Contact Consulting

An independent review of the internal investigation into a homicide committed by a mental health service user in receipt of care from Hampshire Partnership NHS Foundation Trust

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Contents

1. Introduction

NHS South Central is the Strategic Health Authority (SHA) covering Berkshire, Buckinghamshire, Hampshire, the Isle of Wight, Milton Keynes and Oxfordshire. SHAs are the local headquarters of the NHS and South Central is one of ten in England. It serves a population of around four million people.

South Central is responsible for the management of £5 billion of health spending, which includes acute and mental healthcare hospitals, primary care, ambulance and specialist services. The SHA works with the nine Primary Care Trusts (PCTs) in the South Central area who commission and provide a range of health services. Through its Patient Safety Federation, the SHA works to promote and improve the safety of services across the region. Mental Health is one of nine key areas in which it is focusing its work.

Hampshire Partnership NHS Foundation Trust (HPFT) is one of the three specialist secondary care mental health Trusts in the South Central area. It provides specialist mental health and learning disability services for people across Hampshire and the surrounding area, serving a population of 1.4 million people. It was originally established as West Hampshire Trust in 2001 and since then has grown in size, now operating from over 100 sites and employing over 4,500 staff. Foundation Trust status was received in April 2009.

In July 2009 a patient (Patient A) in receipt of treatment and care from HPFT allegedly murdered Patient B at his home address in Waterlooville. The victim and the perpetrator were both patients of the East Hampshire Assertive Outreach team. It is alleged that on 2nd July Patient A attended Patient B's home and fatally stabbed him in the neck. Patient B was found on 3rd July 2009 by community staff. On 8th July 2009 Patient A was arrested in connection with the offence and was charged with murder on 10th July 2009. At the time of writing Patient A had not been tried or convicted of the offence.

When a homicide is committed by a person who is, or has been, under the care of specialist mental health services in the six months prior to the event and was subject to the enhanced care programme approach it is the responsibility of the SHA to commission an independent investigation.

The purpose of such scrutiny is to ensure that internal reviews have been conducted in accordance with the requirements of the Department of Health Guidance HSG (94) 27, as amended in June 2005 and August 2007.

In most cases, this form of scrutiny will replace a full independent inquiry unless there are issues identified which have not been addressed adequately or other areas that warrant further investigation by a panel of external professional experts. The management of, and response to, Serious and Untoward Incidents (SUIs) is a central element of good clinical governance. How organisations learn from such events, and implement the learning to improve the quality of practice is critical to maintaining the confidence of patients, the public and other stakeholders. It is in this context that Contact Consulting, independent consultants with expertise in mental health service development and review, were invited to carry out this review.

2. The scope of this review

It is important to be clear that the scope of this review did not require an examination of the clinical care and treatment of Patient A as this was the remit of the original internal investigation. Nevertheless, during our review, where particular issues have been highlighted they have been set out in this report for the SHA to consider what actions, if any, may be necessary.

The key aims of this review, agreed between Contact Consulting and the SHA were to:

- To provide assurance that a sound Root Cause Analysis (RCA) process was followed by the organisation
- That the correct root causes have been identified
- That robust recommendations have been identified when reviewing the care and treatment of patient A
- That areas of treatment and practice that could have been improved have been identified
- That there is evidence of organisational learning from the incident

The review provides the SHA with an independent opinion of the internal investigation that can be presented to the SHA Board. It may also be referenced by the SHA's clinical governance and patient safety staff in their ongoing monitoring of the Trust's action plan implementation.

3. Methodology

Contact Consulting has undertaken a mixture of desk and fieldwork study to gather the information used to compile the report. We have had access to documents from both HPFT and NHS South Central. These documents have included:

- Internal investigation report – from the SHA
- Action plan – from HPFT
- Minutes and reports providing evidence of action plan implementation progress – from HPFT
- Minutes and agendas of Category Red Incident Review Group (CRIRG) – from HPFT
- Serious & Untoward incident records/ critical event reviews – from HPFT
- Patient safety/risk policies – from HPFT

We have carried out interviews and consultation with a targeted number of key stakeholders, these have included:

- Members of the critical incident internal review team
- Key staff involved in the case
- Medical Director at HPFT
- Chief Operating Officer at HPFT
- Mother of the deceased

NHS South Central wrote to the families of both Patient B and Patient A on behalf of Contact Consulting. The letters outlined the process being undertaken and offered them the opportunity to comment or provide feedback.

