Manager or Person in Charge'* was recorded *"Section 2 patient appears to have absconded from the ward in the company of his friends".*

2.38.4 The *'Names of All Staff on Duty at the Time of Incident plus their Location'* was given as

"(Staff Nurse B) – Ward Office
(Staff Nurse C) – Treatment Room
HCA (Health Care Assistant) – Supervising Tea Trolley
(Nurse in Charge B) ADWM (Acting Deputy Ward Manager) – Checking Observations"

2.38.5 Under *'Grading of Risk – Likelihood of Reoccurrence and Outcome'* there were boxes to be ticked grading risk from *'No risk'* to *'High'.* Patient A was rated as *'Low – could recur/ short term/ self limiting effect'.* Another ticked box indicated *'Document Risk Assessment Undertaken'.*

Low grading of risk

On the Untoward Incident Report Form the likelihood of reoccurrence was graded as 'Low – could reoccur'. Yet this was the third time Patient A had absconded or attempted to abscond in the previous 24 hours: once from AED the day before, and earlier the same day whilst on 10 minute observation. Category 'Medium – likely to reoccur' would have been realistic bearing in mind that Patient A was new to services and there was no established pattern to his behaviour on the ward.

2.39 Police informed

2.39.1 At 17.33 hours, according to the Police log, the Police switchboard was informed by Staff Nurse B that Patient A was missing. The text of the message read *"caller reporting (Patient A) 1.6.79, sec 2 patient missing from ward since 1645 hrs today."*

2.39.2 The control room operator decided upon the category of the call. Calls were graded immediate, delayed or scheduled response. This one was graded as a Grade D or delayed response. That, we were told, meant it was assessed that there was not an offence in process or life at risk.

2.39.3 Control room operators were trained and would have assessed risk but the Chief Inspector told us *"I could well imagine with the routine nature of the calls coming in and missing persons being reported, that it may well be that we have got a missing person..... 'Can you have somebody out?'..... 'Yes, that is fine'..... This again comes back to the routine nature of missing persons from the ward, and it is very much a routine. 'Another person missing from A42'.....We could quite easily be getting two of these a week".* The Community Policeman for QMC confirmed that the usual missing person message would *"Can you attend the Queen's Medical Centre, Ward X..... or wherever... they want to report a patient missing".*

2.39.4 The Chief Inspector told us that the Community Policeman was given the task of responding since he was familiar with QMC. The PC explained that his role as the Community Policeman for QMC was part funded by the QMC Trust. The call came to him in Canning Circus Police Station at 17.50. He took down the details on a missing person form, telephoned Ward A42 at 18.20, spoke to Staff Nurse B and left immediately for QMC. He walked there, arriving at 18.50. The PC explained *"I work on foot, I'm a Community Policeman".* He let hospital security know at 19.20.

2.39.5 It was the Chief Inspector's view that, for a delayed response, the PC had dealt with the matter relatively quickly. The PC confirmed that 'delayed response' means *"you will go when you are available".* Had he been at QMC already his response would have been a little quicker because he would not have had to walk there. But had he been dealing with other things he would have finished those before responding to the request. As it happened the PC was able to respond immediately.

2.39.6 The Chief Inspector commented on the ward's speed of response *"The ward staff's response to finding Patient A missing appears to have been relatively swift..... Whilst, in hindsight, it may be argued that the Police should have been called immediately, the high numbers of individuals who walk out of the ward and return within minutes explains this delay".*

2.39.7 We were told of Police concern at the *"large number"* of individuals reported as missing from QMC acute psychiatric wards at that time, despite being sectioned. In 2000 the numbers reported missing for wards A42, 43 and 44 were 29, 20 and 28 respectively. In 2001, after the homicide, the numbers rose to 71, 23 and 41. The Chief Inspector estimated that a substantial number of these would be sectioned patients. He thought it would be *"around 50 percent".*

2.39.8 We were shown figures revealing that 70 out of the 78 patients missing in 2000 returned to the ward within 24 hours. Of these, 33 were found at their home address and returned by Police and 34 returned of their own volition. Other than Patient A, none had been involved in reported crimes. The Community PC added *"we used to get lots of Section 17 patients being reported to us as having failed to return when they were at home and there was a feeling that we were being used as a bit of a taxi service to go and collect people and bring them back which didn't help when……you were getting vulnerable people being reported as well, which sort of clouded the issue a bit".* Or as put by the Chief Inspector: *"it risks making Officers complacent when a patient genuinely at risk goes missing……. Only when the person is genuinely missing should the Police be requested".*

Making the decision to call the Police

There were 25-30 minutes between discovery of Patient A's absence at 17.05 and notification of the Police at 17.33, though Staff Nurse B reported to the Police that Patient A had actually been missing since 16.45. We must consider whether anything could or should have been done more speedily to find Patient A and prevent the homicide. Any reader of this report will wonder whether a prompt telephone call to the Police might have prevented the train of events that followed. We have already said that the hospital security service should have been informed quickly. Had Patient A been seen on camera leaving the hospital, we think it reasonable to assume that the Police would immediately have been informed. As it was, a local search began within the hospital. The Director of Nursing at the time pointed out to us that in deciding when, and if, to call the Police several factors would have been weighed in the balance. Patient A had returned on a previous occasion, was thought to be in the company of his visitors and appeared to have settled on the ward. These points would have led staff to explore the local hospital area first. However, Patient A was also a detained patient, very much an unknown quantity, had a history of recent violent and threatening behaviour and was in the company of individuals whose exact identity was unknown. Urgency should have been the starting point. The present Trust should ensure there is a policy covering detained patients who are AWOL, and this should be supported by training. This is considered in more detail at Chapter 5.

Recommendations 6.4 and 7.1

Need for risk screening at point reported missing

The speed of Police response was determined by the grading given by the Control Room Operator. The Community PC said he would not normally be told whether a patient was detained under the MHA; nor would he receive detailed information such as whether they were a threat to others. This seems to us to be a potentially dangerous omission. There is a need for more thorough screening of risk at this crucial point. Where a patient is detained under the MHA that information should be conveyed to the Control Room Operator and passed on to the Police Officer who will attend. The Community PC suggested that more questions should be asked of the ward staff such as "Has the person displayed violent tendencies? Have they been aggressive towards people?" We agree. A checklist to screen for risk would help the ward and the Control Room Operator establish urgency at the point at which a patient is reported missing. We recommend that the Police and present Trust work together on devising such a checklist.

Recommendations 7.2 (f) and 7.3

Detained patients in a category of their own

We have the advantage of hindsight. We know now that the man who at the time seemed settled was in fact still disturbed and acutely psychotic. It seems to us that the key was Patient A's detention under the MHA. This was a reminder that, despite appearances, his legal status indicated a need for special caution. Detained patients should be considered as in a category of their own as far as risk is concerned. There should have been some distinction between informal and detained patients in Trust observation and absconding procedures and in the reporting of missing patients. We recommend that a Trust AWOL policy be developed by the present Trust jointly with the Police, and that it emphasise the greater degree of risk that is likely to be associated with a detained patient who is missing from the ward.

Recommendation 7.2

2.40 Patient A's eldest sister phones the ward

2.40.1 Sometime after Staff Nurse B had phoned the Police, but before the PC had arrived, Patient A's eldest sister telephoned the ward and spoke to Staff Nurse B. She said she intended visiting her brother and wished to know how he was. Staff Nurse B said in his Police statement *"Patient A's eldest sister was enquiring about the review that had been done on (him). I told her what had been said and also that (he) had now gone missing with two men who claimed to be his relatives. Patient A's sister in effect said that the men were unlikely to be relatives but friends of his who tended to lead (him) astray. She gave me names and addresses for these people which I recorded on paper and later handed to the Police".*

2.40.2 Patient A's eldest sister says she was told that Patient A had gone missing with two men who said they were his relatives. They had gone to the hospital shop but not returned. The Police had been informed and Patient A's eldest sister was asked to make enquiries at his home.

2.40.3 Shortly afterwards Patient A's other two sisters arrived on the ward with food for their brother. Patient A's eldest sister then phoned the ward again, speaking once more to Staff Nurse B and explaining that her brother had been to his mother's house, changed his clothes, taken some money and was very angry, wanting to know who had been responsible for him going into hospital.

2.40.4 At 19.25 Staff Nurse B wrote *"Police have attended the ward and collected information re his absconsion. To inform sisters and Police should he return early".*

2.41 The homicide

2.41.1 Patient A's friends told the Police that after leaving the hospital they all went to a shop and bought some cigarettes. Saying he needed some clothes Patient A then went home, still with his friends. One of the friends, in written evidence to the Inquiry, made the observation that during this time Patient A was *"blanking"* them.

2.41.2 Patient A spent some 5 to 10 minutes in the house putting on some more clothes. The friends told the Inquiry that he then kissed his daughter and told his anxious wife and mother that he would return to hospital. After walking down the road together Patient A parted from his friends and they believed he was walking back to the hospital.

2.41.3 Patient A's eldest sister later told the Police that after she had spoken to her mother and learned Patient A had been there she was *"scared that (her brother) might be angry with me because he had been taken to hospital".* Patient A's eldest sister rang her husband at work. He reassured her and calmed her down. She took a meal to him at his shop and then went home.

2.41.4 She was later called back there after a neighbouring businessman could not find her husband. A search by the Police found her husband behind the shop and it was evident that he had been killed. Following a chase Patient A was detained by Police, arrested and charged with murder.

2.42 Following the homicide

2.42.1 Patient A was assessed in Police custody the following day by the on-call Psychiatrist, who could elicit very little from him. He appeared preoccupied and guarded, laughing and smiling inappropriately. The on-call Psychiatrist found him unfit to be interviewed by Police.

2.42.2 On 1 January 2001 Patient A was remanded in HMP Nottingham on the hospital wing, and referred to Arnold Lodge Regional Secure Unit for assessment. He was thought to be suffering from a psychotic episode, possibly schizophrenia, depression with psychotic features, drug induced psychosis or organic psychosis.

2.42.3 Patient A was admitted to Arnold Lodge under section 48/49 of the MHA 1983 on 15 February 2001. There a Specialist Registrar in Forensic Psychiatry then working at Arnold Lodge found Patient A to be very distressed. He was convinced others could read his mind and hear his voices.

2.42.4 The Specialist Registrar wrote a report for court dated 9 May 2001 stating:

"In my opinion (Patient A) has a Mental Disorder within the meaning of the Mental Health Act 1983 namely, Paranoid Schizophrenia. This is characterised by psychotic symptoms i.e. second and third person auditory hallucinations, command auditory hallucinations, thought broadcasting, ideas of reference and paranoid persecutory delusional beliefs. In my opinion it is likely that (Patient A) has been suffering from Paranoid Schizophrenia for at least two years".

2.42.5 An Independent Consultant Forensic Psychiatrist commissioned to provide a medico-legal report in connection with the criminal proceedings shared the opinion that Patient A suffered from paranoid schizophrenia in his report for the court dated 17 July 2001.

2.42.6 Patient A was found guilty of manslaughter on the grounds of diminished responsibility, and on the basis of these two reports a hospital order was made under s37/41 of the MHA 1983.

2.43 Diagnosis

2.43.1 The Inquiry Panel has met with Patient A but not attempted any formal assessment of his mental state. The Inquiry's comments on diagnosis are based upon the evidence.

2.43.2 In fact there has been no dispute over diagnosis. Before the homicide the GP, SHO A, the SpR and the Consultant Psychiatrist diagnosed an acute first onset psychosis. After the homicide forensic psychiatrists agreed that the psychosis was paranoid schizophrenia.

2.43.3 We adopt the diagnosis of paranoid schizophrenia. It is consistent with all of the factual evidence we have heard.

2.44 Predictability

2.44.1 It is evident that Patient A had been acutely psychotic in the 24 hours or so before the killing. He concealed his paranoid delusional beliefs that there was money passing between his brother in law and the Consultant Psychiatrist, and that the words of a fruit drink conveyed to him a special instruction to carry out the homicide. He believed he was under pressure from everyone to kill his brother in law, including those inside the family. The family themselves could not have been expected to detect or understand the dangerous content of his psychotic thinking, and he concealed his psychotic ideas in the psychiatric review.

2.44.2 We conclude that this killing, in the context of an acute first psychotic episode, was essentially unpredictable, motivated as it was by a previously undisclosed delusional belief. The phenomenon of believing, as Patient A did, that an event is a personal message with some special meaning or significance following which an action must be taken, is a recognised psychotic symptom that is often concealed.

2.45 Foreseeability

2.45.1 We do not think the killing was foreseeable on the basis of the information then available. Too little was known about Patient A's delusional thinking.

2.45.2 But we have asked ourselves the question the family will ask. If Patient A's eldest sister's concerns had been known, if Patient A's wife had been invited to the psychiatric review and been able to explain that Patient A had tried to discover who in the family had telephoned the Police and GP, would this have made any difference?

2.45.3 We are sure that the family should have been involved in a comprehensive risk assessment on the day of the homicide. This could have alerted the Consultant Psychiatrist to the possibility that Patient A's eldest sister, or her husband, might have been at some risk. Like many patients detained under the MHA Patient A resented his hospital admission. Indeed, this might have caused the Consultant Psychiatrist to increase observation levels as a precaution, at least for a time.

2.45.4 However, even if all the family information had been available, it seems unlikely that the details of Patient A's paranoid psychotic ideas would have been revealed. His wife told the Police he seemed *"all right"* to her, and staff and doctors thought he was settled. It appears he was capable of concealing his thoughts from everyone including his family, friends and professionals, and it was these thoughts that were dangerous.

2.45.5 We cannot therefore say that even with maximum family input this particular homicide, on this particular day, was foreseeable.

2.45.6 However, we do think it was foreseeable that someone might be at risk if Patient A were to leave the hospital before being properly assessed and treated.

2.45.7 Detailed information was not needed. It was already available. It was the first 24 hours of Patient A's first admission to hospital with a first episode of psychosis, diagnosed only the day before, when he had armed himself at home with a knife in response to paranoid thoughts. It was known that he had a history of assault on a member of the public and had already hurt his wife. He was detained under the MHA for these reasons. With this information alone it was foreseeable that somebody could be at risk.

2.45.8 There was an inherent unpredictability to the situation. The unexpected should have been expected.

2.46 Preventability

2.46.1 Asked by us what could have been done differently, Patient A replied *"I don't know. I keep thinking that – to tell me that the voices weren't real could have been something".*

2.46.2 Patient A was acutely mentally ill. He needed to be protected from the consequences of his illness. Admission under s2 MHA and nursing observation were together intended to ensure that he was protected by keeping him in hospital.

2.46.3 It was not necessary for anyone to know that Patient A had suddenly formed an intention to kill. He was acutely psychotic and previously unknown to the mental health services. He simply needed to be kept on the ward.

2.46.4 Had he not been able to leave the ward, he would not have killed his brother in law that day.

2.46.5 In short, we find that this homicide could have been prevented by ensuring that Patient A remained in hospital.

2.47 Failure to prevent Patient A leaving Ward A42

2.47.1 We find that the failure to keep Patient A on Ward A42 came about for six key practical reasons, each of which are examined in more detail later in the report. In no particular order they are:

- The ward door was open
- The ward door was not continuously observed
- The ward ten-minute observation procedure permitted up to 20 minutes observation free time because of handover procedures
- Effective measures were not put in place to contain Patient A on the ward after he had gone missing once
- It was not made sufficiently clear to Patient A's visitors that he was very mentally unwell, legally detained and he should not leave the ward with them
- QMC hospital security were not informed immediately Patient A was found to be missing

2.47.2 In Chapters 3, 4 and 5 we examine ward procedures, observation and the management of patients who go missing. Chapter 6 considers the impact of culture and communication difficulty, given that some visitors to the hospital had interpretation needs.

Chapter 3

Ward A42

3.1 Concerns about Ward A42

3.1.1 We have a number of concerns about Patient A's care and treatment on Ward A42 during the 19 or so hours he was there from the evening of 28 December 2000 to the afternoon of 29 December 2000. Over four Chapters we examine nurse staffing issues, nursing documentation, nursing observation, missing patients procedures and the management of cultural and interpretation needs. This Chapter considers management, staffing and nursing documentation issues connected with Ward A42.

3.2 Trust management structure in 2000

3.2.1 Without conducting a detailed management review we wished to know how policies and procedures were developed at the time of the homicide, who was responsible for management and training, and how problems were resolved in the structure.

3.2.2 We heard that the then Nottingham Healthcare NHS Trust had a Trust Management Board and a series of Clinical Directorates: General Psychiatry and Psychotherapy, Rehabilitation and Community Care Services, Learning Disabilities, Older People's Mental Health, Child and Adolescent Psychiatry, Physical Rehabilitation and Addiction, and Forensic. Each Directorate was headed by a Clinical Director who was a clinically qualified professional who reported to the then Chief Executive. Each Directorate had its own Directorate Management Team. In General Psychiatry the Directorate Management Team included a number of Sector Managers who were answerable to the Clinical Director.

3.2.3 There were also a number of Corporate Directorates, which included the Medical Directorate, Nursing and Quality, Human Resources and Personnel, and Estates and Finance. The Nursing and Quality Directorate was headed by the Director of Nursing, who provided professional leadership for all nurses in the Trust. He developed a Professional Nursing Leadership Group comprising most of the Senior Nurses in the Directorates.

3.2.4 The Director of Nursing described the Senior Nurse role in General Psychiatry to us: *"He would work as a lead professional on nursing issues for that Directorate. So he would have a professional line through to me but he'd have a general management line through to the Clinical Director in General Psychiatry".*

3.2.5 Different aspects of the same issue could be addressed through the general management route and the professional route. The Director of Nursing gave as an example a query about staffing levels, which could have resource implications needing to be addressed by the Clinical Director, and professional standards issues needing to be considered by Director of Nursing. He told us *"sometimes people…if they don't like the answer they hear from their General Manager, they might try and get a different answer from their professional lead."*

He agreed that there was a possibility of confusion of lines of accountability; managerial, professional and operational; , commenting *"I understand how some people find that confusing"* and adding that this could be exacerbated slightly where (as in this case) the Clinical Director and the Director of Nursing were both nurses who would sometimes have different professional judgments.

3.2.6 However, the Director of Nursing pointed out *"the NHS is a complex organisation….. general management and professional lines of accountability running in parallel are common models throughout the NHS. …. I was entirely happy with that management structure and very clear about lines of accountability".*

3.2.7 Policy development took place within the professional structure. The Manager for Nursing and Quality, herself a Registered Nurse of some significant experience, was also Chair of the Clinical Policy Committee. She reported to the Director of Nursing who would meet with her monthly to talk through day-to-day issues, have an annual appraisal and a six-monthly review. She had a co-ordinating role across the directorates and was responsible for drafting policies. She told us that, after a period of consultation with the Directorates, policies would go to the Trust Management Group for ratification. Implementation and training would then be by a 'cascade' system through the operational management side. Chapters 4 and 5 refer to this in more detail in connection with the Trust observation and absconding procedures.

3.2.8 The Director of Nursing described training as having three parts to it. The first was externally commissioned, the second was internally commissioned by the Clinical Directorate as described by the Manager for Nursing and Quality above, and the third was the provision of training within the Human Resources and Personnel Department. The latter applied when a policy had Trust-wide implications.

2.3 Present management structure

3.3.1 The present Chief Executive was appointed in December 2000 and took up his post in March 2001 to be in place for 1 April 2001, when the new Trust became operational. It is not part of the remit of this Inquiry to conduct a review of the management structure since the homicide. However our recommendations are made to the new Nottinghamshire Healthcare NHS Trust, and the Chief Executive has helpfully described to the Inquiry changes he has made in the management structure, including the appointment of medical staff as clinical directors.

3.3.2 He described the way that the present Trust was now *"trying to create an empowered organisation where decision making is as close to where the patient is treated as possible".* He described a structure designed to *"give people discretion…… allow them to take risks….and at the same time maintain a tight grip on a common standard of approach".*

Management concerns

This Inquiry is not conducting a detailed management review. However there are areas of concern arising from the evidence we have heard. These include weaknesses in policy, procedure and training in nursing observation, and the issue of 'missing' patients. There was no distinction between policy and

procedure in these areas. Documents referred to by staff as 'policies' were in fact entitled 'procedures'. There was no rolling programme of training on observation and absconding. Nor was there any involvement of Social Services, Police or Ambulance Service in the drafting or agreement of policies or procedures concerning missing patients. There was no specific policy, or section of the current policy, for patients liable to be detained who are absent without leave in accordance with the MHA Code of Practice.

Accountability

Where ward matters such as staffing had both professional standards and financial implications the lines of accountability had the potential to be unclear. Observation and absconding procedures were devised through the professional structure, in consultation with the Clinical Directorates, but implementation and training was the responsibility of the management structure. Budgets were devolved to ward managers, and details of spending would go back up along the managerial line through the Sector Manager, the Clinical Director, and then to the Chief Executive, but the professional consequences of budgetary decisions might be dealt with by the Director of Nursing. We had the impression that it was not easy for multi-faceted problems arising from ward practice to be identified and addressed cohesively at senior levels within this structure. Nor was it easy for policy or procedure with staffing and training implications to be passed effectively down to those in contact with patients. We are impressed by the Chief Executive of the present Trust's commitment to creating an empowered organisation and urge him to ensure that the actions arising from this Inquiry are effectively addressed within the professional and managerial sections of the organisation in an integrated way, at all levels and as simply as possible.

3.4 Pressures on Ward A42

3.4.1 A42 was a very busy acute ward. The Consultant Psychiatrist told us it was much bigger than the other acute admission wards, with 24 beds. It was always running at over a 100% occupancy level. *"We served the south and west sector of Nottingham, which is the inner city area with multiple difficulties, social problems….high social deprivation, multi-ethnic population, drug abuse, all those things dictated the number of admissions".*

3.4.2 He added that there was a fairly rapid turnover of patients because an active community support programme meant they could discharge early. That high turnover meant A42 could often offer beds to other wards. This produced a lot of stress for ward staff: *"Our nurses were stressed most of the time…..There were difficulties with sickness because of the high stress level. So….we have always talked about the need for a higher number of nursing establishment".*

3.4.3. The consultant Psychiatrist met with the Sector Manager, nearly every week for a triage meeting about new referrals to the Community Mental Health Team (CMHT). It was agreed there were pressures on A42. The Consultant Psychiatrist said *"It was felt that the nursing staff were up to the required level of establishment but they introduced skill mix to improve things…we had discussions about….how we could improve things, so that we could get nurses to do nursing rather than just watching patients…..but I would say that we were always understaffed".* There was an awareness of the commitment of staff who

were *"very keen….always trying to sort of develop new ways of working which is best for the patient and for the ward".* He told us they were *"wonderful staff".*

3.4.4 The Director of Nursing told the Inquiry *"People were very aware of money, and clearly what the Trust has to do is to break even. That is one of its corporate, statutory responsibilities".* He explained that, effectively, budgets were devolved to ward managers. There was training on finance down to ward level with a monthly trend analysis and budget statement issued to ward managers.

3.4.5 A contract with an agency for bank staff meant that when additional nursing cover was needed the agency was approached first, since it was less costly then offering overtime to nursing staff employed by the Trust.

3.4.6 We were told by the Director of Nursing that the Trust was required to do this following the recommendations of an external audit of Ward A42 staffing levels against comparable organisations, conducted in 2000. He told us *"they recommended that we could make some fairly substantial savings, if we reorganised the resources that we had".* He added *"some of the ways in which we felt that they were suggesting making savings would be detrimental to patient care. Moving to two shifts per day and having nurses working exceptionally long hours was one that I particularly argued against".* However, the requirement that use of Bank staff be monitored was, he felt, reasonable.

3.4.7 The Clinical Director explained that they tried to borrow staff from other wards first, so they were not spending money unnecessarily. Sometimes, particularly at night, someone would be designated to keep an eye out on another ward and they would open the doors in between the wards making it one big ward instead of two separate ones.

3.4.8 We heard from the Clinical Director that in December 2000 Ward A42 was underspent by £10,000, possibly because of staff vacancies. At the time a number of community orientated services were being funded in Nottingham. A lot of inpatient staff saw this as a progressive career move and were leaving.

3.4.9 The manager of Ward A42 confirmed that she managed the notional ward staffing budget with the Sector Manager. They would tend to deal with vacancies by employing agency nurses on short-term contracts.

3.4.10 Bed-occupancy on Ward A42 was usually at least 100% and there were 24 beds. This contrasted with fewer beds and lower bed-occupancy on the other QMC acute wards, yet staffing levels were the same. A full complement of staff would have been four on duty during the day and three at night, and they tried to achieve two qualified nurse on each shift. The A42 Ward Manager told us *"we've had an ongoing issue with what we see as A42 having less staff per patient ratio than any of the other wards and we have attempted to address that with higher management".*

3.4.11 The pressures on Ward A42 were vividly illustrated in a document written by the Clinical Director, then Acting General Manager, dated October 2001 and entitled *'Management Response to the Lady Middleton Ward Risk Assessment'*. This provided a comparative analysis of Nottingham's six acute psychiatric wards

(three of them in QMC) based upon data gathered between January and December 2000.

3.4.12 Ward A42 was found to have had the highest bed occupancy rate, the highest number of admissions and discharges, the highest use of intensive care beds, the highest number of detained patients, the highest level of staff turnover and the highest number of untoward incidents recorded.

3.4.13 Of the untoward incidents, Ward A42 had: the highest number of general incidents (28 out of the total of 88); the highest number in the category 'Violence and Aggression' (153 out of the total of 349 - over double the figure of the next ward which had 66 such incidents); the highest number of absconsions (69 out of a total of 157 - over double the second rated ward which had 30 absconsions); and the highest number of unexpected incidents (14 out of 34, the next lowest being 6).

3.4.14 Of the six wards Ward A42 had the lowest use of high observation, its average use being 4.58 occasions per month compared with the highest at 19.42 per month. Of the QMC wards, Ward A42 had the highest use of medium observation, its average per month being 108.33, though it was not the highest user out of the six wards, that being 154.75 per month as against the lowest of 50.75.

3.4.15 The Director of Nursing confirmed that concern about workload on A42 and high bed occupancy led to a bid to increase the ward's establishment. The Sector Manager put forward a business plan arguing for an increase in staffing. However this was not successful.

3.4.16 Rather than attempt to recruit more staff, the Clinical Director described an attempt to deal with the *'underlying causes'*. The 'inpatient collaborative' endeavoured to look at what could be done to reduce the pressure on the ward from the community. The aim was to reduce the number of admissions and reduce the length of stay.

3.4.17 Improvements in the ward environment were also considered important, providing for a more relaxed and less pressured service for patients and staff.

3.4.18 The Chief Executive of the present Trust told us that currently, in common with every other Trust in the country, the Trust has difficulties recruiting nursing staff, but it fares better than average in terms of recruitment and retention. There has been no particular drive to recruit more staff. He described a trend, both within the Trust and nationally, for a move away from acute inpatient services to condition-specific teams based in the community. This has been a national topic for debate amongst those responsible for mental health services.[5]

[5] e.g. Smyth MG (2003) Crisis resolution / home treatment and inpatient care. *Psychiatric Bulletin*, 27, 44 – 4; states that bed pressures, over-occupancy, access problems, poor treatment culture, impoverished environment, low morale, high staff sickness, reliance on agency staff, high detention rates, and particular difficulties around gender and cultural sensitivity are well rehearsed and widely recognized problems. They may get worse if services deal with a smaller, more difficult to manage admitted population as other community services develop.

Ward A42 staffing needs to be reviewed

On objective measures of staffing and ward pressure including bed occupancy, incidents of violence, aggression and absconding, Ward A42 was disadvantaged. A request for an increase in staffing had been turned down and subjectively it was a ward under stress. And yet the ward budget showed an under-spend of £10,000 and we heard no evidence of any difficulty funding vacancies or staff sickness. We gained an impression of nurses who worked hard to economise and managers who had a certain pride in achieving an under-spend. But it appeared to us that the balance between financial and clinical performance had tipped too far in favour of economy. An increase in the number of qualified nurses would have reduced stress, made more staff available to complete documentation, respond quickly to requested observation levels, observe the open door and interact with visitors. Staffing levels at QMC should be reviewed.

Recommendation 6.2.4

Acute inpatient services need to be adequately resourced

There is a danger that with resources focussed on assertive outreach and other community support, acute inpatient services will be become starved of the funding needed for maintenance of high standards of care to those who are very mentally unwell and who need intensive care in hospital. The care of this group of patients should be seen as highly specialist, with resources made available to ensure adequate staffing and training. Gedling PCT should review the funding of acute mental health inpatient services and ensure there is adequate resourcing of staffing and training

Recommendation 8.1

3.5 Nursing on Ward A42

3.5.1 Nurse in Charge B described how each patient had a key worker, though of course that nurse would not be present on every shift. There was no strict team nursing and staff were not responsible for any particular patients on a shift. Patients spoke to whomever they felt most able to approach with a problem.

3.5.2 Staff Nurse A was Patient A's keyworker. She had been on duty on 28 December 2000 when he was admitted. Nurse in Charge B, Acting Deputy Ward Manager on Ward A42, recalled that on 29 December 2000 Staff Nurse B had most involvement with Patient A. She said he had spoken to the relatives and there was *"already the beginnings of a relationship"* with him, though the Police statements of the family do not record that there was any contact between the family and nursing staff.

3.6 Nursing Records

3.6.1 Routine running nursing records were completed in addition to admission documentation, observation records and nursing notes of the psychiatric review.

3.6.2 We note that on 29 December 2000 there were no entries in the nursing records for nearly ten hours - between 06.45 and 16.00 hours - and even then no comment on Patient A's absence from the ward. Nurse in Charge B told us that notes would often be written up at the end of a shift or when there was time to sit down and do it. Had events not intervened she would have expected that

nursing notes would have referred to Patient A's period of absence from the ward, and it would have been mentioned as part of handover.

Weak recording
It is inevitable that nurses will write their notes when there is time, but Patient A was a new patient with a first episode of psychosis. It may have been indicative of the pressure on the ward that there was no recording for a period of nearly ten hours.

3.7 Admission paperwork

3.7.1 Upon a patient's admission to Ward A42 18 pieces of documentation were routinely completed by nursing staff. This was a time-consuming task. Much of the detail was taken from medical notes, section papers and social work notes. In this case Staff Nurse A, Patient A's allocated key worker, partially or fully completed the following:

I Ward A42 Admission Checklist
II Nursing Admission documentation
III Clinical Risk Management Summary Sheet
IV Clinical Risk Management
V Childcare information gathered as part of risk assessment
VI Admission/referral risk assessment checklist
VII A42 Risk Assessment HoNOS chart scale
VIII Global Assessment of Functioning (GAF) Scale
IX Ward A42 Care Plan record
X Care Plan No. 1
XI Care Plan No. 2
XII Care Plan No. 3
XIII Observation Plan
XIV Form 50MS Advice to Patients Rights under the Mental health Act
XV Ward A42 Legal Status Mental Health Act 1983 Record Sheet
XVI Patient details for completion on admission
XVII User and carer information record
XVIII Ward A42 disclaimer

Too much documentation
We were struck by the heavy emphasis on pre-prepared documentation and procedures for each admission that did not appear to have been formally reviewed in recent times. It placed a heavy burden on Staff Nurse A, the nurse completing the documentation and we are not convinced that it added benefit or quality to Patient A's nursing or care planning. Much of it involved duplication of information. Completion of unnecessary documentation on this busy ward wasted precious staff time. This admission paperwork is still being used and we recommend that it be reviewed and where possible the amount of it reduced.

Recommendation 6.1.1

I Ward A42 Admission Checklist

This was a checklist of 23 actions to be undertaken by the admitting nurse. These included routine administrative and practical procedures. Staff Nurse A had fully completed the list.

II Nursing admission documentation

Under the headings *'Reasons for Admission, Personal History, Psychiatric History, Previous Admissions, Medical, Social and Forensic Histories, Mental State Examination and Physical Health'* it was recorded that Patient A was apparently psychotic, had hit his wife on 16 December 2000 and had walked into the lounge with a knife that day. It was thought he was on bail in connection with ABH. He was described as presently smoking up to £5-10 cannabis a day. There was no mention of his absconding from AED.

III Clinical Risk Management Summary Sheet

This one-page document, based on the Sainsbury Centre for Mental Health's risk management model, was a summary sheet for the five-page Clinical Risk Management below. The following information was included:

- Under *Summary of Risk Assessment* Staff Nurse A had written *"(Patient A) could be a risk of physical aggression as presently he is under probation for ABH. He has also hit his wife and threatened her with a knife"*
- Under *Initial Risk Management Plan* Staff Nurse A had stated *"To observe (Patient A) on Medium 10 observation level. To use the personal alarm and to utilise PRN if it warrants. To involve Police if situation warrants such a call"*
- She had added that the situation should be discussed with the Consultant Psychiatrist and that more information was needed *"from his mother and sister and also from his wife if we can contact them tomorrow".*
- At the bottom of the page there was a note adding *"this is based on information from the duty doctor and social worker who obtained their information from (Patient A)'s sister and mother".* Staff Nurse A told us that, had it not been night-time, she would have endeavoured to speak directly to the relatives. She expected that the morning staff would follow it up thoroughly.

IV Clinical Risk Management

This five-page Sainsbury Centre document stated that it was part of an integral comprehensive mental health assessment and care planning process. The following information was included:

- *Risk Indicators*
  Boxes had been ticked for risk factors relating to suicide, neglect and aggression/violence, but no details were given.
- *Assessment*
  It was noted that Patient A had previously used violence, misused drugs and/or alcohol and was unemployed.

V Childcare information gathered as part of risk assessment

Staff Nurse A completed this form to indicate that the safety of Patient A's child may be compromised by his mental health and she noted *"Social worker will be looking into this."*

VI Admission/referral risk assessment checklist level 1 screening test

This one-page *Nottingham Social Services and Nottingham Healthcare NHS Trust* document had not been completed.

VII A42 risk assessment HONOS chart scale

The HoNOS6 chart provided 12 signs or symptoms associated with psychological or psychiatric difficulties. These were scored from 0 to 4 for each area of potential difficulty, 4 being the maximum score. Where scores were given these were

overactive, aggressive, disruptive	0
non-accidental self injury	0
problem drinking or drug taking	3
problems with hallucinations	1
problems with depressed mood	1
Eating	2
Sleep	2

VIII Global assessment of functioning (GAF) scale

This assessment tool consisted of a continuum of codes within a range of 0 to 100. There were 10 sections, each with an explanation of the code. This appeared to be a photocopied page from a book. Under the number *'30'* had been handwritten

"Behaviour is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgement (e.g. sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g. stays in bed all day; no job, home or friends)".

IX Ward A42 care plan record

This logged the dates that the three Nursing Care Plans commenced and discontinued, recording that

- the 72 hour assessment plan would be evaluated in 72 hours but reviewed daily
- the medium 10 observation would be evaluated daily and reviewed "shiftly"
- the section 2 Care Plan would be evaluated and reviewed "as appropriate."

X Nursing Care Plan No. 1

This standard pre-printed document was in a format permitting deletion as appropriate and providing room for additional handwritten notes. Staff Nurse A's handwritten commentary read:

"(Patient A) was admitted following changes in his mental state and behaviour, he appeared to have become labile in mood and threatening in his behaviour, especially towards his wife and family."

[6] HoNOS Chart, Health of the Nation Outcome Scales; Report on research and development, July 1993 – December 1995

XI Nursing Care Plan No. 2

This form concerned nursing observation and is described in Chapter 4.

XII Nursing Care Plan No. 3

This form was in pre-prepared format and required completion of the relevant section of the MHA. It emphasised that the patient could be granted leave of absence under *'Sec 17 MHA SUBJECT TO CONDITIONS'*.

XIII Observation plan

This form is described in Chapter 4 on Observation.

XIV Form 50MS: Advice to patients rights under the Mental Health Act

This form recorded information given under section 132 of the Mental Health Act. This section places a duty on the Hospital Managers to ensure that legal information is given to patients concerning their detention under the Act. The process is commonly called "reading" or "giving" the patient "their rights."

- Staff Nurse A on 28 December 2000 recorded *"In my opinion a further attempt should be made to explain the patient's rights"*
- A further entry made by Staff Nurse A the same day stated *"he should be read again to ensure his understanding"*.
- (There were no further entries on this form but at 16.00 hours on 29 December 2000 Staff Nurse B recorded in the nursing notes *"Rights read under section 2 which appeared to be understood"*)

XV Ward A42 legal status MHA 1983 record sheet

This completed form recorded Patient A's legal status.

XVI Patients details for completion on admission

This form required completion of demographic and personal information. Some details were wrong, we presume because it had come from the social worker's assessment report, which mistakenly recorded Patient A's wife's name as being that of their child.

XVII User and carer information record

This form recorded that Patient A had been given a Patient Information Pack.

XVIII Disclaimer

This form was signed by Patient A to indicate he understood the Trust did not accept responsibility for cash, valuables or other personal property not handed in for safe keeping.

Good completion of risk documentation

Staff Nurse A had clearly spent some time on completion of risk documentation and we think she had done this well. She rightly noted a risk of physical aggression, based on Patient A's past ABH and very recent incidents of aggression and threat towards his wife. She properly recorded risk factors from his history including misuse of drugs, alcohol and his unemployment. She anticipated that there might be a need to use a personal alarm and involve the Police. She recorded that there may be a risk to Patient A's child. She correctly noted that more information should be sought from

the family the following day and that the risk management plan should then be reviewed. We think this was a good assessment. When the family visited the next day the information contained in this documentation should have alerted nursing staff to the possibility that there might be some risk to Patient A's wife or their child, and that this was an opportunity to speak to the family. The risk assessment material was not used as it could, or should, have been.

No key risk assessment document

It would have been difficult for anyone looking for nursing risk information to know where best to find it. Information was scattered and sometimes duplicated because of the nature of the forms. It would have been more helpful if there had been one document containing all the key risk assessment information. We found the most useful and comprehensively completed documents were those devised by the Sainsbury Centre. The Trust should simplify risk assessment documentation.

Recommendation 6.1.2

No risk assessment link with care plan

Although the Sainsbury Centre Risk Assessment stated that it was to be part of the care planning process, there was no evidence of this. The care plans were so standardised as to be bland and unhelpful to any nurse who wished to be properly apprised of the plan for Patient A's nursing care. Risk assessment in nursing documentation should be linked to risk assessment in care planning.

Recommendation 6.1.3

No mention of absconding

The one omission from all of the risk documentation was that of the absconding risk. Staff Nurse A did not make mention of it, despite the fact that it had been recorded in the medical recommendations as one of the reasons for admission under the MHA. Staff Nurse A agreed that she would have seen the section papers since she signed the Form 14 accepting the admission under section 2 on behalf of the managers. She explained that since Patient A was on s2 it was self-evident that he needed to be watched for absconding; "they are refusing voluntary admission, so what does that mean? A patient is an absconding risk". However, we think nursing documentation should require that absconding risk be recorded.

Recommendation 6.1.4

No reference to ethnicity, religious or interpretation needs

None of the forms made reference to need arising from religion or cultural background. We recommend that nursing documentation be revised to record ethnicity, religion and family language. There should be a record that consideration has been given to diet, interpretation need, including that of significant relatives and the nearest relative, and culturally appropriate family support. This should also apply to Care Programme Approach documentation which would have been completed later had Patient A remained on the ward. See also Chapter 6.

Recommendation 6.1.5

Chapter Four

Observation

4.1 The problem of observation

4.1.1 Patient A twice left Ward A42 whilst subject to 10 minute nursing observation. We have asked ourselves several questions:

- Was observation properly decided upon admission?
- Were reviews of observation properly carried out?
- Was Patient A on the right level of observation at the time of the homicide?
- Was the practice of nursing observation satisfactory?