Patient B's mother responded to our letter and we conducted an interview with her. Her comments and views have also been incorporated into the findings of the report.

We have not had contact with Patient A as part of this process.

A full list of those interviewed can be found at appendix one.

4. Summary of the case and actions by HPT

Patient A has a long standing schizophrenic illness and a history of offending behaviour. He first came into contact with mental health services aged 19 when a psychiatrist at HMP Reading YOI assessed him after assaulting a prison officer. A concise summary of the key points in his history is set out here to provide factual context for the findings from our interviews and our conclusions.

Patient A's history is lengthy and complex. His illness was characterised by a number of strongly held views and beliefs, which were often more extreme in content when he was unwell. They included homophobic delusions, hostility towards and delusions about Irish people and the Catholic Church and its members.

Patient A had a history of violent behaviour towards others, including convictions for Actual Bodily Harm when aged 21. He assaulted a fellow hostel resident when aged 23. It is also reported that he had attempted to strangle his mother and that he had threatened her with a knife in the past. In 1996 he cut his own earlobes with a razor. In 2000 another resident at his hostel stabbed Patient A.

Between 2000 and 2006, Patient A enjoyed a period of relative stability in respect of his mental health, engaging with local services and being compliant with Clozapine medication. Late in 2006 this stability began to break down when he became non-compliant with medication.

In July 2007 Patient A had threatened a local shopkeeper with a baseball bat, and had tattooed his neck with the word 'kill'. After threatening the shopkeeper, Patient A was subsequently detained under Section 2 of the Mental Health Act (MHA). This was later upgraded to Section 3 MHA.

In August 2007 Patient A made claims about killing local vagrants to the police when he was younger and threatened to kill members of the IRA when he left hospital. He was referred to the AOT in October 2007. Prior to discharge from hospital in January 2008 it was clearly stated that he became unwell when not compliant with medication. Patient A left hospital in February 2008 and was seen once by a Consultant Psychiatrist. In October 2008 he was transferred to the Waterlooville CMHT, due to his stable mental state at that time.

In January 2009 Patient A was reported to have been carrying a knife and expressing thoughts about harming Irish people and Catholics. It is alleged that he broke the windows of an Irish woman's home in his block of flats. On the same day he assaulted the caretaker of a local school and was arrested. He was subsequently placed on Section 3 MHA at the local Psychiatric Intensive Care Unit.

In March 2009, Patient A was seen by a Forensic Psychiatrist, Dr. D who referenced issues of dangerousness, requested further information and recommended transfer to Southfield House, the local low secure unit at Tatchbury Mount in Southampton.

Dr. D made this recommendation, in part, on the basis of his concerns about the levels of risk DC presented to the public. On 3rd April 2009 a multi-disciplinary team meeting stated that there was "currently no need perceived need for Southfield" and at the patient review meeting the chronology on the CIR shows that the "Consultant not in favour of transfer to Southfield".

Patient A moved from the PICU to an open male ward in May 2009. His community care was transferred back to the AOT. In the middle of June a multi-disciplinary meeting was held to begin discharge planning, although his care co-ordinator was on leave so this process was delayed.

On 26 June Patient A was discharged from hospital on a Community Treatment Order (CTO). He was then seen in the community by his interim care co-ordinator (his usual care co-ordinator was on long term sick leave) on 1st July. He was reported to be stable and amenable, although the thoughts about the IRA persisted, he denied ideas of violence.

Patient B, a patient of the AOT was found dead in his flat on 3rd July 2009. He had been fatally stabbed in the neck.

Patient A was last seen by the AOT on 6th July, three days after Patient B's death and two days before Patient A's eventual arrest. Patient A was arrested on suspicion of murder on 10th July.

Following notification of the offence on 3rd July an initial management review was conducted. On receipt of this report it was decided to move immediately to an independently chaired internal review process.