4.1.2 Before addressing these questions we examine the Trust Observation Procedure.

4.2 Trust Observation Procedure

4.2.1 The Trust *"Procedure on Observation of Inpatients with Mental Health Problems receiving Inpatient Care"* names the previous Director of Nursing and the Medical Director as being responsible for the document published in March 1997.

4.2.2 We heard that there was no Observation Policy and that the Procedure and Policy were considered to be the same. Many staff referred to the document as the 'Observation Policy'.

4.2.3 Included in the list of references in the footnote to the document are:

- UKCC Code of Professional Conduct
- Bethlem Royal and Maudsley Hospital – Manual of Clinical Psychiatric Nursing Principles and Procedures
- Mental Health Act 1983

4.2.4 The Procedure set standards for nursing practice. It stated *'the necessity for placing the patient on Low/Medium/High observation will be a multi-disciplinary clinical decision, documented separately but consistently in the care plan and medical notes'.* It referred to conducting observation *'according to the patient's current care plan, negotiated if possible with the patient'.* Handover was to be *'in the presence of the patient (if appropriate) to discuss progress and evaluation of care'* and stated *'the nurse who is observing the patient will discuss with him or her how time will be constructively occupied'*, the outcome of this providing *'a useful assessment of the patient's current risk'.*

Good practice standards
The Trust Observation Procedure set good practice standards for the management of observation. We noted that the observation of Patient A was carried out by qualified staff and we heard from Nurse in Charge B as to the therapeutic value of observation.

4.2.5 There were three classes of observation

- *'Low'* stated *"Patients in this category will be allowed the maximum amount of freedom, including leave of Trust premises, identified within the patient's care plan".*

- *'Medium'* applied to patients who were *"at greater than normal risk of endangering themselves or others. The level of observation will depend on the individual need but will include:-*

  (i) the specified designated nurse;
  (ii) regular time checks of between five and thirty minute intervals determined by the Consultant or his/her Deputy in conjunction with the nursing team;
  (iii) not being allowed off the premises without a safe level of nursing cover, in agreement with the Consultant or his/her Deputy. In some circumstances patients may be allowed off the ward if accompanied by a responsible person (eg family or another professional), at the discretion of the Nurse in Charge."

- *'High'* was for those *"in immediate danger of harming themselves or others. Patients in this class must be observed 24 hours a day by an individual designated nurse who will ensure they remain within intervention distance (not behind locked or closed doors). The time of commencement and termination of high observation must be recorded in the patient's care plan notes."*

4.2.6 There was no mention of a patient's risk of absconding and how that should be taken into account when deciding upon the level of observation.

4.2.7 Arrangements for being allowed off the premises made no distinction between informal patients and those detained under the MHA. Nor was it clear in the context of QMC whether the 'premises' were the ward, the Mental Health Trust premises or QMC premises.

Observation Procedure did not mention risk of absconding
A revised observation policy should require that risk of absconding be assessed and recorded for any detained patient placed on observation.
Recommendation 6.2.2(g)

The Observation Procedure tried to do too much
In addition to observation itself, the observation procedure sought to provide rules for patients going off the ward. This made it unnecessarily complicated. Informal patients could not be legally prevented from leaving the ward. Detained patients could be. But there was no distinction between them in the procedure. The purpose of the procedure should clear. If it is to set rules for leaving the ward at QMC it should, for all detained patients, state the point at which s17 leave is needed, and in the case of each patient state how far they are permitted by the doctor to go within the hospital. If the phrase "allowed off the premises" is to be used, it needs clarification. The complexity of boundaries is discussed further in Chapter 5. The Trust Observation Procedure should be revised or replaced to ensure that its purpose is clear and

where relevant it makes it clear that detained patients' movement off the ward are limited by s17 leave and restrictions imposed by the RMO.

Recommendations 6.2.2, 6.2.2(e) and (f)

4.3 Trust Procedure out-of-date

4.3.1 By the time of the homicide there had, nationally, been new guidance on observation of patients within inpatient wards but this had not been incorporated into a new Trust policy or procedure.

4.3.2 Would this have made any difference?

4.3.3 We examine national guidance in place at the time and consider how it differed from Trust Procedures. The position is complicated because national guidance itself was not consistent. Whether or not intermittent observation can ever be safely used was, and still is, disputed. Two documents published in 1999 had conflicting views.

4.4 Conflicting national views

4.4.1 In 1999 the Standing Nursing and Midwifery Advisory Committee (SNMAC) supported the use of intermediate observations in practice guidance that was intended to be a template for use in developing protocols and practice. Later the same year the National Confidential Inquiry[7] questioned whether intermediate observations should be used at all, but did not go so far as to positively recommend their banning.

4.5 SNMAC Safe and supportive observation of patients at risk [8]

4.5.1 The SNMAC recommended keeping intermittent observation but aimed to set high standards by emphasising that observation was an opportunity for therapeutic interaction with the patient, and that this was a highly skilled activity requiring training.

4.5.2 SNMAC guidance recommended four, rather than three, levels of observation: general, intermittent, within eyesight and within arm's length.

4.5.3 Intermittent meant checking intermittently (defined as between 15 and 30 minutes), and '*is appropriate when patients are potentially, but not immediately, at risk'.*

4.5.4 Rather than one 'high' observation category there were two levels which necessitated keeping the patient constantly in view.

4.5.5 The lowest of these was 'within eyesight', which was '*required when the patient could, at any time, make an attempt to harm themselves or others'.* Colloquially, it could be described as keeping a constant eye on someone. This level of

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[7] *Safer Services; National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (1999) Royal College of Psychiatrists

[8] Standing Nursing and Midwifery Advisory Committee (SNMAC) June 1999: *Practice Guidance; Safe and supportive observation of patients at risk; Mental Health Nursing "Addressing Acute Concerns"*.

observation is triggered at a lower point than the 'high' of the Trust Procedure which requires that the patient be *'in immediate danger of harming themselves or others'*.

4.5.6 The highest level 'within arm's length' is self-explanatory.

4.6 Safer Services; National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

4.6.1 This later report casts doubt on the safety of any intermittent or intermediate observation:

"… our findings raise serious doubts about the value of current observation protocols. To our knowledge there has never been a clinical trial of the kind of observation practices that are in widespread use. It also seems that there is great variation nationally in the observation of patients at risk Whether observation at intervals .. are of any value in preventing suicide, self-harm or absconding must be in doubt…"

4.6.2 This report recommended: *"Alternatives to intermediate level observations should be developed for patients at risk".*

Conflicting national guidance
These two prestigious documents published one year before the incident, and giving highly varying advice about intermediate levels of observation, are both still on the Department of Health website and continue to provide conflicting advice, although the SNMAC has recently been disbanded[9].

Trust Observation Procedure in the national context
The Trust Procedure should have been reviewed after these documents were published in 1999. We recommend that the Observation Procedure now be revised to incorporate the more stringent requirements of SNMAC guidance or most recent best evidence on the management of intermittent observation. The Trust should also consider how it might develop alternatives to intermediate observation in the longer term, as suggested by the Confidential Inquiry.

Recommendations 6.2.1 and 6.2.2(a)

4.6.3 We bear in mind the Trust Procedure and SNMAC guidance when considering the points below.

4.7 Was observation properly decided upon admission?

4.7.1 There were misunderstandings and areas of disagreement between the admitting doctor and the Nurse in Charge of Ward A42 at the time admission was requested. The evidence indicates that each understood the reason for observation differently and each sought a different method of managing the situation. The eventual decision to admit to Ward A42 with 10 minute observation was a compromise. We examine how this was reached.

[9] Although the SNMAC was formally disbanded at the end of March 2005, SNMAC guidance on observation has not been withdrawn.

4.7.2 Nurse in Charge A told the Inquiry she favoured a forensic setting for Patient A because her worry was Patient A's risk to others. She expressed to the SpR her anxiety about nursing Patient A on an acute ward, bearing in mind his aggression over the previous few days.

4.7.3 But the SpR did not have the impression that there was any present concern about Patient A's risk to others. The GP had, after all, interviewed Patient A in her surgery and was happy for him to be sent to the Accident & Emergency Department with his family.

4.7.4 In fact the SpR's main concern was that Patient A might harm himself. He was *"very tearful, subdued and frightened"* and she did not feel he needed to be held on a forensic ward. Indeed, her view was that transfer to a locked ward with disturbed patients would be detrimental to his health. No forensic beds were available anyway.

4.7.5 So, voicing her concern that Patient A might be a suicide risk, the SpR requested that he be admitted to Ward A42 and that Nurse in Charge A place Patient A on a high level of nursing observation*: "I requested this gentleman be placed on constant observations and I was told that this was not possible. At the time I assumed this was due to staffing levels on the ward".*

4.7.6 Nurse in Charge A stressed in her evidence that she did not at any time state they did not have enough staff to facilitate high observation or say that high observation was not possible. She recalls that she questioned the need for a high level of observation because, she told us, *"it is an infringement of someone's rights….I didn't want to antagonise him by having someone within arm's length".* She said she took into account his aggressive behaviour and that at night they had fewer staff. They would have needed to nurse him in the high dependency unit on the ward, leaving only two staff in the day area some distance away. They would then have had to ask the adjoining wards for extra staff, contact the Senior Nurse for suggestions, ring an agency or offer overtime.

4.7.7 The SpR in her written evidence said *"I explained that A&E was quite busy and I wanted to move him as soon as possible. The nurse then told me to give (Patient A) 20mg of Droperidol and 2 mg of Lorazepam before he was transferred".*

4.7.8 The SpR explained she was not happy to medicate. She did not feel it was a suitable alternative to a direct level of observation. They did not have a diagnosis, Patient A had not been medicated before and she did not want to over-sedate him or mask any psychopathology he had not verbalised. However, they agreed that Lorazepam would be given initially to relieve his anxiety and he was given 2 mg in AED before transfer to Ward A42.

4.7.9 The eventual agreement that Patient A would be nursed on a medium level of 10 minute observation was, the SpR told us, a compromise, *"but a reasonable compromise in the circumstances".* She conceded that it was difficult for nursing staff to agree to a constant level of observation, which had resource implications, without seeing a patient first. The SpR was satisfied that Patient A would be going to the ward with his family and the ASW, would be greeted by a nurse and clerked in. It was understood that nursing staff would assess Patient A and could

increase his level of observation at any time if necessary. The SHO would also review Patient A within one to two hours and re-discuss his observation level. The SpR told us *"I felt that if his level of agitation remained it would necessitate constant observations".*

4.7.10 Strong opinions revealed during the course of hearing evidence suggest that, although there was an eventual compromise, there had been disagreement bordering on dispute over observation. The SpR told us *"I was dissatisfied that constant observations were not available immediately for this patient."*

4.7.11 We note that the Trust had a procedure for dealing with disagreement over observation level contained in its Observation Procedure. Written in March 1997 this stated:

"If there is disagreement between the Registered Nurse and the Dr about the level of observation to be carried out, the higher level is implemented until the issue is decided by consultation with senior colleagues of both professions. The Consultant's clinical decision with regard to observation, following consultation, must be adhered to".

4.7.12 If the dispute was about nursing resource implications of observation the Observation Procedure dealt with that too:

"If in the nurses' view the nursing resources in the ward do not cover the provision of the level of observation, the Ward Manager/Designated Directorate "F" Grade will be consulted…….. If this consultation does not resolve the problem, the final responsibility for resource levels rests with the Clinical Director or Trust Board Manager On-call…… the Senior Registered Nurse on Duty and the Nurse Manager will make temporary arrangements for observation of the patient while consultation takes place and has the authority to authorise overtime.

4.7.13 Although there had been disagreement over Patient A's observation there was no discussion about use of this procedure at the time. It was not mentioned to us, either by the SpR or Nurse in Charge A.

Observation level a compromise

Patient A's observation level was decided by a process of negotiation and compromise under pressure. AED was busy and the SpR's main priority was to remove Patient A from there to a safe environment. Ward A42 would have needed to reorganise its staffing for the night in order to provide constant observation levels and the SpR told us she took into account that they try to work as a team. These were the realities of the moment and we are sure that the professionals involved acted in the belief that they were protecting the interests of Patient A and any others who might have been at risk from him.

Staffing pressures and observation level

Despite that integrity, we have not been able to escape the conclusion that clinical need was compromised by staffing expediency. No ward should be put in the position of seeking to negotiate itself out of an observation level recommended by a senior psychiatrist because of staffing difficulties. No psychiatrist should feel under pressure because of staffing to modify a clinical

decision. We recommend that the present Trust review nurse staffing on the wards at QMC, taking into account the needs of nursing observation.

Recommendation 6.2.4

Observation Procedure not used to resolve disagreement

The Observation Procedure for disagreement was a good part of the procedure, it was intended for exactly this sort of situation, and yet it was not used. The clear intention was to err on the side of caution by favouring the highest level of observation. There was then the added protection that nursing staff would have to consult with a psychiatrist before reducing the level. This must be clinically correct. Had the process been used, Patient A would have been admitted to Ward A42 at a high level of observation and the Nurse in Charge would have raised the nursing resources issue with the Designated 'F' Grade. Those making decisions about observation level should be aware of the Observation Procedure and not flinch from using it to resolve a difference of opinion. This should be incorporated into training on observation for nursing and medical staff.

Recommendation 6.4

Different understandings

There was no common understanding of the reason for Patient A's observation. the SpR's request for high observation was intended to prevent suicide. Nurse in Charge A believed this to be a 'forensic' admission, raising anxiety about staff safety. It was unsatisfactory that such different views existed. A requirement to record the reason for observation in terms of risk to self and/or others may have resolved this misunderstanding. We recommend this is included in a new Observation Policy.

Recommendation 6.2.2 (b)

4.8 Were reviews of observation level properly carried out?

4.8.1 The SpR had relied upon expected opportunities for review to reassure her that 10 minute observation would be satisfactory, at least initially. She knew that nursing staff could increase observation if necessary without any need for consultation with a doctor.

4.8.2 The first opportunity for medical review came at 01.30 when the on-call doctor completed a physical examination, noting that Patient A was talkative and *"astonishingly settled".* We are satisfied that no change in observation was justified at this stage.

4.8.3 Patient A had reportedly not slept for three days previously, and this, coupled with the anxiolytic drug *Lorazepam* which had been administered, may also have contributed to the deep sleep that Patient A entered into for the remainder of the night and late into the following morning. Observations are recorded as having been undertaken every ten minutes during the night and, as detailed in the previous chapter, concern was expressed over his respiration and the inability of nursing staff to rouse him from his sleep during this period, leading to the nursing staff seeking advice from the on-call doctor.

4.8.4 Further opportunities for review of observation level arose during the course of the next day, after Patient A had awoken and risen from his slumbers. However

there was no apparent change in his mental state and no alteration to his observation level.

4.8.5 Upon review by the Consultant Psychiatrist at 14.00 hours, medium observation was confirmed. In his post incident statement the Consultant Psychiatrist, Patient A's RMO, said *"In view of these [risk] factors we agreed that he should be kept on the ward, under close observation, until such time as he was adequately treated … We felt that it would be… appropriate to continue to nurse him on medium observation level".* In our commentary in Chapter 2 we have already indicated that this decision cannot be faulted based on the presentation of Patient A at the time. He had not absconded that night and after he had awoken he had appeared much more settled.

4.8.6 We think it probable that if Patient A had been admitted on a high observation level it would have been reduced by the following day anyway. By SNMAC standards, and those of the Trust Procedure, medium or intermittent observation would seem to have been right.

4.8.7 However, the situation was different after Patient A had been discovered missing at 16.00 hours. As we have said in Chapter 2, it was not sufficient to reiterate the observation procedure and rely on the fact that he had changed into his pyjamas.

RMO should have been told about observation difficulties

Nurses did not feel that an increase in observation level could be justified, and we shall conclude later they were probably correct about this, bearing in mind the Trust Observation Procedure. However, they should have informed the RMO that with medium observation, their staffing levels and the open door, they could not provide sufficient supervision to prevent Patient A leaving the ward again, especially during observation handover period. The policy should require that nursing staff inform a detained patient's RMO if for any reason intermittent observation no longer offers the level of security intended for the patient.

Recommendation 6.2.2(k)

Code of Practice guidance

Where a detained patient is absent without leave the Code of Practice at Paragraph 21.6 states that the RMO should be informed immediately. Whether, having left the ward, gone to the shop and to the door of the hospital, Patient A was absent without leave is a legal point which we discuss at Chapter 5. However, Patient A had gone missing. Even though he had returned he was a new patient and an unknown quantity. The RMO should have been told.

Risk of absconding

At the point of Patient A's admission, absconding had been an issue. He had tried to leave AED during his assessment and the s2 medical recommendation gave this as a reason for his detention under the MHA. The risk of absconding assumed less importance as Patient A seemed to accept being on the ward, and at the psychiatric review Patient A indicated his willingness to stay. Patient A's eldest sister's concerns about risk to herself and her family, voiced to the SpR and the ASW, might have raised some continuing concerns after Patient A had gone missing from the ward, but they were not recorded and were unknown to staff who were dealing with him that afternoon.

4.9 Was Patient A on the right level of observation at the time of the homicide?

4.9.1 We think it is very difficult to say with certainty, especially because it is hard to eliminate hindsight bias. But also because we have to consider what is meant by 'right'.

Observation level consistent with Trust Procedure
In the psychiatric review Patient A had denied ideas of self-harm or harm to others but there was still thought to be the potential for violence, according to the notes of Staff Nurse B. This is consistent with the Trust medium observation level. After he had gone missing and returned at 16.00 hours there was still nothing indicating that Patient A came into the Trust's high observation category of 'immediate danger of harming others'. The Consultant Psychiatrist even with hindsight, thought he would not have increased Patient A's observation level at that point. We conclude that according to the Trust Observation Procedure Patient A was appropriately placed on medium observation.

SNMAC guidance may have resulted in higher observation
The Consultant Psychiatrist confirmed to us that at the psychiatric review he had considered any risk to be 'potential'. This placed Patient A's observation squarely within the level of SNMAC intermittent checks. Indeed his 10 minute checks were more frequent than the 15-30 minute checks recommended by the SNMAC. Once Patient A had been missing from the ward it might have been reasonable to consider that he needed 'within eyesight' level observation because he was still very unknown and could, if he absconded again, 'at any time make an attempt to harm himself or others'. Adherence to SNMAC observation levels may have resulted in a higher level of observation being used. We recommend that the present Trust's Observation Procedure use SNMAC definitions or other best recent guidance.

Recommendation 6.2.2(a)

4.10 Was the practice of observation on Ward A42 satisfactory?

4.10.1 Patient A remained on Medium 10 observations throughout his stay on Ward A42. This kind of intermittent observation is routine on psychiatric wards around the country. On Ward A42 it was combined with the additional task of ensuring that all patients who were on general observation and requiring a nurse escort when leaving the ward were present on the ward at hourly intervals, and keeping an eye on the open ward door when possible.

4.10.2 This was a demanding task. The nurse needed to be constantly alert to the need to review observation level.

4.10.3 The arrangement was that one nurse undertook observation for an hour and then another nurse took over. This was always on the hour and handover took 5 to 10 minutes. On 29 December 2000 Patient A was one of six patients being observed every ten minutes. Thirteen additional patients were subject to general observation for their whereabouts to be checked every hour, on the hour.

4.11 Recording of observation

4.11.1 Nursing observation details were recorded on three forms, which we describe below.

4.11.2 *(i) Nursing Care Plan No. 2*

Staff Nurse A indicated on this form that Patient A was subject to medium observations, a nurse was to check him every 10 minutes and that he was restricted to the ward.