The panel comprised two independent members and two members from within HPFT both the internal members worked in different localities to the one in which the offence took place. The panel members were:

- Review Panel Member A — Chair
- Review Panel Member B — Critical Incident Review Lead
- Review Panel Member C — Medical advisor
- Review Panel Member D — Consultant Nurse/Nursing Advisor

The panel conducted their review between 20 August 2009 and 8th October 2009. The panel meetings were supplemented by regular email and telephone liaison and consultation between panel members. The formal panel meetings took place on the following dates:

- 20th August 2009
- 4th September 2009
- 7th September 2009
- 10th September 2009
- 11th September 2009
- 29th September 2009
- 6th October 2009
- 9th October 2009 (report submitted)

The process commenced two weeks after the incident occurred. Root Cause Analysis (RCA) was used as the main methodology. RCA investigations are a well recognised way of conducting this type of process as they offer a framework for reviewing patient safety incidents (and claims and complaints). Investigations can identify what, how, and why patient safety incidents have happened. Analysis can then be used to identify areas for change, develop recommendations and look for new solutions.[1]

The investigation involved the review of a wide range of documents including:

- Case notes
- HPFT policies and guidance
- Training records of staff involved
- National guidance on risk management
- Patient A's police offending record

Interviews were also held with key staff involved in Patient A's care, including members of the Assertive Outreach Team and locality management.

NHS Hampshire Primary Care Trust is responsible for commissioning local mental health services. They were made aware of the incident through reporting on the Strategic Executive Information System (STEIS). It does not appear from our review that the PCT were engaged in the internal investigation.

All members of the panel contributed to the writing of the final report. Although Review Panel member B took a leading role in the development of the text and co-ordinated comments and views from the panel as a whole, the Chair of the panel had final sign-off of the report.

The investigation report concluded that there were a number of significant service delivery problems that contributed to the incident. In particular it highlighted three key areas for concern:

- The failure to understand the need for and the development of a comprehensive risk assessment for Patient A and a resulting failure to appreciate and manage the level of risk he posed when discharged.

- A lack of clarity regarding roles and responsibilities between the clinicians involved in Patient A's care.

- A failure to communicate between teams and individuals as well as with the police

The investigation report made a number of recommendations. These were set out through the body of the report and then summarised again at the end of the report. The recommendations all linked specifically to individual items within the Terms of Reference.

[1] National Patient Safety Agency – Patient Safety Resources http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

Following the publication of the investigation report HPFT developed an action plan to respond to and implement the recommendations. The action plan has been monitored through the Category Red Incident Review Group (CRIRG). This group is part of HPFT's wider clinical governance structures. The Medical Director has assumed lead responsibility for the implementation of the action, which he has updated regularly to reflect the progress made thus far.

5. Findings from the stakeholder interviews and document review

The previous section has set out the detail of the case and the actions taken by HPFT in response to the incident. The findings from the stakeholder interviews and the results of the desk based document study have been reviewed. A number of issues and themes have emerged during the process and can be summarised as follows:

- There was a lack of information available about the facts relating the events of 2nd July. The panel did not have access to police information regarding the details of the incident. The police investigation was still underway when the panel met and wrote their report. At the time of writing, Patient A was still at Broadmoor Hospital with a potential hearing to determine his fitness to plead in the week commencing 5th July 2010. (See addendum for update)

- Members of the panel did not feel that the judicial process had impeded their work.

- HPFT responded swiftly to the incident by conducting an initial management review. The decision to move immediately to an independently chaired internal review of the case was appropriate in the circumstances.

- The Chief Executive of HPFT drew up the Terms of Reference. The panel had an opportunity to review and comment upon them prior to them being finalised. The panel made a number of suggested amendments before the Terms of Reference were signed-off.

- The composition of the panel, with two external members and two from other parts of HPFT represented a sensible approach that ensured independence and a robust approach. Furthermore, the clinical membership of the panel was significant, including as it did, a Medical Director from another NHS Trust and a Consultant who has particular expertise in critical incident review.

- The Chair was present for every interview, but due to the tight timescale for the review, not all members of the panel were able to be present for all the interviews.

- The review process was robust, thorough and conducted in a professional manner. The appropriate professionals were interviewed and a wide range of documentation was reviewed.

- The timescale presented some logistical challenges for the panel. The panel did not meet until 45 days after the incident, and under the timescales at the time, then 90 days, had only a further 45 days to complete the review. This would have been tight enough, but was exacerbated by the summer holiday period.

- Root Cause Analysis was the expected model for the review and was adopted by the panel. One member of the panel felt that RCA does not fit easily with

the reporting formats used by HPT. Nevertheless, RCA is clearly visible as the approach used.

- One person did not write the report; rather each member of the panel took a lead for a particular section. Review Panel Member B did take on the role of co-ordinating this process and drew together all the contributions to produce drafts of the report. Some of this work was done via email exchange as well as in panel meetings. There was a positive sense of a collaborative approach.

- Panel members reported that they had felt supported by HPFT throughout the process and that there had been no interference in their work.

- Particular attention was paid by the panel to engaging with the family and carers of both Patient B and Patient A.

- The degree to which members of staff had been briefed prior to their attendance before the panel is unclear. Some reported not knowing what to expect and being unclear about the process.

- The is no evidence to indicate that the Primary Care Trust, or its representatives, either from the commissioning team or the clinical governance team were directly engaged in the review process. At the time of writing we understand that PCT representatives will be meeting HPFT to discuss the case, it is not clear what role, if any the PCT intends to take in the monitoring of the action plan implementation process.

- There exists a degree of defensiveness among the AOT staff about their work with Patient A. Respondents told us that they felt that the panel had at times been very challenging of their practice, especially in relation to risk management, but felt this was not a valid challenge. They also pointed to what they regarded as factual errors in the early drafts of the report. The core sentiment that appears to persist is that they could not and would not have done anything differently.

- Our interviews with AOT staff would support the view of the panel that there had not been a thorough or ongoing discussion about risk in relation to Patient A. Indeed, there had been an over reliance on one court report written by a psychiatrist some time ago. Additionally, the retention of knowledge about Patient A by one member of the AOT team and this knowledge not being widely shared or discussed was a key factor in the inadequate response to risk identified by the panel.

- The AOT was a particularly stable team, with a very low rate of staff turnover. This was presented to us a positive position, which had helped them to be especially familiar with their clients. The panel contends that in fact this familiarity meant that there was a lack of clinical challenge within the team. One respondent suggested that there was *a cosy relationship between team and clients*.

- We concur with the panel's view that key clinical risk information provided by the Consultant Psychiatrist Dr. D was not appropriately taken into account during the decision making processes relating to Patient A and his discharge.

- Dr. D's concerns about levels of risk and the potential benefits of a move to Southfield Low Secure Unit were not appropriately considered or acted upon.

- We heard the view from some respondents that report is well written but hard to navigate, with recommendations throughout the text as well as at the end.

- There are a large number of recommendations in the report. A number of respondents felt that it might have been possible to reduce the overall number and that this might have made action planning easier.

- HPFT has produced a robust action plan, supported by senior clinical leadership for its' implementation. The recommendations from the report have been grouped to allow HPFT to conduct their planning and implementation more effectively and swiftly. There are 36 separate items for action included in the plan.

- There is evidence of work underway and in some cases completed in relation to the action plan.

- The action plan contains a helpful additional column for the provision of update information, outlining the progress that has been made in implementing each recommendation.

- Further work is needed to address the cultural issues in relation to risk assessment, management and practice within the AOT.

- HPFT have taken the decision, based on legal advice not to release the report to the victim's mother, Person N. This is due to the ongoing criminal investigation and judicial process. We were therefore unable to ask questions that were specifically about the content of the report, or anything detailed about process. However, we did hear from Person N that she had met with two HPFT staff in February 2010 who gave her some verbal feedback on the reports recommendations. Person N still maintains that information sharing in this case has not been adequate or timely and feels she should be able to see the full review report. Once the judicial proceedings are concluded, HPFT will provide Person N with a redacted copy of the full CIR report. (See addendum for update)

6. Key messages and conclusions

From the review of the information gathered from the stakeholder interviews and review of documentation a number of conclusions may be drawn in relation to the specific assurances required by the SHA.

The independently chaired internal investigation was carried out using a robust and recognised methodology. Root Cause Analysis formed the basis for the approach. This is approach is favoured in such investigations and as such we conclude that the process conforms to best practice.

The report appropriately highlighted a number of root causes for HPT to consider, these included:

- Adequacy of risk assessment and risk recording
- The status of the Trust risk policy, it's implementation and adherence to by clinical staff
- Decision making in relation to forensic services assessment and referral
- Training issues
- Reliance on one clinical opinion
- Engagement with other agencies, in particular the police
- The culture of the AOT and a lack of clinical leadership

It is our view that the recommendations of the review are robust and sound. There are a large number of recommendations and it might have been helpful to consider whether they could have been grouped under key headings, or indeed reduced in number. It is our view that recommendations must be deliverable with specific outcomes.