Standardised notes were printed on the form stating:

1. *For patient to be aware of observation level and rationale*
2. *Care plan to be reviewed if observation levels change*
3. *Any increase in observation levels can be implemented by the nurse in charge, but ideally in consultation with MDT*
4. *Decrease in observations must be in consultation with MDT*
5. *Designated nurse to carry out observation levels*
6. *Escort off the ward by others e.g. family/professionals can be at discretion of nurse in charge. Ideally "others" will be decided by MDT. Nursing staff to discuss and clarify same.*

4.11.3 *(ii) Observation Plan*

The Observation Plan contained a table, above which were four bullet points:

- Record of observation levels
- Reasons for observation level changes to be specified
- Specific instructions (e.g. high obs patient in line of sight at all times)
- Time limits specified. Escorted (Specify by whom)

Staff Nurse A had signed and dated the first entry at 21.20 hours on 28 December 2000, indicating that the observation level was *"Medium 10."* Staff Nurse B had signed the only other entry on the form. It was dated 29 December 2000 and said *"Review",* presumably referring to the psychiatric review held at 2pm that afternoon. He too recorded *"Medium 10".* In a separate column headed *'Sec 17 completed'* he had correctly noted *"N/A".*

4.11.4 *(iii) The Daily Observation Record*

The Inquiry was shown an Observation Record chart which listed all patients subject to observation on Ward A42. A new form was made up every morning to start at 7.00am. On 29 December 2000, the list included 19 names. Six of these were recorded as requiring *"10 minute"* observations. The rest were marked as *"ESC"* meaning that they were on general observation and needed an escort to go off the ward.

Weakness of the observation documentation

Like the Observation Procedure, this documentation referred to patients on medium observation being permitted 'escort off the ward by others'. No distinction was made between detained and informal patients. There was potential here for confusion. We refer to this again in Chapter 5.

4.12 The observation routine

4.12.1 One member of staff was responsible for the observation of all patients on medium observation for an hour at a time. On 29 December 2000 the nurse would have been required to tour the ward every ten minutes to locate the six people requiring 10 minute observations. The remaining 13 patients on general observation did not require any particular level of observation but the nurse would be expected to know their whereabouts at the end of the hour including which patients had left the ward with nurse escorts.

4.12.2 The nurse would not sign a patient off every ten minutes, but at the end of the hour he or she would sign the Observation Chart to record that all 19 patients listed were on the ward and were safe and well. The designated nurse would rotate every hour. At that point there would be a handover of the observed patients' whereabouts.

4.13 The difficulty of observation on Ward A42

4.13.1 Generally speaking A42 was considered to be a difficult ward to observe. We heard that the ward was always busy and its physical layout, with a long corridor and bedrooms off that, meant that there was much private space in which patients might not be seen. The Inquiry panel was able to visit the hospital prior to building alterations and confirm that this was so.

4.13.2 Records indicate that the ward was under pressure. It was a 24-bedded area and on 28 December the IT information system recorded that 32 patients were assigned to the ward, some of whom would have been on home leave. 15 of those patients were detained under the MHA, one of these being Patient A. On 29 December there were 6 patients on the ward listed as subject to 10 minute observation. We were told that this was an average number of observations for that ward.

4.13.3 Nurse in Charge B described good practice to the Inquiry, commenting that observation provided a contact point for patients in need of some therapeutic input. If someone was seen to be in distress or isolating themselves it would be an opportunity to see what the problem was. However, dealing with anything in depth would require another nurse to take over so that the observation nurse could carry on with his/her task. There was no time for any lengthy handover or discussion of the reasons for observation because of the need to keep the observations going.

4.14 Watching the open ward door

4.14.1 Ward A42 was an 'open ward', meaning that the doors were kept unlocked. In addition to observation of patients there was a need for somebody to watch the open ward door. The design of the ward did not make this easy. The door was not visible from the nursing office and it faced a busy social space often full of patients, visitors, TV and activity. The exit was straight onto a busy main hospital corridor.

4.14.2 Although we heard from Nurse in Charge B that no-one was designated the task of watching the open door of the ward, Staff Nurse C told us that there was a 'general understanding' that during the observation hour an attempt would also be made to keep an eye on the door, but that in practice this was impossible because there would be a need to observe patients at the other end of the ward. Sometimes another nurse might be available to watch the door, but not always.

4.14.3 Nurse in Charge B told the Inquiry that there was no standard practice for keeping an eye on the door; *"it was just whoever was around".* With honesty and the advantage of hindsight she was able to say *"..when I look back it sort of really quite frightens me that we did that at the time, because I think 'Oh gosh', I'm surprised more people didn't leave the ward".*

4.14.4 The Consultant Psychiatrist recalled that there had been times in the past when patients had left, and there had been discussion off and on about this: *"...once you leave the ward you could be anywhere, it's such a [large] place, and then it becomes very difficult to know whether a person has gone to D floor or has gone out....run out and gone to the car park or into the canal or whatever".*

4.14.4 Nurse in Charge B could think of no occasion when there had been any formal review of the observation policy and the risks associated with the open door; *"..the observation policy was in place.....I guess it was questioned, but it's just always been there and we just follow the policy.....I'm quite sure we did discuss it, but I don't know whether we felt that we were in a position to change the policy that was already in place".*

4.15 Observation of Patient A

4.15.1 Patient A was included on the Daily Observation Record Chart from 7am on 29 December 2000. The chart was initialled every hour up to and including 17.00 hours. Staff Nurse B began his hour of observation at 15.00 hours. Staff Nurse C took over at 16.00 hours and Nurse in Charge B from 17.00 hours.

4.15.2 Staff Nurse C told us he knew that Patient A had been aggressive towards members of his family but had not known that he tried to abscond from AED. Nurse in Charge B understood that Patient A was on observation because he was a new patient, an unknown quantity, had been violent towards his wife and there was some concern about risk to others. She had also not known that he tried to abscond from AED.

Virtually impossible task
It was a virtually impossible task to ensure the safety and containment on an open ward of 6 patients on 10 minute observation and 13 patients on once an hour general observation.

Unrealistic expectation
It was completely unrealistic to expect that the nurse observing patients would also be able to watch the open door of the ward. Intermittent observation of the door was almost worse than no observation. Either they had responsibility for this task or they did not. It should have been clear.

Better information needed on observation chart

Nurses should have been familiar with all the patients they were observing from information contained in nursing notes, medical notes and section papers. This included information on Patient A. However, the task of observation would have been much easier if the observation chart had made provision for the recording of certain essential information. As it was, there was no note of the patient's legal status. No reason was given for a patient's observation, no assessment of the risk of absconding, no record of any absences from the ward, no note made of review requirements or a nurse's concerns. More detailed recording of patient observation should permit a nurse at handover to know exactly what is necessary about each patient. The observation paperwork should be reviewed and revised urgently.

Recommendation 6.2.3

4.16 Ward door now locked

4.16.1 Since the homicide Ward 42 has been upgraded. There is a new window in the ward office to improve observation of the door. In addition, a "swipe card" lock has been fitted. Those wishing to enter or exit the ward must now either use a swipe card or ask a member of staff to open the door for them.

Code of Practice criticism of locked doors

The MHA Code of Practice addresses the practice of locking doors on open wards at Chapter 19, paragraphs 19.24 to 19.27. It states: "The management, security and safety of patients should be ensured by means of adequate staffing. Service providers are responsible for ensuring that staffing is adequate to prevent the need for the practice of locking patients in wards, individual rooms or other areas." We recommend that the present Trust review its locked door and its staffing arrangements on the ward to ensure the safety, security and dignity of patients.

Recommendation 6.2.5

The difficulty of managing detained patients on open wards

The Trust Director of Nursing put it very well, saying "nursing staff are assigned to observe patients not doors". He also described to us the dilemma for staff "in balancing patient dignity and human rights against risk". Acute admission wards generally admit both detained and informal patients. The management of security on such wards is not easy when there is also a need to respect the freedom of those who are not detained under the Act. The Mental Health Act Commission has a special responsibility to safeguard the rights of detained patients.[10] We refer the Trust to the MHAC Ninth Biennial Report[11] paragraphs 4.51-4.55, and recommend discussion with local Mental Health Act Commissioners on this subject. Detained patients can be contained on open wards through intensive observation and engagement. We advise that the present Trust review its arrangements for locking ward A42.

Recommendation 6.2.5

[10] The Mental Health Act Commission has a responsibility under s120 MHA 1983 to *"keep under review the exercise of the powers and discharge of the duties conferred or imposed by this Act so far as relating to the detention of patients."*

[11] MHAC Ninth Biennial Report states *"we continue to find wards that appear to be continually locked as a result of the inadequate number or management of staff, rather than because of any inherent management problems of the patients. This is a misuse of the power of compulsion…."*

4.17 Training in nursing observation

4.17.1 There was no training requirement built into the observation procedure and no-one giving evidence to the Inquiry knew of any on-going training on the procedure. We heard from a Senior Nurse that formal training was provided to staff only when a policy was new or changed. The Director of Nursing told us that this would have been related only to the implementation of the Procedure.

4.17.2 The Manager for Nursing and Quality told us that responsibility for on-going provision of training was expected to fall to the Operational Managers. The Sector Manager and the Clinical Director understood that skills in observation and the 'missing persons procedure' were largely gained at ward level 'on the job'.

Training in observation needed

As stated by the SNMAC, observation is a skilled and demanding task. We recommend that a rolling programme of training be provided for all staff who are required to carry out nursing observation. This should be linked with training on the management of patients who are missing and absent without leave.

Recommendation 6.4

4.18 Concluding Comments

4.18.1 It appears that medium observation twice failed to prevent Patient A leaving Ward A42, and yet we have concluded that according to the Trust Procedure and SNMAC guidance he was probably correctly placed on intermittent observation.

4.18.2 Our findings lead us to support the view of the Confidential Inquiry. Intermittent observation cannot properly protect against individuals who act self-destructively, harm others or leave an open ward during the unobserved 8 or 9 minutes when they can avoid detection. Handover procedures have the potential to make an unobserved period longer than 10 minutes, so that in reality a patient might remain out of sight for 20 minutes or more, as was the case with Patient A. Both the occasions he was found missing were at observation handover time. Observation at intervals is particularly inappropriate for patients who are on an open ward, previously unknown to mental health services and where there is a risk of absconding.

4.18.3 Although in our view inherently flawed, practical improvements can be made in intermittent observation which will improve its safety. We recommend these improvements be implemented by the present Trust in Nottingham.

4.18.4 It is an unhappy state of affairs for patients and for staff that there should be conflicting national guidance. With the demise of the SNMAC, the status of existing guidance is unclear. The Inquiry has written to the Department of Health expressing its concern at this situation.

The Trust should make intermittent observation safer

- *We reiterate our opinion that intermittent observation should not be used on an open ward where there is an assessed risk of absconding, especially where absconding might result in harm to self or others. Where comprehensive assessment of a patient has not been possible this should be considered an added risk. These points should be incorporated into a new Trust observation policy in order to make intermittent observation as safe as possible.*

  Recommendations 6.2.2(h) and (i)

- *For all detained patients subject to intermittent observation the daily observation chart should record:*
  - *a) The patients legal status under the MHA and what, if any, s17 leave from the hospital is permitted*
  - *b) where within the hospital a patient is permitted by the RMO to go and whether escorted or not*
  - *c) the reason for observation described in terms of risk to self and/or others*
  - *d) an assessment of the risk of absconding and any consequent risk to self or others*
  - *e) a record of any absences from the ward*
  - *f) in the case of any patient who has been absent from the ward, a note that the RMO or duty psychiatrist has been informed and the observation level reviewed.*

  Recommendations 6.2.3 (a) to (f)

- *It should be possible to continue ten-minute observation throughout an observation handover period but the evidence suggests it did not happen in the case of Patient A. We recommend a review of observation handover to establish what improvements, if any, need to be made.*

  Recommendation 6.2.7

- *The present Trust should ensure its observation policies and protocols are based upon the most recent best evidence and published guidance, audited, reviewed regularly and up-dated when necessary.*

  Recommendation 6.2.2(a)

National guidance

We recommend that the Department of Health take note of this Inquiry's views upon the serious weaknesses of intermittent observation, especially on open wards where there is a risk of absconding. Future guidance should explicitly address this point.

Recommendation 8.2

Chapter 5

Missing, absconding and AWOL

5.1 Limiting freedom

5.1.1 Patients detained under the MHA have a legal limit placed on their freedom to leave the hospital. This distinguishes them from 'informal patients' who are voluntarily in hospital and who can leave at any time[12]. Within the hospital a detained patient must co-operate with medical treatment and that may include remaining restricted to a ward area.

5.1.2 In this Chapter we examine what nursing and medical staff understood by Patient A's restriction to the ward, what it meant to be detained and missing, absconding or absent without leave, how the situation was managed when Patient A was discovered, on two occasions, to be absent from the ward, along with the Trust procedure and documentation involved.

5.2 The Trust Procedure

5.2.1 There was one all-inclusive Trust-wide Procedure for the management of patients who were described as missing and absconding. It covered all Trust facilities and all mental health and learning disability patients who were detained, and informal as well as day patients and those attending outpatient appointments.

5.2.2 The Nottingham Healthcare NHS Trust *Guidelines and Procedures on Action to be Taken when a Patient Absconds, Relating to Inpatients and Day Patients Mental Health and Learning Disability* was dated February 1999. There was no formal written policy, and the Procedure was generally referred to by staff as the "Absconsion Policy".

5.2.3 The Quality Assurance Manager and author of the document, was Chair of the Clinical Policy and Procedures Committee. She told us that the procedure had been drafted following consultation within each Clinical Directorate. There was no Social Services or Police involvement.

5.2.4 The four-page document included guidelines on risk assessment and a procedure for action to be taken when a patient absconds. It stated *"Each patient will have documentary evidence of a risk assessment for absconsion incorporated in the care plan".*

5.3 Trust checklist and untoward incident form

5.3.1 A one-page *Checklist for QMC Psychiatric Acute Ward Missing Patient Considered to be at Risk* was devised specifically for use on the QMC psychiatric acute wards. The QMC security service had not been consulted over the drafting of the checklist.

[12] Although s5(2) or s5(4) of the MHA can be used to prevent an informal patient leaving if certain criteria are satisfied.

5.3.2 There was an all-purpose *Accident/Untoward Incident, Near Miss and Serious Untoward Incident Report Form,* which was applicable to a wide range of possible accidents and incidents such as prescription errors, thefts and falls as well as missing patients. It was applicable to employees, patients and visitors.

5.4 Police Missing Persons Form

5.4.1 Nottinghamshire Police had a form entitled *Missing Person (Including Voluntary patients missing from Hospital)* for completion by the Police based upon information received by them.

Good practice reference to risk assessment and care planning
The strength of the Trust Procedure was that it required documentary evidence of a risk assessment for absconsion be incorporated into the care plan. This was good practice. However it did not say which care plan. In Patient A's case there was no Care Programme Approach care plan in place because he had just been admitted, and the nursing care plans did not document the risk of absconsion. Nor did the psychiatric review on 29 December 2000 expressly record that point. And observation documentation did not record risk of absconding either. The Trust Absconding Procedure should be linked with the Observation Policy and supported by training to ensure that staff are aware of the need for a documented risk assessment for absconsion.

Recommendations 6.4 and 7.2 (a) and (g)

5.5 QMC Missing Patient Policy

5.5.1 QMC University Hospital Trust had its own Missing Patient Policy and Procedure. This covered the whole of QMC although it was not applicable to the Mental Health Unit because that was a different Trust with its own procedures. The QMC Community Policeman told us there would be a point when a patient had left the psychiatric care area and was walking out of the hospital and where QMC procedures might potentially apply. They were not used in connection with Patient A.

5.6 QMC Community Police Service

5.6.1 The QMC Community Policeman told us that his post is part-funded by the QMC Trust, although the reality is that about 30% of his time is spent dealing with the psychiatric wards.

Good management development
The Community Policeman described a bimonthly meeting of the Department of Psychological Medicine, the Ward Managers from the acute psychiatric wards, the Police, the security service and the Emergency Department. This had been set up since the homicide and there are plans to include the East Midlands Ambulance Service and local service user groups. It seems to us that this productive development provides a good setting for work on the Inquiry recommendations concerning detained patients who are AWOL.

Recommendation 7.2

5.7 Absence without leave (AWOL)

5.7.1 One thing is clear: on 29 December 2000 at 4.45pm when Patient A walked out of QMC he was absenting himself without leave from the hospital where he was detained under the MHA.

5.7.2 Absence without leave has a legal definition contained in the MHA at s18. It includes a patient subject to s2 who *"absents himself from the hospital without leave granted under section 17".* The only person who can authorise leave under s17 MHA is the patient's RMO. No such leave was granted and Patient A was absent without leave under the Act when the homicide was committed.

5.7.3 Trust documentation did not use the term Absent Without Leave, only that Patient A was 'missing' or 'absconding'. Nor was the phrase 'absent without leave' used anywhere in the Trust Absconding Procedure.

Vulnerability

The Police, QMC and Trust missing persons' procedures were all based on vulnerability. They did not differentiate between detained and informal patients. Of course there may be a great deal of concern about any individual who is mentally unwell and who appears to be missing, whether detained or not, but detained patients come into a special category. There are legal consequences when they are missing, including powers available to convey the patient back to hospital. The Code of Practice requires that there be immediate notification of the RMO and nearest relative.

No policy for detained patients who were AWOL

There was no dedicated Trust policy, procedure or checklist for action in the case of detained patients who were absent without leave. There should have been. The MHA Code of Practice at Paragraph 21.5 states "It is the responsibility of the Hospital Managers……..to ensure that there is a clear written policy in relation to action to be taken when a detained patient…… goes absent without leave". Details are given of the guidance that such a policy should include. The present Trust, Social Services, Police and other relevant organisations described above, should ensure there is a policy and procedure specifically applicable to detained patients who are AWOL, drafted to comply with s18 MHA and the Code of Practice. This should always be used when a detained patient is AWOL.

Recommendation 7.1

No Trust requirement to inform the RMO

*The MHA Code of Practice states at Paragraph 21.6 that the hospital policy on detained patients should include the requirement that where a patient is absent without leave the nurse in charge should "ensure the patient's RMO is immediately informed". This important point was specifically ruled out in the Trust Procedure which stated in bold type "**There is no requirement as a matter of routine to contact the doctor if a patient absconds".** Patient A's RMO was not notified until the following day, well after the homicide. To this extent the policy was not adequate for its purpose and it did not comply with the Code of Practice. A future AWOL policy should require that the RMO is always informed when a detained patient is AWOL.*

Recommendation 7.2(b)

No Trust requirement to inform the nearest relative

The MHA Code of Practice states that a hospital's policy concerning AWOL detained patients should give guidance that in almost all cases the patient's nearest relative be informed immediately. Patient A's eldest sister was the first relative to be informed, although it was not at the initiative of the nurses and there is no evidence that she was specifically asked to inform Patient A's wife, as the nearest relative. The nearest relative and family should have been notified quickly of Patient A's absence and told to call the ward or Police if he arrived home. A future Trust AWOL policy should ensure that the nearest relative is informed.

Recommendation 7.2(e)

5.8 The boundary of the Trust

5.8.1 When Patient A left the hospital he was indisputably absent without leave. But what was the position when he went to the shop or the door of the hospital to see off his family?

5.8.2 The position was legally less clear. At some point he will have left mental health Trust premises and entered QMC general hospital Trust premises. But the situation of a Trust within a hospital was not envisaged by the Act. As a result, there is no decided legal position on whether the RMO needs to authorise s17 leave when a patient leaves the mental health Trust or the general hospital[13].

5.8.3 In any event the boundary of the mental health Trust was unclear. The psychiatric wards in QMC are off corridors on Floor A of the general hospital. There was no clear demarcation between mental health Trust property and general hospital QMC Trust property. The QMC shop on B Floor was definitely part of the general hospital.

5.8.4 Bearing in mind this uncertainty, perhaps it is not surprising that there was no clear understanding of the point at which a detained patient needed s17 leave and without it became AWOL. The Trust did not have a uniform approach to this throughout the hospital.

5.8.5 Nurse in Charge B thought detained patients could go to the shop and hospital reception on B Floor of the hospital without s17 leave because it was within the hospital.

5.8.6 The Clinical Director described the mental health Trust as contained largely on A Floor South Block. He said *"s17 is not required for a patient to go onto A Floor but is required when outside "the Mental Health area" of the QMC, which would include the shop on B Floor".*

[13] See Richard Jones *Mental Health Act Manual* 8th Edition at para 1-208 for a discussion of this point. The MHAC considers that s17 leave is only needed when leaving the general hospital site. Anselm Eldergill and Richard Jones favour the view that the mental health Trust is effectively a hospital within the general hospital, so that s17 leave would be needed upon leaving the Trust premises. The Draft Mental Health Bill continues to make reference to leave of absence from a 'hospital'.