There is evidence of the lessons learned being implemented. Examples of this include:

- The revision and roll out of a Trust wide risk policy (CP92) supported by a clear communication plan to support implementation.

- Training review and identification of staff who have undertaken mandatory risk training within the last three years

- Monitoring and audit processes in place for ensuring that staff have undertaken training

- Ongoing work to refine the roles of Consultant Psychiatrists in relation to mental state examinations and risk assessment for patients considered to be dangerous.

- Roll out of a single records system (RiO)

- Steps taken to improve engagement and communication with local police

The timescales involved in the internal investigation were challenging, but achievable. However, the Trust may wish to consider how it can engage panel members swiftly and enable them to meet as soon as possible after the incident to enable them to meet the deadlines set nationally and locally.

The report, whilst thorough and robust, is not the easiest document to navigate, with recommendations spread throughout the text. HPFT and the SHA may want to consider whether the development of a template for such reports would be useful. Such a template could assist panel members in the development of their reports and order their thinking, as well as providing some consistency of approach in report writing and structure.

The original report and our review have both identified concerns about the inadequacies of risk assessment and consideration of dangerousness within the AOT. The response of some AOT respondents in our review, that they would do nothing different is of concern. It would indicate that there is still a good deal of work to do to embed the learning from this incident at a local level, beyond the implementation of policies and procedures. It is clear that there remain fundamental cultural issues in relation to management, custom and practice within the AOT that must be addressed.

Following discussions with the SHA and HPFT during our review, it is our recommendation that further work should be undertaken to assist HPFT to identify in more detail the cultural and managerial changes that are required within the AOT in relation to risk assessment and management as well as broader managerial and practice matters. This could take the form of a brief review of current management, custom and practice within the AOT, specifying the potential changes needed to improve management and practice, and to provide focused support to implement those changes including direct work with AOT staff.

We also recommend that the SHA and HPFT liaise with the PCT to consider how best it can engage more fully in the monitoring of the action plan implementation process, and what role it could or should take in any potential future case reviews.

To summarise, having reviewed the process and findings of the internal investigation it is our conclusion that it was conducted thoroughly and based on a robust and recognised methodology.

The conclusions reached by the panel are, in our judgment, correct and were based on sound evidence. It is our view that the recommendations made in the report are sound. There is demonstrable evidence of the lessons learned being addressed and of the action plan being implemented, although there is more to do, as outlined above, in relation to embedding best practice locally within the AOT.

Incidents such as those involving Patient A are rare. When they do happen it is imperative that lessons are learned that can minimise the chances of them happening again.

Although this review has necessarily highlighted some areas for improvement and ongoing intervention, the independently chaired internal investigation process and HPFT's response thus far to its recommendations demonstrates that they have learning and improvement from such incidents firmly at the centre of their work.

APPENDIX ONE

List of those interviewed

Name	Title	Organisation
Review Panel Member A	Independent Chair of the review panel	
Person H	AOT Team Manager	HPFT
Person K	Area Manager	HPFT
Review Panel Member C	Medical Advisor to panel	OBMH NHS Trust
Person N	Mother of deceased	
Person F	AOT – CPN	HPFT
Person B	AOT – OT	HPFT
Person I	AOT – CPN	HPFT
Dr. Huw Stone	Medical Director	HPFT
Review Panel Member B	Consultant Psychiatrist & CIR Lead	HPFT

List of those consulted

Jane Elderfield	Chief Operating Officer	HPFT
Julie Kerry	Associate Director – Mental Health	NHS South Central
Pat Shirley	Director of Nursing (now retired)	HPFT

Others mentioned

Dr D	Forensic Psychiatrist	HPFT

The designations for those interviewed or mentioned correspond directly to the anonymised version of the CIR Report reviewed.

Addendum

Update on current position

The final version of this report was completed at the end of July 2010. Following a meeting between the author, the SHA and HPFT in late August it was agreed that this short addendum would be added to the report, with the aim of providing the most up to date summary of the case and actions taken by HPFT.