5.8.7 The Consultant Psychiatrist believed that detained patients could go to the hospital shop, even though it is on different Trust premises, without s17 leave.

5.8.8 The Medical Director understood that the Trust boundary was at the door of the ward and s17 leave was needed to go to the shop on B Floor.

5.8.9 The Director of Nursing believed that any detained patient leaving the ward needed s17 leave.

5.8.10 The Manager for Nursing and Quality thought the mental health Trust area included the psychiatric wards and surrounding corridors.

Legal clarification needed by the Trust
Present Trust managers should take legal advice and establish precisely where the Mental Health Trust boundary is at QMC. The Trust should decide at which point it considers a detained patient must have s17 leave and without it becomes AWOL. All practitioners should be informed of the Trust's views.
Recommendation 6.3.1

RMO's need to be clear about s17 leave in QMC
Until there is a clear Trust legal position, and because QMC premises are so complicated, we recommend that RMO's tell staff exactly how far they have decided a patient can go before they are considered AWOL or need s17 leave.
Recommendation 6.3.2

5.9 Missing and absconding

5.9.1 Whether or not Patient A was AWOL at the point he went to the shop or the door of the hospital to see off his family, he was certainly regarded as 'missing' from the ward.

5.9.2 When he was missing on the second occasion the Missing Patient Checklist was partially completed and he was described as having 'absconded' on the Untoward Incident Form.

5.9.3 The Trust Procedure defined a 'missing patient' as

"missing from a clinical area they are attending and applies to any patient, who because of their mental or physical condition, is considered to be likely to act in a way which may endanger themselves or others".

5.9.4 The Trust Checklist form used the definition *'missing patient considered to be at risk'* and made no mention of a possible risk to others.

5.9.5 An absconsion was defined in the Trust Procedure as *"any unauthorised absence necessitating staff intervention".*

5.9.6 The Checklist made no mention of absconding.

5.9.7 The Trust Untoward Incident Form contained a heading *'Absconsion'* beneath which there were three tick boxes: *'Absconsion', 'missing patient'* and *'attempted'*. On the form completed for Patient A *'missing patient'* had been ticked.

5.9.8 The author of the Trust Procedure, said there was a *"wealth of areas of overlap"* between a missing and an absconding patient. A missing person could be taking unauthorised leave or failing to return home. Absconsion could, she thought, apply to somebody who is detained and also to an informal patient, though she was aware that she had colleagues who would disagree with that.

5.9.9 The Manager of Ward A42 also thought the distinction between missing patient and absconsion was difficult. She thought anyone who left the ward without being given authority was a missing patient. If they were seen leaving and refused to return they were then absconding. 'Absconded' showed a bit more premeditation.

5.9.10 That same sense of *"having wilfully taken himself away"* was also described by the Clinical Director as a feature of absconding.

5.9.11 Adding to the complexity, when a patient went missing it was from a *'clinical area'*. The Trust's Manager for Nursing and Quality understood the clinical area to include the psychiatric wards and the surrounding corridor.

5.9.12 The Medical Director said *"I suppose the definition of a clinical area in its broadest term at the Queens Medical Centre is the whole of A Floor, or on B Floor the ward in which the patient is nursed".*

5.9.13 The Clinical Director understood that the 'clinical area' referred to the inpatient ward area on Floor A of QMC and the outpatient clinic area on Floor B. Since the wards straddled the main transit corridors at QMC the clinical area would straddle a public walkway as well, though the corridor itself would not be classed as a clinical area, and when a patient was on observation nurses would need to escort them across.

5.9.14 Nursing procedure and guidance on observation may not have clarified matters. Nursing Care Plan No 2 contained standardised guidance to nurses on the management of patients on medium observation, including '*Escort off the ward by others e.g. family/professionals can be at discretion of nurse in charge. Ideally "others" will be decided by MDT. Nursing staff to discuss and clarify same'.* The Observation Procedure referred to patients on medium observation being *'allowed off the premises if accompanied'.*

5.9.15 The Clinical Director was under the impression that a patient on ten minute observation would be nursed on observation *"within the body of the ward"* but be escorted to other wards or sitting rooms which were across corridors. If it was felt appropriate they could leave the ward within that ten minute period, but if there were concerns about the patient then they would be accompanied.

5.9.16 Nurse in Charge B and Staff Nurse C, on duty on Ward A42 during the day shift on 29 December 2000, gave evidence that on other wards patients were permitted to leave the ward with an escort, but that A42 was stricter in that this was not permitted. They added that sometimes nurses who were new to Ward A42 had to be reminded of this restriction.

5.9.17 Having decided that Patient A should be nursed on medium ten-minute observation, the Consultant Psychiatrist told us he understood this to mean *"he would not be allowed to go out of the ward unaccompanied or—mainly without the escort of a nurse, and that had to be agreed, even before he could leave, with me (RMO)".* He informed us that in between 10 minute checks he would expect a patient to receive a higher level of observation than general observation. He said *"staff ought to know who goes or comes".* He believed that the Observation Policy required the named nurse to record his/her observation of the patient every ten minutes although this was not in fact stated in the Procedure.

5.9.18 The clearest recorded indication of an intention to ensure Patient A did not leave the ward at all came from Nursing Care Plan No. 2, where Staff Nurse A had unambiguously described Patient A as *'restricted to ward'.*

Patient A restricted to the ward

We are satisfied that there was an intention to restrict Patient A to the ward. That intention was most clearly set out in the Nursing Care Plan No. 2 written by Staff Nurse A. The Consultant Psychiatrist had specified medium observation, believing this meant that Patient A could not leave the ward, even accompanied by a nurse, without his permission.

Confusing observation procedure

Although we think there was a clear intention to restrict Patient A to the ward, we have found during the course of hearing evidence that there was an area of potential confusion concerning the Observation Procedure. The procedure stated that a patient on medium observation was 'allowed off the premises if accompanied'. This was confusing since no distinction was made between informal and detained patients. The former could not be prevented from going off the premises, and the latter were bound by s17 leave outside the hospital. This part of the procedure needs clarification. The same is true for the Trust nursing guidance on medium observation, which permitted "the patient to leave the ward with the agreement of the nurse in charge if escorted by staff or family". We would like to be reassured by the comment of the Director of Nursing "I do not believe anyone would reasonably interpret the observation policy as allowing a ***detained*** *patient to leave the ward with relatives/friends, as this requires section 17 leave (his emphasis)". However, Patient A's RMO and the nurse in charge of A42 that afternoon did not think leaving the ward required s17 leave.*

Interchangeable terms

The Trust Absconding Procedure did not distinguish between detained and informal patients. Instead it focussed on the terms 'missing' and 'absconding'. This was confusing. The terms were used interchangeably and the distinction was unclear to managers and practitioners. We recommend that the present Absconding Procedure be replaced by two procedures: one for detained patients who are AWOL, and the other for all other patients missing from the ward. We recommend that the term 'absconding' be reserved for patients who are detained under the MHA.

Recommendation 7.1

Clinical area
The Trust Procedure defined a patient as missing from a 'clinical area' but in QMC it was not clear what that clinical area was. As with the legal boundary of the Trust, opinions differed. If this definition of missing patient is to remain, the 'clinical area' needs clarification.

Recommendation 6.3.1

No distinction between detained and informal patients
Neither the Trust Observation Procedure nor the Absconding Procedure distinguished between informal and detained patients. Both emphasised vulnerability and care as their criteria for intervention but without any reference to legal status. This was carried through into evidence given to the Inquiry. Few of the witnesses above distinguished between detained and informal patients.

5.10 Action taken when Patient A was missing

5.10.1 On the first occasion that Patient A was found to be missing he returned quickly and no documentation was completed.

5.10.2 On the second occasion the Checklist was partially completed by Staff Nurse B who had recorded the name of Patient A's consultant, his legal status, observation level, time recorded missing, by whom and the nature of the risk/ concern, noting this as *"paranoid psychotic illness".*

5.10.3 He indicated by ticks in boxes that a local search had been undertaken and neighbouring wards, Police and relatives notified. Other tick boxes remained blank. The medical Officer, RMO, security, A&E, Senior Manager and Senior Nurse QMC had not been notified.

5.10.4 On the Trust *Untoward Incident Form* Staff Nurse B had recorded that there had been no witness to the event, that the Duty Doctor had not been called and that the Chief Executives Office/Trust Senior Manager On Call had not been advised.

On-call Director should have been notified
The Director of Nursing told us that there was a rota of Directors to be on-call out of hours and they would expect to receive a report that somebody was missing. This, of course, needed some prioritisation by the staff. With the numbers of patients missing it may have been difficult to assess urgency.

Nurses should have contacted the RMO, QMC security staff and nearest relative
The checklist should have been followed and these individuals informed. The MHA Code of Practice states that there should be immediate contact with the RMO and the nearest relative when a detained patient is AWOL. We recommend that psychiatric wards nurse training in the Code of Practice and AWOL procedure at QMC emphasise the importance of notifying the RMO, nearest relative and security service immediately.

Recommendation 6.4

5.11 Training and audit

5.11.1 The Trust procedure concluded with a note headed *"Training: It is expected that the requirements of these guidelines and procedure will be brought to the attention of all staff, by the designated holders of the Clinical Policies and Procedures Manual".*

5.11.2 The Manager for Nursing and Quality, author of the Procedure document, informed us that the designated holder of the Clinical Policies and Procedures Manual would be the ward manager. It would be for the tier of management above the ward manager to make sure that training happened. She acknowledged there was no evidence that any training had taken place. That impression was shared by the directorate lead for non-medical training at the time.

5.11.3 The Manager for Nursing and Quality also informed the Inquiry that there had been no audit of either the Observation or Absconsion Procedures.

Inadequate training

It was simply inadequate that there had been no training in the application of the Trust Absconding Procedure. The present Trust should review its training to ensure that staff are aware of the Code of Practice expectations when a detained patient is AWOL.

Recommendation 6.4

Need for audit

An audit of the Observation and Absconding Procedures may have picked up their weaknesses. It is vital that these procedures are audited regularly.

Recommendation 6.5

Policies rather than procedures

We note that throughout the giving of evidence most staff referred to Observation and Absconding 'policies' although they were both headed 'procedure'. The Medical Director thought they were a combination of both, adding that there is now "a more careful approach" in the Trust, with separate policies and procedures.

5.12 Concluding comments

5.12.1 We conclude that there was an intention to ensure Patient A would not leave ward A42. However, the layout of the psychiatric wards at QMC, the open ward door, vague nursing observation guidelines which permitted escort off the ward with family on permission of the nurse-in-charge, different nursing practice on different wards, uncertainty over the limits of the clinical area, the Trust boundary or the point at which Patient A would have become AWOL under the MHA, and the reportedly high numbers of patients leaving the ward and returning, combined to make this a complex task.

5.12.2 Once a patient was found to be missing from the ward, procedures and documentation which made no reference to detained patients who were absent without leave did not help staff distinguish urgent from non-urgent.

5.12.3 Indeed, a lack of distinction between the management of detained and informal patients has been a feature of the observation and absconding procedures. This was unacceptable. A sense of special attention and urgency was needed for detained patients.

5.12.4 Although it is not new and it concerns deaths of detained patients rather than homicides, we consider the following to have relevance here. We quote from *Deaths of Detained Patients: A review of reports to the Mental Health Act Commission*[14]*;*

"In some hospitals there is a laissez-faire philosophy among staff which ostensibly defends patients' rights to have maximum possible choice and freedom but which in fact neglects the duty staff have to protect patients from harm. Patients who abscond are often noted to have absconded previously….. ***Units with a high level of absconding are advised to review both the physical environment and care policies.*** *….. Policies often allow a period of several hours to elapse before hospital grounds are searched and relatives and Police are alerted. This study revealed that 38% of patients who died after absconding died within 6 hours of leaving the hospital….* ***There is no value in waiting several hours to see if the patient returns voluntarily; a detained patient's absence should trigger a search at once".*** *(Emphasis in original report)*

[14] Sube Banerjee, William Bingley and Elaine Murphy: *Deaths of Detained Patients: A review of reports to the Mental Health Act Commission; a joint report of the Mental Health Act Commission, the Division of Psychiatry and Psychology, United Medical and Dental Schools of Guy's and St Thomas' Hospitals.* Published by the Mental Health Foundation, 1995. At page 25.

Chapter Six

Care and Culture

6.1 The need to understand

6.1.1 This chapter needs to be written for three reasons. Firstly, the Inquiry has revealed to us a British Moslem family, with a strong sense of their South Asian family background, who have been critical of the services they have received. Although we did not receive any complaints of discrimination based on ethnicity from the family or from Patient A, we note the words used by NIMHE in the 2003 publication *Inside Outside: "There are significant barriers to minority ethnic groups seeking and successfully accessing services. Furthermore they are much less satisfied with services when contact is made"*[15]. We must look further at whether services responded to this family's needs with cultural sensitivity.

6.1.2 Secondly, the Inquiry's terms of reference require us to

"…review the suitability of Patient A's treatment, care and supervision….including any relevant cultural, ethnic or religious needs…."

6.1.3 Thirdly, since the homicide there has been a growing national concern over the mental health care of black and minority ethnic users and, whilst ours is not a wide-ranging brief to examine this issue, we hope that our Inquiry findings will add to the information base on this important subject.

6.1.4 It is beyond the remit of this Inquiry to do more than touch on the complex national debate in this area, but our recommendations are consistent with national trends.

6.2 The evidence we received

6.2.1 We heard from family members who described their experience of services and represented the views of others in the family who did not wish to speak directly to the Inquiry and/or were then in Pakistan. Professional witnesses expressed their opinions and represented their organisations' views.

6.2.2 We heard from a Diversity Advisor for the Nottinghamshire Healthcare NHS Trust, the Manager for AWAAZ - an Asian Mental Health Resource Unit in the voluntary sector, and from the Project Manager for the Nai Zindagi Project, which is Social Services funded and provides a service to Asian women who have, or who care for people, with mental health difficulties.

6.2.3 Information provided to the Inquiry included a directory of Black and Asian community organisations and Equality and Diversity strategies, along with training material.

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[15] *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*; The National Institute for Mental Health in England, published by the Department of Health, 2003, www.nimhe.org.uk At page 12.

6.3 Expert advice

6.3.1 We are fortunate to have received expert advice from Professor Kamlesh Patel OBE, Head of the Centre for Ethnicity and Health at the University of Central Lancashire, National Director of the Department of Health Black and Ethnic Minority Mental Health Programme, Chair of the Department of Health Black and Ethnic Minority Mental Health Programme Board, Chair of the Mental Health Act Commission, and Commissioner of the Healthcare Commission. He is co-author of *Engaging and Changing* and has written the Forward in *Delivery Race Equality.*

6.3.2 Professor Patel was provided with a confidential copy of the draft report and his advice sought upon matters concerning ethnicity and policy. We have drawn upon his expertise in the writing of this chapter and throughout the report where it has been relevant. In particular he has been able to direct us towards areas of policy development where they concern mental health services to Black and minority ethnic groups, in particular local South Asian communities.

6.4 The national picture in 2000

6.4.1 Equality legislation at the time of the homicide was the Race Relations Act 1976 (RRA). The National Service Framework in 1999 had stated that health and Social Services should combat discrimination, and the Macpherson Report into the death of Stephen Lawrence (1999) had defined institutional racism as

6.4.2 *"…..the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping, which disadvantage minority ethnic people"*[16].

6.5 The Trust Equality Strategy in 2000

6.5.1 A Diversity Advisor to the present Trust, appointed after the homicide, told us that the first Trust Equality Strategy dated 1996 had focussed on recruitment and workforce equality issues.

6.5.2 In June 2000 the Trust extended its focus from equality in the workplace to equality of service provision. A Trust report entitled *Equal Opportunities – Agenda for Change, securing Management Commitment* had stated "*The Trust Board of Nottingham Healthcare Trust has recognised the need to create an organisation where the principles of equality and fairness are integrated into policies and practices throughout the organisation*".

6.5.3 Reflecting upon the implications of the Macpherson Report, the report commented "*Institutional racism is a problem for the organisation as a whole. To begin to tackle the problem, everyone in all organisations needs to ask some basic questions, such as:*

[16] Macpherson, W. (1999) *The Stephen Lawrence Inquiry; Report of an Inquiry;* The Stationary Office. At page 43.

- Are we acting fairly?
- Does the service we provide reach all communities it is meant for, and does it meet their needs?
- Are we applying the same professional standards in every situation?"

The Trust position at the time of the homicide
At the time of the homicide the Trust had responded to national concerns about institutional racism arising from the Stephen Lawrence Inquiry by expressing an intention to tackle racism and deal fairly with those who receive services.

6.6 Voluntary sector services in 2000

6.6.1 We heard from two organisations that were operational at the time of the homicide. Neither had contact with Patient A's family but they could have been appropriate agencies to offer help, either directly to Patient A or to his family. Both had, and still have, connections with the Trust and Social Services.

6.7 AWAAZ

6.7.1 The manager of this Asian Mental Health Resource Unit in the voluntary sector told us that it had been established for the past seven years. Initially funded by the Primary Care Trusts it now receives part of its funding from Social Services. It is supported by the present Trust, and the Chair of the organisation is a CPN within the Trust.

6.7.2 AWAAZ provided, and still provides, one-to-one support, group therapy and advocacy for Asian people from the Indian Sub-continent experiencing any form of mental health difficulty and needing support, including preventative care. They work alongside social workers and community psychiatric nurses. Trust staff have AWAAZ leaflets and can make referrals, or patients can make contact themselves.

6.8 Nai Zindagi ('New Life') Project

6.8.1 The Acting Project Manager for this Social Services funded project, described it to us as a service for Asian women within the city who have, or care for people with, mental health difficulties.

6.8.2 Referrals are from staff, the criteria being that the woman concerned, or the person they care for, is subject to CPA and has a care co-ordinator. They aim to get referrals from staff when Asian women are admitted to hospital so they can provide a link between the patient, family and ward staff.

6.8.3 There was, and is, no provision for direct referral from the user or carer. If such a contact is made, then an individual might be referred on to AWAAZ.

A good service
Between them these organisations seem to have offered a wide-ranging service to those in need of help, and they have both been supported by the Trust and Social Services.

6.9 Social Services, Probation and Police in 2000

6.9.1 We have not investigated the compliance of these organisations with the RRA, or indeed the Race Relations (Amendment) Act 2000 (RRAA). It would be an enormous task, and it goes beyond the remit of the Inquiry, which is to examine Patient A's care and treatment. The Nottingham Mental Healthcare NHS Trust had as its whole purpose the provision of care for mentally disordered individuals, and bears some responsibility for engaging other relevant organisations in reducing inequalities in mental health service provision in Nottingham.

6.9.2 We have already commented within Chapter 2 upon ASW confusion over names during the MHA assessment and recommended that ASW cultural awareness training should address this point.

6.9.3 Although the family have not suggested there was any cultural bias to the action taken by Police or Probation, Patient A's eldest sister told the Inquiry that she found the experience of obtaining help for Patient A a struggle. She felt the initiative was left with her and that both Probation and Police could have done more.

6.9.4 We invited anecdotal accounts of AWAAZ and Nai Zindagi's contacts with Police, and found them to be variable. The Manager of AWAAZ recalled that when she had previously worked at a hostel her experience of Police involvement in domestic violence incidents had been that they were very helpful.

6.9.5 The Acting Project Manager of the Nai Zindagi Project said her experience of Police handling of domestic violence in ethnic minority communities had been very varied. At times the Police had been *"very sensitive and very informed and very aware of issues and very willing to take on board opinions of specialists or other professionals"*. But at other times their attitude had been *"rather old-fashioned"* and they had not wanted to get involved because *"it's a domestic"* or *"because of an extended family there is an attitude that it's best for them to deal with it themselves".*

6.9.6 The Chief Inspector of Nottinghamshire Police, when asked to comment from his own experience on how often South Asian communities would choose to ask for Police intervention with respect to domestic violence, replied *"My own perception, which is quite often not necessarily backed up by the stats, would be that they would ask us less frequently than the white community….. I would say that South Asian women are less likely to call us than their white counterparts".* Speculating upon the reason for that he said *"I think it is possibly down to the strength of the family unit and possibly to the shame".* The Chief Inspector added that the Police would not ignore pleas for help from any family.