Action planning

HPFT has continued to implement the action plan it developed following the CIR. The action plan was most recently updated in June 2010; this is done prior to every HPFT Assurance Committee Meeting. A copy of the June action plan is appended to the hard copy of this report.

In particular, HPFT has commissioned a specialist in risk assessment and risk management to work with practitioners. Some of this work will focus on the importance of effective transition between services.

Consideration is being given to how best to address the developmental needs and cultural changes highlighted in the CIR and in this report.

HPFT has held meetings with representatives of the Hampshire Constabulary to identify ways in which ongoing liaison and response to serious incidents can be improved.

Judicial process

In respect of the judicial process, Patient A was assessed and found to be unfit to plead. In light of this a 'trial of the facts' was held in July 2010. This attracted some local media interest. Patient A remains in Broadmoor Hospital under Section 37/41of the Mental Health Act. Should he be assessed to be well enough in future his defence may enter a fresh plea and a full trial may take place. It is impossible to know when or if this might happen.

Inquest

HPFT have met with the Coroner and Assistant Chief Constable of Hampshire Constabulary. The Coroner has seen the CIR and has requested transcripts from the 'trial of the facts'. The Coroner will then make a decision about whether or not to hold an inquest.

Liaison with Person N

HPFT have now shared the original CIR report with the Person N. The report was appropriately anonymised. It is reported that Person N found it a helpful process and welcomed the opportunity to read the report in full. It has been agreed that once this report has been presented to the HPFT and SHA Boards, this anonymised version will also be made available for Person N to read.

Final Summary Report on the Serious Incident No 2009/6255

Introduction

This report is intended to summarise the interventions and actions arising from the Serious Incident that occurred in July 2009.

Summary of Incident

On 3 July 2009, Patient B was found dead at his home by staff from the local care services. He had been stabbed in the neck. Five days later Patient A was arrested by police and on 10 July 2009 was charged with the murder of Patient B. In July 2010 Patient A was found Unfit to Plead and following a Trial of the Facts when he was found to have committed the act, he was admitted to Broadmoor High Secure Hospital under Section 37/41 of the Mental Health Act 1983.

Both Patient A and Patient B had received services from the local Assertive Outreach Team. Patient A had suffered from Paranoid Schizophrenia and had a long offending history. He had been admitted to the local Inpatient Unit under Section 3 of the Mental Health Act 1983 in January 2009, following an incident when he had allegedly threatened a School Caretaker and set fire to a waste bin at the school. Early on in that admission, Patient A had been aggressive and had shown evidence of Paranoia and Delusions throughout his admission. Patient A had been discharged from the Inpatient Unit on 26 June 2009 on a Community Treatment Order.

Process of Investigation by Hampshire Partnership NHS Foundation Trust (HPFT)

An Initial Management Review (IMR) was carried out within 24 hours of the notification of Patient B's death. It was decided that the usual internal Critical Incident Review should include independent members. A panel consisting of four members was set up which included an independent Chair, a Consultant Psychiatrist from HPFT who was the Critical Incident Review Lead, an independent Medical Advisor from another Mental Health Trust and a Consultant Nurse from within HPFT to act as Nursing Advisor for the panel. Terms of Reference were agreed by the Chief Executive in consultation with other senior staff. The review was carried out between 20 August and 8 October 2009. The final report was received by the Trust on 10 November 2009. This report included 36 separate recommendations. An Action Plan to address these recommendations was drawn up by the Medical Director and Chief Operating Officer in December 2009 and agreed by the Trust Clinical Governance and Risk Committee on 13 January 2010.

Summary of Terms of Reference

The following were the objectives given to the review panel.

1) To inform the Trust of any immediate issues or concerns as identified as part of the CIR and of any issues that emerge that require immediate action in advance of the final report.

2) Review the sequence of events and actions to provide a timeline from July 2007 to the date of the incident

3) Determine the Root Cause of the incident and identify the issues highlighted by the review of Patient A's treatment and care

4) Review a number of specific Treatment and Care issues including decision making, liaison and handover arrangements between the Inpatient Teams and Assertive Outreach Team, the request for a Forensic Psychiatry Assessment and the response to that assessment, the process for setting up the Community Treatment Order, compliance with a number of relevant Trust policies, liaison with police including Multi-Agency Public Protection Arrangements (MAPPA) and discharge planning for Patient A.