6.9.7 The Chief Inspector told us that since the Stephen Lawrence Inquiry in 1999 there had been *"a lot"* of ethnicity awareness training for beat Officers in the Nottinghamshire Police, with every Officer now receiving two days' training and senior Officers getting five days of training. He said that Nottinghamshire Police have a target of 3.52% minority ethnic Officers to be met by 2010. When evidence was given to this Inquiry they were at 3.06%. It is not known what the figure was at the date of the homicide. The Officers directly involved with Patient A were white.

6.9.8 We heard from the Assistant Director of Interventions, Nottinghamshire Probation Area, that in the 1980s joint cultural awareness training was run by Police, Probation, Education and Social Services. This was replaced by racism awareness training following strong representation from local community groups that it was needed.

6.9.9 The two Probation Officers involved in this case had undertaken a five day racism awareness course in 1998. They attended a further two day course in 2001.

6.9.10 Commenting upon the management of Patient A's mental health crisis admission to hospital, the Senior Probation Officer emphasised that the situation in Patient A's family had been *"ongoing for some time",* she considered them to have been *"desperate for help"* when they eventually telephoned and it was for this reason they took the family's concerns seriously. Asked whether in her opinion there was a cultural component to this she replied *"It's precisely because I thought there was a cultural component to this case that I drew that conclusion".* She commented *"I was also concerned that the lack of English speakers in the family further compounded their isolation and difficulty in obtaining help".*

6.10 Research on comparative use of services

6.10.1 Research suggests South Asian patients are less likely than White or Black groups to be admitted for inpatient psychiatric care[17] and a pattern of accessing services only at times of crisis has been identified amongst South Asian communities[18].

6.10.2 There is no evidence for (or against) a view that this pattern of service use is through choice. The cause may be a lack of knowledge of services and the stigma of seeking help[19]. One study found that only a minority of Asian people regarded the family as a viable support structure, but suggested that a 'myth' of South Asian people 'looking after their own' may be used by professionals to exclude social support[20].

6.10.3 In a Sainsbury Centre study entitled *Breaking Circles of Fear* it was said that ethnic minorities do not engage with mental health services until they come to

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[17] Bhui, Stansfeld, Hull, Priebe, Mole and Feder, BJP (2003) 182, 105 – 116 *Ethnic variations in pathways to and use of specialist mental health services in the UK:*. This systematic review of all quantative studies compared use of mental health services by Black, White and South Asian groups in the UK.

[18] See *Mental Health Act Commission Tenth Biennial Report 2001-2003; Placed amongst strangers; twenty years of the MHA 1983 and future prospects for psychiatric compulsion;* paragraph 16.14 citing work by the University of Central Lancashire's Centre for Ethnicity and Health which identified a *"pattern of accessing services only at times of fundamental breakdown or crisis amongst South Asian communities, although this is caused not so much by distrust of services as by lack of knowledge of them, and stigma of seeking help, with networks of family, friends or specialist South Asian Community-based staff taking on roles provided to other communities by primary care services".*

[19] See footnote 18

[20] See *From Pathology to Postmodernism: a Debate on 'Race' and Mental Health*: Suki Desai, Journal of Social Work Practice Vol 17, 1, 2003, at page 98 *"the commonly held myth that South Asian people 'look after their own' is used to exclude social care support. Yet Beliappa (1991) found evidence that is contrary. In her study only 13% of Asian people sampled regarded the family as a viable support structure and even this was limited to concerns about general health and child care issues".*

crisis point because "*they may fear being misdiagnosed or mistreated by a 'coercive system' and prejudiced staff, they are sometimes in fear of their lives"* and may perceive mainstream services as *"inhumane, disrespectful, unhelpful and inappropriate, feeling that their voices are not heard"*.[21]

6.10.4 We could find no data for figures on comparative use of mental health services in Nottingham.

Accessing services

Isolation, difficulty obtaining help caused by lack of English speakers, shame, strength of the family unit, stigma, lack of knowledge of services and distrust have each been suggested as possible barriers for South Asian families trying to access services. We recommend that the subject of accessibility of services to the South Asian community in Nottingham be addressed in a number of ways and by different organisations. Gedling PCT jointly with Nottingham City Social Services should commission a community-led needs based assessment of mental health services, making recommendations for improvement. At the same time local providers should aim to promote their services and make them more accessible to the local community through a range of measures outlined at 6.18.5 of this report.

Recommendations 3 and 10

6.11 The service provided to Patient A's family

6.11.1 It should not be forgotten that Patient A was successfully admitted to psychiatric hospital under the MHA on 28 December 2000 through the actions of the family, Police, Probation, GP, ASW and psychiatrists.

6.11.2 However before, during and after the hospital admission, the service to Patient A could have been improved through better communication with, and support for, the family. Communication and support required an awareness of language and cultural difference. Where there was a lack of communication it is likely to have reduced the amount of information available for assessment of Patient A.

6.12 Communication

6.12.1 There was confusion and poor or no communication with carers and the nearest relative at some points of Police, social work, psychiatric and nursing contact, notably:

- the Police visit to the home on 21 December 2000, when Patient A's mother and wife were unable, without an interpreter, to explain their concerns;
- the ASW's failure to speak to the nearest relative on 28 December 2000;
- the absence of significant communication by nurses with family members who visited Patient A on 29 December 2000, including a failure to inform them that Patient A should not leave the ward;
- and a failure to invite Patient A's wife to the psychiatric review on 29 December 2000.

[21] Breaking the Circles of Fear Executive Summary, Sainsbury Centre for Mental Health, 2002, p.4 quoted in the Commission for Racial Equality Response to the Draft Mental Health Bill Consultation, 13 September 2002.

6.12.2 When it occurred, failure of communication meant that the voice of the family was not heard - a recurring theme in homicide and suicide inquiries.[22]

6.12.3 Each occasion of poor communication may have been the result of a separate and unrelated episode of poor practice. However, it did not help that there was no Trust interpreting policy, particularly since the interpreting issues in this Inquiry have been less to do with the availability of interpreting services and more to do with an awareness of the need for them. Family often seemed to be available and so no thought seemed to be given to an alternative, independent interpreter for Patient A's mother and wife who remained largely silent figures to professionals.

6.12.4 Patient A's eldest sister was relied upon heavily. This put her under a great deal of pressure. She interpreted and represented her brother's mental health needs whilst at the same time endeavouring to protect her family and maintain family confidence. So great had been her anxiety that she approached Probation anonymously. During his admission she expressed her fear that her brother would hold her responsible for his hospitalisation.

6.12.5 We asked the Manager of AWAAZ about communication and she told us *"…there is more than one carer in an Asian family, so there needs to be communication with the carers over what is going to happen, what are the procedures and what is going to be the follow-up".* In her view independent interpreters should be used rather than family members. She said *"Well, you could be having conflicts with members of the family so you have to ask is the interpretation being done right…. You need someone who is independent".*

6.12.6 The Code of Practice, at paragraphs 1.3 to 1.7, refers to the importance of making an independent interpreter available for patients, stating *"the patient's relatives or friends should not normally be used as an intermediary or interpreter".* Whist not directly addressing the interpreting need of nearest relatives or carers it does say *"All those involved in the assessment, treatment and care of patients should ensure that everything possible is done to overcome any barriers to communication that may exist".*

Need for revised Code of Practice guidance

The evidence of this Inquiry suggests that an independent interpreter with mental health expertise may be necessary during a MHA assessment so that the nearest relative can be informed of his or her rights. Interpreting may also be needed for family members who could be at risk or feel otherwise compromised or uncomfortable. We recommend that the Code of Practice accompanying new legislation consider incorporating this point as guidance.

Recommendation 8.3

No Trust interpreting policy

There was no Trust policy on interpreting services, no guidance to staff on the circumstances in which interpreters should be used and the Trust interpreting

[22] *Safer Services; National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (1999) Royal College of Psychiatrists; and Margaret Reith *Community Care Tragedies; a practice guide to mental health inquiries* (1998) Venture Press. See also the chapter on Contact with Family at page 47 in *The Inquiry into the Death of David Bennett.*

service was not available 24 hours a day. A Trust A4 sheet of paper dated March 1998 entitled "Interpreting/Translation Service" listed Mirpuri Punjabi as a language the Interpreting Agency bank could provide, stating that it was not available out of hours, although there was an intention to draw upon Police interpreters if necessary. The Mental Health Act Commission National Visit 2 1999 provides information on the circumstances in which interpreters should be used. We recommend that the present Trust ensure all staff know how to gain access to an interpreting service 24 hours a day. We also recommend that the Trust draw up an interpreting policy adopting the recommendations of 'Engaging and Changing' that:

- *'family members, acquaintances and untrained staff should not be asked to act as interpreters at clinically significant events', and*
- *'Interpreters should be made available to explain treatment and care to carers where English is not the carer's preferred language', and*
- *'policies should advocate the introduction of training courses for all staff who are expected to use interpreters'.*

Recommendations 6.7.1 and 6.7.2

The added value of interpreters

An independent interpreter can do more than simply provide translation. An interpreter with knowledge of the minority ethnic community can help professionals understand a family's concerns. An interpreter with knowledge of the mental health services can sensitively convey relevant, accurate information to distressed users and carers, bearing in mind that there are usually several carers in Asian families and communication needs to be especially clear. The Manager of AWAAZ and the Diversity Advisor for the Trust, spoke of a need for increased resources to fund interpreting services, and we recommend that the present Trust, jointly with Social Services, review the provision of interpreters both for patients and family members. A programme of mental health training specifically for interpreters should be considered. Interpreters are, in our view, a human resource worth more than just their value for translation purposes.

Recommendation 9.1

6.13 Support

6.13.1 Like all families experiencing a mental illness in their midst and compulsory admission to hospital for the first time, Patient A's family were in crisis.

6.13.2 Patient A's eldest sister had felt very unsupported during the course of arranging admission, telling us she was left to take the initiative although she did not know how to access services. By the evening it was not surprising that she was tense and emotional and that Patient A's mother was having difficulty accepting what was happening.

6.13.3 The following day Patient A's wife, mother and two sisters did what almost every family would do under similar circumstances. They brought pyjamas, toiletries and Get Well cards to the hospital.

6.13.4 Remarkably, a psychiatric review took place whilst Patient A's wife was present on the ward, yet neither she nor any other relatives were invited.

6.13.5 Had the family felt more involved and supported at the time, it is possible that their satisfaction with the service would have been greater. Improved support may have also helped with communication.

The family's frustration

Although she succeeded in almost single-handedly arranging hospital admission, Patient A's eldest sister described to us her mounting frustration as she struggled to obtain help for her brother, and we accept her remarks as indicative of the real difficulty she experienced. It was unsatisfactory that Patient A's eldest sister should have felt so unsupported. In particular, once the MHA assessment was under way the family should have been able to expect that they would receive support from somewhere. Had there been good integration of voluntary organisations into mainstream services it would have been natural for the ASW or hospital staff to make a telephone call to AWAAZ and ask for their support to Patient A's family.

More use of voluntary organisations needed

AWAAZ and Nai Zindagi are a resource that should be used and valued. We heard from the Nai Zindagi project manager that although they have leaflets, they need them in different languages and more people are needed to make links with psychiatrists and nursing staff. We recommend that the present Trust, jointly with Social Services and the voluntary sector, consider how support services for Black and minority ethnic users and families can be better publicised and used more effectively. Care should be taken not to use voluntary sector projects as a substitute for primary care services.[23]

Recommendation 9.2

Stigma of mental illness

The manager of AWAAZ told us that the stigma of mental illness might mean that carers from the South Asian community are reluctant to go to a psychiatric hospital ward and speak to ward staff and doctors. Patient A's family did visit the ward although there is no evidence that they took the initiative and asked ward staff or doctors for information. This may or may not have been connected with stigma but under the circumstances the responsibility was on staff to make approaches to the family. Race awareness training should consider the issue of stigma.

Recommendation 6.7.3

The Trust should make a statement of commitment

'Engaging and Changing' recommends that Trust policies make a statement "encouraging the engagement of a range of befriending and advocacy community-based organisations to attend to the day to day communication needs of Black and minority ethnic detained patients". We advise that this recommendation be adopted by the present Trust and Social Services and a commitment be made in these terms.

Recommendation 9.3

[23] Ref footnote 18

6.14 The impact on assessment

6.14.1 Where there was a failure of communication with the family, professionals deprived themselves of potentially valuable information for the assessment of Patient A.

6.14.2 With hindsight the family had information which, had it been known from the start, could have changed the course of Patient A's admission and treatment. Early Probation contact with family might have revealed his disturbance at home, resulting in a more comprehensive Probation court report and earlier diagnosis of mental disorder. Better Police and Probation communication with the family might have led to a more planned MHA assessment. Better acquisition of family risk information during and after admission might have resulted in a more comprehensive risk assessment.

6.14.3 All the family visitors had been in conversation with Patient A and would have been able to comment upon his mental state when with them. Risk assessment might have taken into account the wife's views based on the recent history of violence towards her and possible risk to their child, his attempts to abscond from AED, the family's marriage relationships upon which Patient A's delusional thinking had become focussed, anxieties about confidentiality and fear of reprisal for breaching family trust.

6.14.4 Of course, even if the family had been given every opportunity to communicate fully with the clinical team, we cannot know what precise information would actually have been revealed to professionals, whether any of it would have changed the outcome of the psychiatric assessment or altered the nursing observation level on 29 December 2000. In the chain of events we cannot say that it would have prevented the killing. Only that the best decisions are most likely to be made with the fullest information and that this would have been best practice.

Culturally sensitive assessment

Cultural awareness training programmes and supervision for all staff in contact with patients, family and carers should stress that assessment must, wherever possible, include families, whatever their ethnic origin or language and taking into account that there may be several carers in a family[24]*.*

Recommendation 6.7 3

Trust documentation should support assessment

Trust documentation did not include information on ethnicity, religion, family language, diet, significant relatives and need for interpreting and culturally appropriate family support. Good documentation should encourage good communication with relatives and it should assist the process of assessment. Nursing and CPA paperwork should be reviewed and revised to ensure culturally relevant information is included. This topic is currently being addressed by the Mental Health Act Commission (MHAC) and the present Trust may be benefit from their advice on this subject.

Recommendation 6.7.4

[24] Inside Outside at p26-27 comments *"assessments should aim to establish a care plan that is mindful of individual religious, cultural and spiritual beliefs, and has a clear identification of recovery and outcome, so that Black experience of mental health services becomes less negative."*

6.15 Trust developments since the homicide

6.15.1 Since the homicide the Trust has produced an *'Equality and Diversity Strategy'* dated May 2002 which, according to the document itself, satisfies the RRAA requirement to publish a Race Equality Scheme.

6.15.2 Commitment is made within the document to the involvement of users and carers in service development, and we heard that there is now a forum which brings together senior managers from the Trust, community and service user representatives.

6.15.3 We were informed that training on the Strategy has been incorporated into a mandatory management training programme developed by the University of Central England, with the intention that the training will be brought in-house and provided on a rolling programme basis. Topics cover power and oppression, recognising issues of equality and diversity, and listening to patients.

6.15.4 The Diversity Advisor for the Trust, appointed since the homicide, explained that he and a part-time worker cover the whole of the Trust. Their task is to ensure that the Trust meets its requirements arising from legislation, take responsibility for oversight of training on the Equality and Diversity Strategy, and develop networks to offer help with cultural enquiries.

6.15.5 The Diversity Advisor expressed his opinion that these tasks were too much for one and a half post-holders. Adding that additional resources should be made available for translation services and more staff employed to deal with equality issues, he remarked *"issues of diversity and equality cost money".*

6.15.6 Reflecting upon changes in the local mental health service since the homicide in December 2000, the Manager of AWAAZ considered there had been improvements, including the development of an Asian Day Care Service. She told us that before the present Trust took over in April 2001, AWAAZ's working relationship with the local mental health services *"wasn't as effective as it is now"* and that they have subsequently been *"very involved on ethnic minority issues and we have been invited to various consultation events as well. So there is a lot more involvement…. there is effective communication".*

6.15.7 However, she echoed the Diversity Advisor's comment that there needed to be more resources to expand interpreting services. She felt they were also in need of increased funding to provide more support for carers.

Trust compliance with the RRAA

Nottingham is a multi-cultural city. The Trust has published an Equality and Diversity Strategy that, as far as we can see, satisfies the requirement of the RRAA to publish a Race Equality Scheme. Through the involvement of user representatives, the establishment of race and equality forums, the establishment of Diversity Advisor posts, the development of training programmes and support of minority ethnic voluntary sector organisations, the Trust have demonstrated a commitment to promotion of race equality.

Equality and diversity training

Despite good intentions demonstrated within the Trust by those nursing and medical staff asked by the Inquiry, none had received recent cultural awareness training and they believed it was not mandatory. It appears that the programme of equality and diversity training in the Trust is proceeding very slowly, having begun at management level. Such training is essential for front-line staff and should be a priority. We were impressed with the enthusiasm and dedication of AWAAZ and Nai Zindagi, and we are sure this would transmit itself very positively to Trust staff if these and other local minority ethnic organisations could participate in in-house training programmes. Not only would it raise cultural awareness, but it is likely to benefit users directly through the improvement of channels for referral to the voluntary sector. Cultural awareness training within the Trust should be mandatory for all staff including those who are in direct contact with service users and carers. The Trust and Social Services should together consider how local minority ethnic groups can provide input into cultural awareness training[25]*.*

Recommendations 6.7.3 and 9.4

Resources

We were concerned to hear the Diversity Advisor, the Manager of AWAAZ and the Nai Zindagi Project Manager all refer to a need for increased resources. On the face of it, each unsatisfied need outlined to us could be resulting in disadvantage and discrimination for minority ethnic users of mental health services in Nottingham. However, we pick out interpreting services, and user and carer support services as two areas of need arising from this Inquiry, both with resource implications. We recommend that the present Trust and Social Services jointly review funding and service need in these areas.

Recommendation 9.1

6.16 Police and Probation since 2000

6.16.1 The Inquiry has been informed by Nottinghamshire Police that local minority groups are currently involved in Police training and service provision through the Race and Diversity Strategic Board and the Race and Diversity Panel.

6.16.2 In addition *Delivering Race Equality* (2005) states *"NIMHE will support the Association of Chief Police Officers (ACPO) in its review of post-qualification training in mental health. This will help to ensure that the training addresses racial and cultural capabilities. The review is expected to be completed in June 2006 and the roll-out of the training should begin by June 2007".*

6.16.3 We were told that Nottinghamshire Probation Area had set up *"an extensive programme of Racism Awareness training, which has developed over the years through Anti Racism training into broader based Diversity Training which continues".*

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[25] *Delivering Race Equality* states *"All managers and clinical staff, however senior or junior, should receive mandatory training in all aspects of cultural competency, awareness and sensitivity. This should include training to tackle overt and covert racism and institutional racism……All training…..should be regularly updated"*

Community involvement in training

Together it appears that Police and Probation in Nottingham run well-established and continuing training programmes. In the case of the Police, local minority ethnic groups are involved in training and service provision. We recommend Nottinghamshire Probation Area and Nottinghamshire Police ensure that local South Asian mental health groups are well represented in these training initiatives.

Recommendation 2.3

6.17 The national position since 2000

6.17.1 Since the homicide there has been a growing awareness of the need to improve mental health services to Black and Minority Ethnic users and their families, and we summarise this very briefly here.

6.17.2 A number of publications have been influential, including: *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*[26]; the *Independent Inquiry into the Death of David Bennett*[27]*;* Department of Health document *Engaging and Changing: Developing effective policy for the care and treatment of Black and minority ethnic detained patients*[28]*;* and most recently, in January 2005, the Department of Health publication *Delivering Race Equality in mental health care: An action plan for reform inside and outside services and The Government's response to the independent inquiry into the death of David Bennett.*[29]

6.17.3 *Inside Outside*[30] stated

"There does not appear to be a single area of mental health care in this country in which black and minority ethnic groups fare as well as, or better than, the majority white community. Both in terms of service experience and the outcome of service interventions, they fare much worse than people from the ethnic majority do".

6.17.4 Institutional racism was defined in *Inside Outside* as *"a feature of institutions where there are pervasive racist attitudes and practices, assumptions based on racial differences, practices and procedures which are discriminatory in outcome, if not in intent, and a tolerance or acceptance of such differences".* This definition differs from that used in the Stephen Lawrence Inquiry (see 6.4.2 of this report).

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[26] See footnote 14

[27] Norfolk, Suffolk and Cambridgeshire Strategic Health Authority (December 2003) *Independent Inquiry into the Death of David Bennett;* www.nscstha.nhs.uk/11516/david%20Bennett%20inquiry.pdf

[28] *Engaging and Changing; Developing effective policy care for the care and treatment of Black and minority ethnic detained patients;* Kamlesh Patel, Moira Winters, Jon Bashford, William Bingley; National Institute for Mental Health in England, Centre for Ethnicity & Health, Faculty of Health, University of Central Lancashire and Mental Health Act Commission, Department of Health July 2003, www.doh.gov.uk/changeagetteam

[29] *Delivering Race Equality in mental health care: An action plan for reform inside and outside services and The Government's response to the independent inquiry into the death of David Bennett,* Department of Health, published 11 January 2005

[30] *Inside Outside* at page 10

6.17.5 The *Independent Inquiry into the Death of David Bennett* was unequivocal in its conclusion that there is institutional racism in the NHS, based on the Stephen Lawrence definition. They recommended *"There should be Ministerial acknowledgement of the presence of institutional racism in the mental health services and a commitment to eliminate it".*

6.17.6 The Government response contained in *Delivering Race Equality (DRE)* states:

"Racism, discrimination or harassment in any form are unacceptable and an affront to the core values of the NHS. In DRE we have been frank and open about the problems we face in NHS mental health care, which include both direct and indirect discrimination". [31]

6.17.7 The Department of Health approach in *DRE* is a practical one focussed on community-led needs assessments and policy reforms where services are discriminatory. Its publication at this point is timely for those whose task it is to plan non-discriminatory services in Nottingham. Our recommendations should be read alongside *Delivering Race Equality*.

6.17.8 We advise that in addition to the publications mentioned in this section, policy-makers in Nottingham refer to the Mental Health Act Commission's Tenth Biennial Report *Placed Amongst Strangers (2003)*[32]. Other services' experiences of development work with local South Asian communities may also prove helpful.[33]

6.18 The place of Patient A in the national picture

6.18.1 We cautiously place this Inquiry in the context of the national debate on mental health services for Black and Minority Ethnic communities.

6.18.2 None of the family or professional witnesses in this Inquiry have suggested to us that cultural factors or racism were an issue and we have not been asked to examine whether the service received by Patient A's family was representative of that received by other South Asian users of mental health services locally.

6.18.3 We have framed our findings in terms of service and training improvements that could have resulted in earlier, planned hospital admission, more satisfaction for the family and greater information available to professionals for mental health and risk assessment of Patient A.

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[31] The full quote adds *"It is possible to hide behind the label of institutional racism – to confuse the act of recognising it with real action to reform services. If services are discriminatory, then ultimately the responsibility for solving the problem lies with everyone involved in planning, managing and providing the services. …… In this action plan the Government accepts its share of that responsibility and offers its support to those who must reshape front line services. We have been clear about what we will do to root out and eliminate discrimination. The action DRE describes, such as making the workforce more culturally capable and strengthening the relationship between service providers and local communities, has the power to create a new culture of non-discrimination that can improve practice, improve attitudes and produce equity".*

[32] Mental Health Act Commission Tenth Biennial Report 2001-2003 *Placed amongst strangers* Twenty years of the Mental Health Act 1983 and future prospects for psychiatric compulsion; TSO 2003 and www.tso.co.uk/bookshop

[33] Confidential Review of Mental Health Service Provision for South Asian Communities in Bury and Rochdale (Adults) compared to the standards and targets set out in the National Service Framework for Mental Health, October 2001; J Bashford, Jasbir Kaur, Helen Stevenson, William Bingley, Kamlesh Patel.

6.18.4 Whilst our remit has not been to conduct any broad audit of whether Patient A's care has been typical of that experienced by other South Asian users of services in Nottingham, or indeed nationally, we note that had we been asked to do so, the task would have been almost impossible. There is a dearth of comparative statistics on standards of care received by different ethnic groups, and when other demographic variables such as religion, social class and language are taken into account there is even less information available[34].

6.18.5 Fortunately that position should change during 2005 when MHAC, NIMHE and the Healthcare Commission are gathering information nationally in the form of a Black and Minority Ethnic (BME) *'national mental health census'*. [35]

Areas for improvement in Nottingham

We conclude that improved communication and family support by all the professionals might have made the family's experience of receiving care better, led to earlier and easier admission and might have provided professionals with more information upon which to base their assessments of Patient A. We cannot know whether it would have prevented the homicide.

Promoting and improving the accessibility of services to the South Asian community

Local providers of services should promote and improve the accessibility of mental health services to the South Asian community in Nottingham through: ensuring that as far as possible workforces reflect the diversity of the local community and are not just tokenistic; through jointly agreed and implemented mandatory race and culture training across all agencies with rolling training programmes and inclusion within induction; appointment of non-executive Board members with a special interest in race and culture; creation of dedicated slots at Board meetings perhaps once or twice a year; cross-agency theme days and cultural diversity working groups, perhaps chaired by non-executive members with a special interest in this issue.

Recommendation 10

Race and culture training

The importance of training is emphasised in the publication 'Delivering Race Equality' in which the Government responds to Recommendations 1-3 of the David Bennett Inquiry. It states "staff providing mental health services need the right training, supervision and leadership if they are to give all their patients culturally sensitive and safe care." Training for professionals should be multi-disciplinary, mandatory, based on a rolling programme and involve local South Asian community groups.

Recommendations 2.3 and 9.4

User satisfaction

The Trust should develop a means of measuring user satisfaction in order to provide feedback upon the service provided to minority ethnic communities.

Recommendation 6.7.5

[34] Ethnic variations in pathways to and use of specialist mental health services in the UK: Bhui, Stansfeld, Hull, Priebe, Mole and Feder, BJP (2003) 182 and in *Inside Outside* page 10.

[35] A national mental health census of all inpatients will be carried out in 2005 jointly by the Mental Health Act Commission, NIMHE and the Healthcare Commission.

Community-led needs based assessment

In 2000 the previous Trust's Equality Strategy asked the question "Does the service we provide reach all communities it is meant for, and does it meet their needs?" We cannot know on the basis of this Inquiry whether Patient A's care was typical of the mental health service provided to the South Asian community in 2000, even less so in 2005. However we think this remains a good question for the Trust to ask itself – and indeed for other organisations locally to ask themselves and each other. A means should be established of answering that question. We recommend that Gedling PCT and Nottingham City Social Services jointly commission a community-led ethno-sensitive needs assessment, based upon which service improvements should be identified and implemented by relevant service providers.

Recommendation 3

6.19 Final comments

6.19.1 We think that Nottingham has professionals within its midst who have ideas and enthusiasm for tackling cultural issues. They should form part of mainstream services with supportive policies.

6.19.2 Setting high standards for those with cultural and interpreting needs should have the effect of raising standards for all.

6.19.3 We have focussed our recommendations on the improvement of services for the local South Asian community of which Patient A was a part. However we hope that each organisation will consider the involvement of other minority ethnic groups in local initiatives.

6.19.4 Disadvantage and discrimination is suffered by many groups, including those from poor socio-economic backgrounds, Deaf people, older people, women and others. Indeed the relatives who sought help for Patient A were also female and in the case of his wife, only seventeen years old. The principle of equality of service should apply to all.

Chapter 7

Conclusions

7.1 Patient A was not unusual

7.1.1 Patient A was not unusual. Like many other detained patients admitted to acute psychiatric wards for the first time, the mental illness had been developing for some while before diagnosis. In many ways his presentation would have seemed unremarkable.

7.1.2 His care was not unusual either. Ten minute observation was being carried out on five other patients that day.

7.1.3 The fact that Patient A's care was similar to that of many others makes this report of significance for those who provide day-to-day care on acute admission wards in Nottingham and beyond.

7.2 Seven areas of concern

7.2.1 Although Patient A's contact with services was brief, this is a complex report. At first sight his care engaged simply those on the ward and his RMO, but they in turn operated in the context of procedures, staffing, training, financial constraints, professional standards, a need for cultural sensitivity, the framework of the MHA 1983, the Code of Practice and other national guidance. The following seven key areas of concern merely skim the surface of this complexity. They are in roughly chronological order:

1. Probation and Police need mental health training

- Mental illness is difficult to diagnose in its early stages but neither of the Probation Officers involved had received any in-service training in mental health. Training in mental health for beat Police Officers was, we were told, limited. We think this is surprising given the high levels of mental disorder amongst those in the prison population[36]. We recommend a review of mental health training for Probation and Police in Nottingham with the aim of improving current awareness

- With improved ability to identify and manage mental disorder and more knowledge of the MHA, Probation and Police might have been better able to deal with Patient A's mental health crisis by telephoning the family GP, as the GP suggested should have been done. They could also have explained to the family that the nearest relative had a right to request an assessment under the MHA

[36] The Office for National Statistics in 1997 found that nine out of ten prisoners have at least one of five disorders (Neurosis, psychosis, personality disorder, alcohol abuse or drug dependence). Between 12% and 15% of sentenced prisoners have four of the five.

2. Families need to be heard, with interpreters if necessary

- This Inquiry is yet one more of those which finds there was a failure to listen to the family[37], but here there was an added dimension. Listening to the family was almost certainly made more difficult by language and cultural difference.

- Real listening involved hearing more than just information. There was a need to appreciate the several carers in the family, understand family structure, concerns over confidentiality and Patient A's eldest sister's fear of reprisal for breach of family trust. Patient A's eldest sister was relied upon heavily, names were confused, incorrect information about the nearest relative recorded and Patient A's wife not informed of her rights under the MHA. An independent interpreter from the South Asian community with knowledge of mental health services may have been able to help with both information and understanding. We think the South Asian community groups in Nottingham are underused. They are a valuable resource.

- This was less about provision of interpreters and more about when and how to use them. There was no Trust interpreting policy and we recommend there should be. We also recommend that a future Code of Practice advise the use of an interpreter for communication with the nearest relative during MHA assessment. The interpreting needs of relatives are being recognised nationally and our recommendations accord with those in *Engaging and Changing.*

3. Families need culturally sensitive support

- We find that the family experienced real difficulty, distress and frustration in the process of accessing help for Patient A, describing it as a struggle to be taken seriously. We recommend the Trust considers how it might develop measures of mental health service user satisfaction.

- There were local South Asian community organisations with mental health expertise that could have been approached to help support the family and represent their interests. The Family was in crisis and needed help. Patient A's eldest sister in particular felt under pressure as the spokesperson for the family and interpreter. She almost single-handedly ensured that Patient A was admitted to hospital, and was fearful that her role in his admission would result in dangerous recrimination by her brother. Crisis support and assistance should have been offered to them.

- We recommend that South Asian community organisations are more widely publicised in AED and in the acute psychiatric wards at QMC. They were under-used and should have a higher profile in the Trust.

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[37] *Safer Services; National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (1999) Royal College of Psychiatrists; and Margaret Reith *Community Care Tragedies; a practice guide to mental health inquiries* (1998) Venture Press. See also the chapter on Contact with Family at page 47 in *The Inquiry into the Death of David Bennett.*

4. Intermittent nursing observation has inherent weaknesses

- The RMO believed ten-minute observation would be sufficient to detain Patient A on the ward in hospital. It was not.

- Either Patient A needed to be on a higher level of observation or the ten-minute observation had to be supplemented by additional ward security to prevent him leaving the ward.

  (i) Higher observation level
  Two things might have resulted in a higher observation level. The first was family involvement in risk assessment. This may have led to a greater level of risk being identified. The second was an up-to-date Trust observation procedure. It was out-of-date and did not meet national nursing guidance standards. Had it done so it is possible that its lower threshold would have resulted in 'line-of-sight' observation being used, at least for a while. The Trust should ensure its observation policy complies with best national practice and guidelines.

  (ii) Additional ward security
  Ten-minute observation was relied upon to prevent Patient A leaving the ward, but alone it could not do that. There was unobserved time in between each ten-minute observation, an open ward door, no-one to watch it continuously, a difficult ward layout for observation and too few staff during observation handover. A patient determined to leave simply needed to wait for an opportunity. Significantly, each occasion Patient A was found to be missing was after observation handover. Observation level must take into account a ward's general level of security, which may need to be altered to ensure that intermittent observation is effective. We recommend there is a review of staffing taking into account the need to make observation as safe and secure as possible, especially during handover.

- The problem with nursing observation – and this is a national problem – is that there is a difference of opinion over whether it should ever be used. Observation at intervals is sanctioned by national nursing guidance and is considered satisfactory for the majority of patients who need to be observed. This is disputed by the Royal College of Psychiatrists' *Confidential Inquiry* which considers that intermittent observation is inherently unsafe. We agree. This lack of national clarity is very unsatisfactory and this Inquiry has already expressed its concern to the Department of Health on this subject.

- We recommend that the present Trust aims in the long term to end intermittent observation and find alternatives.

- In the meantime, we make detailed recommendations intended to make observation at intervals safer, including ensuring that where there is a risk of absconding and a risk of self-harm or harm to others, intermittent observation is not used on an open ward.

- We recommend that the Department of Health incorporate these safeguards into future published guidance in order to improve the safety of intermittent observation.

5. Risk assessment should involve family members

- Poor communication with, and support for, Patient A's family reduced the amount of information for risk assessment reaching the psychiatric team.

- In particular, Patient A's eldest sister's fear that Patient A would leave hospital and harm her or her husband, expressed twice during the process of admission, had not been noted and was not therefore known to the RMO. Patient A received four family visitors on the day of the homicide but none of them were invited to participate in any assessment or attend the psychiatric review. Patient A's wife was not invited even though she was the nearest relative, was on the ward whilst it took place, had been assaulted by her husband and the child was with her. There was no recorded assessment of risk to her or the baby at the review. Nor was there any assessment of the impact upon Patient A's health of so many visitors less than 24 hours after his first admission suffering from an acute psychotic episode.

- With thorough involvement of the family the RMO might have heard that Patient A had been asking who had called Police and GP. The RMO might have realised that Patient A's eldest sister felt vulnerable because of the possibility of recrimination. This might have caused him to increase the observation level. But on the other hand there was agreement that Patient A appeared calm and settled on the ward. And we now know that the real risk arose from Patient A's psychotic delusional beliefs which he did not disclose to anyone, least of all the RMO whom he had incorporated into his delusional system.

- We cannot know what difference any additional information would in fact have made but, given the availability of several members of the family on the day after admission, they should have been involved in risk assessment as a matter of good practice. The failure to include them meant that assessments were not comprehensive when they could have been.

6. When a detained patient is missing the situation is urgent

- Patient A was missing on two occasions on the afternoon of the homicide. On neither occasion was the RMO informed.

- On the first occasion he went to the door of the hospital to see off his family and then to the hospital shop. After he had returned he was reminded by staff that he should not leave the ward. His absence was not noted.

- Less than an hour later he left the ward with friends and within a few hours had killed his brother in law. The psychiatric wards were situated in a very large and busy general hospital. Although the hospital area

was searched, the QMC security service was not told until the Police let them know over two hours later. CCTV cameras located at the doors of the hospital could have been scanned by security staff to establish whether Patient A had left the building. We have been able to see a still photograph showing him leaving the hospital at 16.44 hours, twenty minutes before his absence was noticed. That information would, we were told, have been available to ward staff had they asked the security service at the time.

- When the Police were informed, no note was made that Patient A was a detained patient. The high numbers of patients going missing made Patient A unexceptional and not a high priority.

- We conclude that there was insufficient urgency in the response to Patient A's absences from the ward. One simple thing was needed - a prioritisation based upon detention under the MHA, both by the hospital and by the Police.

  (i) The hospital
  Detention under the MHA received no special consideration in Trust procedures. Neither the observation procedure nor the absconding procedure distinguished between detained and informal patients. There was no policy covering detained patients who are AWOL as required by the MHA Code of Practice, and no requirement that the RMO and nearest relative be informed of a detained patient's absence as required in the Code of Practice. This position should be urgently rectified by the Trust. The starting point for detained patients should be that they are given the highest priority when missing, with risk assessment reducing that priority if warranted.

  (ii) The Police
  Patient A was categorised as requiring a *"delayed response"* meaning that it was non-urgent. We recommend that the Police together with the Trust devise a risk-screening tool that prioritises patients detained under the MHA and provides basic information about the individual's risk to themselves or others. This should be completed when a patient is reported as missing from hospital. As with the hospital, the highest priority should be given to detained patients until risk factors indicate the priority level can be reduced.

7. Failure to detain Patient A in hospital

- On the day of the homicide ten-minute observation was thought to be reasonable, but it failed in its task. We conclude that this was for six key practical reasons:

  (i) The ward door was open.
  (ii) The ward door was not watched continuously.
  (iii) The ward ten-minute observation procedure permitted up to 20 minutes observation-free time because of handover procedures.
  (iv) Effective measures were not put in place to contain Patient A on the ward after he had once gone missing.

(v) It was not made sufficiently clear to Patient A's visitors that he was very mentally unwell, legally detained and he should not leave the ward with them.

(vi) QMC hospital security were not informed immediately Patient A was found to be missing.

- From the evidence we have heard, we do not find that there was any individual failing. Responsibility must be shared between those charged with Patient A's care on that nursing shift, those responsible for management of the ward, those charged with ensuring adequate staffing of the ward, those responsible for observation, absconding procedures and training, and those ultimately responsible for ensuring that acute psychiatric wards at QMC are secure for detained patients at all times.

7.3 Three broad themes

7.3.1 Three broad themes emerge from this report:

A. Detention under the MHA was insufficiently prioritised

- If there is one lesson which should emerge from this Inquiry it is that the MHA matters. Detained patients are in a category of their own. They are deprived of their liberty under the Act because there is a duty to protect others and the patient from the effects of their mental disorder. This places them in a different position to informal patients. That must be borne in mind as services are planned and delivered.

- Trust observation and absconding procedures did not distinguish between detained and informal patients, and there was no policy specifically to deal with detained patients who are absent without leave, as required by the MHA Code of Practice. This did not set the right tone for staff to prioritise the care of detained patients.

- Much legal time has been devoted to the issue of what in fact constitutes 'detention'. European law has concluded that it is characterised by 'complete and effective control'[38]. That is what the law presumes exists when a patient is detained under the MHA. In the case of Patient A that is what should have existed, but did not.

[38] See footnote p.3 at page 17 above, and R (G) v MHRT [2004] EWHC 2193 (Admin) High Court 7 October 2004; and R (Secretary of State for the Home Department) v MHRT [2004] EWHC 2194 (Admin) High Court 7 October 2004

B. Acute inpatient services were under pressure

- On both subjective and objective measures, Ward A42 was under pressure. Like many other acute admission wards it operated at over 100% bed occupancy. Of the psychiatric wards at QMC, Ward A42 had the highest bed occupancy rate, the highest number of admissions and discharges, the highest use of intensive care beds, the highest number of detained patients, the highest level of staff turnover and the highest number of untoward incidents recorded. A bid to increase the number of nurses was turned down and other measures developed instead to attempt to reduce the pressure on the ward from the community. The aim was to reduce the number of admissions and reduce the length of stay

- There is a trend within the Trust and nationally, for a move away from acute inpatient services to condition-specific teams based in the community. This has provoked a national debate. There is a danger that, with resources focussed on assertive outreach and other community support, acute inpatient services will be become starved of the funding needed for maintenance of high standards of care to those who are very mentally unwell and who need intensive care in hospital. The care of this group of patients should be seen as highly specialist, with resources made available to ensure adequate staffing and training.

C. Race and cultural issues need further attention

- The purpose of this Inquiry was not to undertake an analysis of how racially sensitive the services were or are in Nottingham. It was to examine the individual care of one man and his family. We conclude that with more attention paid to the culturally sensitive issues of listening, communicating and supporting, risk assessment might have been improved and the family equipped with more information about Patient A's mental illness and detention under the MHA. We cannot know what impact, if any, that would have had upon the final, fatal outcome. However as a matter of good practice this Inquiry recommends that the Trust jointly with other local organisations initiate or further develop the following, in order to ensure that services are measurably responsive to local minority ethnic need:

  i. Interpreting services and policies
  ii. Integration of ethnic minority support groups into mainstream psychiatric care
  iii. Race and culture training
  iv. Measures of user satisfaction
  v. Community-led needs assessment jointly commissioned by statutory services

7.4 Concluding comments

7.4.1 When, with the benefit hindsight, the mental health care of any individual is examined under the microscope it is inevitable that weaknesses will be revealed.

Psychiatric care is a difficult task, requiring hard work from dedicated professionals.

7.4.2 Much is expected of suicide and homicide Inquiries. Sometimes reports are criticised for picking out individuals in a so-called 'blame culture'. Sometimes there is disappointment that individuals have not been sufficiently blamed. In this report we have examined the care and treatment of Patient A from every angle in order to make constructive recommendations for improvement in practice procedure, policy and planning.

7.4.3 We conclude that although the homicide itself, arising out of Patient A's undisclosed psychotic beliefs, was unpredictable and unforeseeable, it was foreseeable that if he were to leave hospital he could act in a way that was dangerous.

7.4.4 The homicide could have been prevented by ensuring that Patient A did not leave the hospital. He could have been prevented from leaving hospital by placing him on a higher level of observation or by making ten-minute observation safer, by keeping a continuous watch on the open ward door and not permitting him to leave the ward with or without visitors. Much of this report has been concerned with the possible reasons that this did not happen.

7.4.5 The failure to achieve this was not just a failure for the homicide victim, the family and Patient A. It was also a failure for those doctors and nurses who, in good faith, were working hard to provide his care in the expectation that every other part of the care framework would support their own efforts.

7.4.6 As is recognised in serious clinical and indeed non-clinical incidents, a number of factors can contribute and combine together to produce the final event. Our report has described just such a combination of factors contributing to this outcome. They operated at different levels of the various organisations and interacted with each other making it impossible to locate causation in any one part of the structure. Alone, most were benign. But together they were potentially dangerous.

7.4.7 In order to operate successfully, the pieces of any mental health care jigsaw puzzle must come together in two places - the top and the bottom. They may be fragmented in the middle. Perhaps that is inevitable. But those who receive services experience it as a whole package. And those with a strategic view of services should commission and provide it as a whole package.

7.4.8 We conclude that there needs to be an organisational overview of the way in which the various components of the service come together to ensure that detained patients on acute psychiatric admission wards at QMC are safe and secure. Responsibility for ensuring that the pieces of this jigsaw puzzle fit together in the future must lie with those in a position to see the structure as a whole.

Chapter 8

Recommendations

No.	Organisation	Recommendation [see report pages]
1	Nottinghamshire Police	1.1 should review their procedures on the use of interpreters [11] 1.2 ensure that Police call logs record any need for an interpreter and that Officers attending the incident are aware of such a need [11] 1.3 Ensure that Officers are aware of the need to provide complainants with a full opportunity to express themselves, if necessary through the use of an independent interpreting service [11] 1.4 Review current diversity training for Police Officers to ensure that it sufficiently addresses the need for sensitive use of language [17] and 1.5 Review current training and guidance to Police Officers to ensure that it addresses basic mental health legislation and the identification and management of mentally disordered individuals [18]
2	Nottinghamshire Probation Area and Nottinghamshire Police	2.1 should review their strategy for the management of emergency care of mentally disordered offenders [15] 2.2 review their post qualifying refresher training to ensure it covers emergency mental health legislation, the powers of the nearest relative and the identification of mentally disordered individuals [15] 2.3 ensure that mental health training supports the strategy at 2.1, devising joint training programmes with the inclusion of Social Services where possible, making sure that training addresses racial and cultural capabilities as stated in *Delivering Race Equality* and ensuring that local Black and Minority Ethnic groups, including South Asian mental health groups, play an active part in training programmes [95, 97]
3	Gedling PCT jointly with Nottingham City Social Services	should jointly commission a community-led ethno-sensitive needs based assessment of the mental health needs of the local South Asian community and based upon that needs assessment consider what service improvements, if any, should be undertaken by local providers [88, 98]
4	Nottinghamshire Healthcare NHS Trust jointly with the Emergency Department of Queen's Medical Centre and with	4.1 should ensure there is a guidance note available for all staff working in the Emergency Department, describing the occasions when an independent interpreter should be used, how to access an interpreter 24 hours a day and making reference to the MHA Code of Practice where appropriate [20] 4.2 prepare an information note on the community support organisations available for individuals and families from

	the advice of local representatives of minority ethnic groups	minority ethnic groups who are in distress because of a mental health problem. This should be available to staff in AED and the acute admission wards at QMC [24]
5	Nottingham City Social Services	5.1 should provide training to ASW's on the use of independent interpreters for carers, especially where there is a need to inform the nearest relative of his 1or her rights under the MHA and where complex family names and relationships need to be understood [22] 5.2 ensure that ASW reports accompanying an admission under the MHA record all concerns about risk raised by the family [23]
6	Nottinghamshire Healthcare NHS Trust	**6.1 Admission** 6.1.1 should review Trust nursing admission documentation reducing the amount of it where possible [51] 6.1.2 simplify risk assessment documentation [55], 6.1.3 link risk assessment to care planning [55], 6.1.4 record any risk of absconding [55], and 6.1.5 note interpreting or other needs connected to a patient's ethnicity [55] **6.2 Observation** 6.2.1 should consider a long term plan for alternatives to the use of intermittent observation as suggested by the Confidential Inquiry [60] 6.2.2 revise or replace the Trust Observation Procedure with a new observation policy and protocols based upon most recent best evidence and published guidance, audited, reviewed regularly and up-dated when necessary [59] The policy should ensure that for **all** patients a) levels of observation accord with definitions in the SNMAC *Safe and supportive observation of patients at risk (June 1999)* or other most recent best guidance [60, 65, 71] b) the reason for observation is agreed between the psychiatrist and nurse in charge of the ward or disagreement recorded [24,63] c) the reason for observation, expressed in terms of assessed risk to self and/or others, is recorded [24] d) any absence from the ward is recorded [31] and for **detained** patients e) the legal status of the patient and any s17 leave is clearly recorded in all observation records [59] f) any restriction on the patient's movement within the hospital is noted e.g. restriction to the ward [59] g) risk of absconding and any consequent risk to self and/or others is assessed and recorded [24,58]

		h) intermittent observation is not used on open wards where there is a risk of absconding **and** an associated risk to self/others [71] i) where a comprehensive risk assessment of the patient has not been possible this is recorded and considered as an added risk [71] j) the RMO is always informed if a detained patient is absent from the ward without permission, and a review of observation level undertaken [32, 36] k) the Trust AWOL procedure is always instigated for any detained patient who is AWOL from the hospital [64] l) the patient's RMO is informed if, for any reason, intermittent observation no longer offers the level of security intended for the patient [32] 6.2.3 should revise the Trust nursing observation paperwork [69] to ensure that for detained patients the following information is recorded on the daily observation chart [71] a) The patient's legal status under the MHA and what, if any, s17 leave is permitted b) where within the hospital a patient is permitted by the RMO to go, and whether escorted or not c) the reason for observation described in terms of risk to self and/or others d) an assessment of the risk of absconding and any consequent risk to self or others e) a record of any absences from the ward f) in the case of any patient who has been absent from the ward a note that the RMO or duty psychiatrist has been informed and the observation level reviewed 6.2.4 review staffing levels on the wards at QMC [50] taking into account the needs of nursing observation [63] 6.2.5 review the practice of locking ward doors at QMC taking into account the MHA Code of Practice at Chapter 19, paragraphs 19.24 to 19.27 and seeking advice from the Mental Health Act Commission on good practice [69], 6.2.6 make it clear to all clinical and nursing staff that patients must not be invited to change into their pyjamas to prevent absconsion; reference the MHA Code of Practice at paragraph 19.32, [32] 6.2.7 review nursing observation handover to establish whether any improvements need to be made to ensure that observation is maintained during this period [71] **6.3 Boundaries** 6.3.1 take legal advice on the boundary of the Trust within QMC, the point at which s17 leave is needed for a

		patient detained on QMC psychiatric wards [77] and the definition of 'clinical area' if this term is to continue in use for missing patients [80], 6.3.2 until the Trust legal position on s17 leave is clarified, require that consultant psychiatrists inform staff how far their patient can go within the hospital without s17 leave [77] **6.4 Training** ensure that all staff receive regular mandatory training on the MHA, Code of Practice and AWOL procedures for detained patients [39, 81], ensuring staff are aware that the RMO, nearest relative and QMC security service should be informed as soon as possible [80]. Training on a new observation policy and procedure should include how to manage disagreements over observation level [63], link observation with the management of patients who are AWOL [70] and ensure staff are aware of the need for a documented risk assessment for absconsion [74] **6.5 Audit** audit observation, missing patient and AWOL procedures regularly [81] **6.6 Family and visitors to psychiatric wards** 6.6.1 ensure that there is clear responsibility for arranging family attendance at psychiatric reviews [28] 6.6.2 provide guidelines to nursing and medical staff on the management of visitors to psychiatric wards [26,33] which should include: a) an assessment of a patient's fitness to receive visitors, especially during the first 24 hours of an admission [28], b) any risk involved either to the patient or visitor [26], c) the recording of visitors to detained patients [26] d) the information to be given to family and visitors, bearing in mind confidentiality[29,33] **6.7 Interpreting and race awareness** 6.7.1 produce a policy on interpreting services drawing upon guidance in the publication *'Engaging and Changing'* [90] 6.7.2 ensure that all Trust staff know how to access an interpreting service 24 hours a day [90] 6.7.3 ensure there is a rolling programme of mandatory race awareness training developed with the input of local Black and minority ethnic mental health groups, for all staff who are in direct contact with service users and carers. Training should address the points raised in this report including the importance of the involvement of families in assessment, and taking into account the possible stigmatising effects of mental illness [91, 92, 94] 6.7.4 review and revise nursing and CPA paperwork to ensure it includes information on ethnicity, religion, family

			language, diet, significant relatives and need for interpreting and culturally appropriate family support[92]
		6.7.5	measure minority ethnic user satisfaction with mental health services [97]
7	Nottinghamshire Healthcare NHS Trust jointly with Nottinghamshire City and County Social Services, Nottinghamshire Police, Queen's Medical Centre, QMC Security Service and East Midlands Ambulance Service	7.1	should cease using the Trust Absconding Procedure and replace it with two policies: one covering patients who are detained under the MHA and absent without leave in keeping with s18 MHA and the Code of Practice [39, 75], and one other for all other patients who are missing from the ward. The term 'absconding' should be reserved for detained patients [79]
		7.2	develop the AWOL policy jointly with those organisations relevant to its operation [74]. The policy should emphasise the greater degree of risk likely to be involved when a detained patient is missing [40], and require that: a) all detained patients have their risk of absconding assessed and recorded [74] b) the RMO is always informed when a detained patient is absent without leave [75] c) at QMC the hospital security service is always informed [37] d) information provided by the hospital to the Police fully addresses risk to the patient and/or others, e) the nearest relative is informed [76] f) when the Police are informed they are told that the patient is detained under the MHA [39] g) the AWOL policy be linked with the Trust observation policy and care plans [74]
		7.3	review the management and prioritisation of patients who are reported to Police as missing from the psychiatric wards at QMC, and devise a risk screen tool for use by nurses and Police [39]
8	Gedling PCT	8.1	review the funding of acute mental health inpatient services to ensure there is adequate resourcing of staffing [50]
		8.2	convey to the Department of Health the recommendation of this Inquiry that future guidelines on nursing observation advise intermittent observation not be used on an open ward where there is an assessed risk of absconding [71]
		8.3	convey to the Department of Health the recommendation of this Inquiry that any new MHA Code of Practice incorporate within it guidance that an independent interpreter be considered where it is necessary to inform a nearest relative of his or her rights during an assessment under the Act, or where it is necessary to communicate because the patient or carer might be at risk [89]

9	Nottinghamshire	9.1	should, with Nottingham City PCT, review funding and service need in the areas of (i) interpreting services, including mental health training for interpreters [90], and (ii) ethnic minority community group user and carer support [94]
		9.2	consider how support services for Black and Minority Ethnic users can be better publicised and used more effectively [91]
		9.3	together make a statement of commitment to developing community-based organisations and attending to the communication needs of Black and Minority Ethnic detained patients as recommended in *Engaging and Changing* [91]
		9.4	consider how Black and Minority Ethnic community groups, including South Asian groups, can contribute to Trust and Social Services race awareness training [94, 97]
10	Nottinghamshire Healthcare NHS Trust, Nottinghamshire City Social Services, Nottinghamshire Police and Nottinghamshire Probation Area		Should, individually and jointly where possible, positively promote and improve the accessibility of mental health services to the South Asian community in Nottingham through representation at Board level and the other suggestions detailed at 6.18.5 of this report [88, 97]

APPENDIX A

Terms of Reference

Terms of Reference for the Independent Inquiry into the Care and Treatment of Patient A

With reference to the homicide on 29 December 2000, to examine the circumstances of the care and treatment of Patient A by the mental health and social care services.

The Inquiry to review:

1. The quality and scope of Patient A's health and social care including:

    - The circumstances of his admission to Acute Mental Health Wards at Queens Medical Centre on 28 December 2000, his observation and risk assessment in hospital, and the circumstances surrounding his absence from hospital on 29 December 2000.

    - The arrangements between Nottingham Healthcare NHS Trust and the Police in connection with procedures concerning Patient A's absence at that time.

2. The suitability of treatment, care and supervision provided including:

    (a) assessment of health and social care needs
    (b) any past psychiatric history or other factors influencing assessment of health and social care needs
    (c) the actual and assessed risk of potential harm to self and others
    (d) any relevant cultural, ethnic or religious needs.

3. The extent to which the care provided complied with statutory obligations, the Mental Health Act Code of Practice, local operational policies, relevant Department of Health guidance and recognised good practice.

4. The processes for training and development of staff in risk assessment.

5. Collaboration and communication between the agencies involved, and assessment of whether all appropriate professional agencies were involved.

6. The adequacy of support, information and liaison with the patient's family

7. To prepare a report of Inquiry's findings and make recommendations as appropriate to Nottingham Health Authority (or its successor body)

8. To review progress made into implementation of the Inquiry's recommendations against an agreed action plan.

APPENDIX B

Procedure to be adopted by the Inquiry

Procedure to be adopted for the Independent Inquiry into the Care and Treatment of Patient A

1 The following describes the procedure which the Inquiry will follow in order to obtain evidence and produce its report.

2 Following a review of the documentation the Inquiry will consider which individuals should be invited to give evidence.

3 Each witness of fact identified by the Inquiry will receive a letter which will:

- Inform them of the Terms of Reference and the procedure to be adopted by the Inquiry;
- Invite them to provide a written statement outlining the issues which should be covered by them in that statement;
- Explain that after receiving their statement the Inquiry will decide whether they should also be invited to attend the Inquiry to give oral evidence;
- Inform them that if/when they attend the Inquiry they may bring with them a friend, relative, member of a trade union, lawyer, member of a defence organisation, advocate or anyone else they may wish to accompany them, with the exception of another Inquiry witness;
- Inform them that it is the witness who will be asked questions and who will be expected to answer;
- Inform then that their evidence will be recorded and a verbatim transcript sent to them for their signature confirming its accuracy.

4 Witnesses of fact will be asked to affirm that their evidence is true.

5 Any point of potential criticism will be put to a witness of fact, whether orally when they give evidence or in writing at a later time, and they will be given a full opportunity to respond before the report is written.

6 Representations may be invited from professional bodies and other interested parties as to present arrangements for persons in similar circumstances.

7 Anyone else who feels they may have something useful to contribute to the Inquiry may make written statements for the Inquiry to consider.

8 All sittings of the Inquiry will be held in private.

9 The evidence which is submitted to the Inquiry, either orally or in writing, will remain confidential to the Inquiry, save as disclosed within the body of the Inquiry's final report and executive summary.

10 Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments which appear within the narrative of the Report and any recommendations will be based on these findings.

11 The findings and recommendations of the Inquiry will be contained in a final report which will be presented to Gedling Primary Care Trust and which will be published.

APPENDIX C

People interviewed at hearings, most of whom also provided written statements

Relationship/position at the time of the homicide or as stated
Patient A
Patient A's eldest sister and wife of victim
Approved Social Worker, Nottingham City Council Social Services
Senior Probation Officer Nottinghamshire Probation Area
Probation Officer, Nottinghamshire Probation Area
Patient A's General Practitioner
Consultant Psychiatrist, Nottingham Healthcare NHS Trust
Specialist Registrar in Psychiatry, Nottingham Healthcare NHS Trust
Duty Specialist Registrar, Nottingham Healthcare NHS Trust
Ward Manager, Nottingham Healthcare NHS Trust
Ward A42 Nurse in Charge A, Nottingham Healthcare NHS Trust
Ward A42 Nurse in Charge B, Nottingham Healthcare NHS Trust
Staff Nurse A, Nottingham Healthcare NHS Trust
Staff Nurse C, Nottingham Healthcare NHS Trust
Senior Nurse, Nottingham Healthcare NHS Trust
Director of Nursing, Nursing and Quality Directorate, Nottingham Healthcare NHS Trust
Manager for Nursing and Quality, Nottingham Healthcare NHS Trust
Clinical Director, General Psychiatry Directorate, Nottingham Healthcare NHS Trust
Sector Manager for Ward A42, QMC, Nottingham Healthcare NHS Trust
Medical Director, Nottingham Healthcare NHS Trust
Diversity Advisor, Nottinghamshire Healthcare NHS Trust (post-homicide)
Chief Executive, Nottinghamshire Healthcare NHS Trust (post-homicide)
SHO, Department of Psychological Medicine ,Queens Medical Centre
Security Guard, Queens Medical Centre
Chief Inspector, Professional Standards Unit, Nottinghamshire Police (post-homicide)
Community Policeman, Queens Medical Centre
Manager, AWAAZ (Asian Mental Health Resource Unit)
Deputy Manager, Nai Zindagi Project (Asian Mental Health Resource Unit)

People who provided only written statements or other information

Relationship/Position
Friend of Patient A
Consultant Psychiatrist, Queens Medical Centre
Detective Superintendent, Nottinghamshire Police
Police Officer A, Nottinghamshire Police
Police Officer B, Nottinghamshire Police

APPENDIX D

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APPENDIX E

Abbreviations used in the Report

AED	Accident and Emergency Department
ADWM	Acting Deputy Ward Manager
ASW	Approved Social Worker
AWAAZ	Asian Mental Health Resource Unit
AWOL	Absent Without Leave
CCTV	Closed Circuit TV Camera
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
DPM	Department of Psychological Medicine
DRE	Delivering Race Equality
EDT	Social Services Emergency Duty Team
GP	General Practitioner
HCA	Health Care Assistant
HoNOS	Health of the Nation Outcome Scale
MDT	Multi-disciplinary Team
MHA	Mental Health Act 1983
MHAC	Mental Health Act Commission
NIMHE	National Institute for Mental Health in England
PCT	Primary Care Trust
PRN	Medication given when required
QMC	Queens Medical Centre, Nottingham
RMO	Responsible Medical Officer
RRA	Race Relations Act 1976
RRAA	Race Relations (Amendment) Act 2000
SHO	Senior House Officer
SN	Staff Nurse
SNMAC	Standing Nursing & Midwifery Advisory Committee
SpR	Specialist Registrar