South Central SHA Review of Incident

An independent review of the internal investigation into the homicide committed by Patient A was commissioned by South Central SHA. The key aims of the review were:

- To provide assurance that a sound Root Cause Analysis process was followed by the organisation
- That the correct root causes had been identified
- That robust recommendations had been identified when reviewing the care and treatment of Patient A
- That areas of treatment and practice that could have been improved had been identified
- That there is evidence of organisational learning from the incident

This review did not specifically require an examination of the clinical care and treatment of Patient A. All relevant documentation was reviewed and interviews with key members of staff both from the local services and senior managerial staff were carried out. The mother of Patient B was also interviewed.

Summary of Findings of Critical Incident Review

The report of the Critical Incident Review identified that the Root Cause of the incident was Patient A's mental illness and resulting delusional beliefs. A number of significant contributory factors were also identified which could be summarised under the following three areas:

- A failure to understand the need for and the development of a comprehensive Risk Assessment for Patient A and a resulting failure to appreciate and manage the level of risk he posed when discharged
- A lack of clarity regarding roles and responsibilities between the Clinicians involved in Patient A's care
- A failure to communicate between teams and individuals as well as with the police

The report also made 36 recommendations which covered three areas listed above.

Findings from the Independent Review Commissioned by South Central SHA

The review found that the independently chaired internal Critical Incident Review had been carried out using a robust and recognised methodology. Root Cause Analysis had formed the basis for the review and the independent review concluded that the process used had conformed to Best Practice. The review highlighted a number of root causes. It also concluded that the recommendations of the review were robust and sound and suggested that it might have been helpful to group these under key headings.

The review identified evidence of lessons being learned and implemented as a result of the Critical Incident Review. However, there was also a recommendation that further work should be undertaken with HPFT to review the Assertive Outreach Team's practice in relation to Risk Assessment and Risk Management and other practice issues. It was suggested that this should include direct work with the Assertive Outreach Team. It was also recommended that the SHA and HPFT liaise with the Primary Care Trust (PCT) to consider how best to engage it more fully in the monitoring of the Action Plan implementation process.

The independent review concluded that the panel's conclusions and recommendations were correct and based on sound evidence. There was evidence of lessons being learned and of the Action Plan being implemented though there was further work to be undertaken with the Assertive Outreach Team specifically.

Themes from the Critical Incident Review

As noted, the Critical Incident Review highlighted three particular areas of practice in their report. On reviewing the report and the recommendations it was felt that these could be grouped under four main headings with a number of sub-headings; these were:

1) Risk Assessment

- Policy
- Practice
- Training

2) Clarity of Roles

3) Communication

- Record Keeping
- Transition
- Liaison with Police

4) Response to the Forensic Psychiatry Report

Summary of Themes from the Independent Review Report

The Independent Review Report highlighted a number of root causes:

- Adequacy of Risk Assessment and risk recording
- The status of the Trust Risk Policy, its implementation and adherence by Clinical staff
- Decision making in relation to Forensic services at Assessment and Referral
- Training issues

- Reliance on one Clinical opinion
- Engagement with other agencies, in particular the police
- The culture of the Assertive Outreach Team and the lack of Clincal Leadership

Actions Resulting from Both Review Reports

As noted above, the Action Plan was developed using the headings and sub-headings listed above.

Recommendation Theme	Action Undertaken	Outstanding Actions
Risk Assessment		
Policy	HPFT Risk Assessment and Management Policy completely re-written and single Risk Assessment Screening Tool from RiO Electronic Patient Record agreed.	None
Practice	Risk Assessment and Management Policy launched in Clinical Directorates and single Risk Assessment Tool implemented as part of complete roll out of RiO Electronic Patient Record System	None
Training	Risk Assessment training confirmed to be mandatory and progress reviewed quarterly as part of Training Dashboard Risk Assessment training comprehensively reviewed and based on revised policy and supporting guidance notes Specific Risk Assessment training for Acute Care Pathway in Adult Mental Health Directorate undertaken in two of the four areas initially, including the area where the incident occurred. This training was delivered by a nationally recognised external provider.	None
Clarity of Roles		
	Specific Risk Assessment training for Acute Care Pathway in Adult Mental Health Directorate included work around definition of Team's function and each Team Member's role and responsibility in relation to Risk Assessment, Care Planning, communication and record keeping. Externally facilitated work undertaken with the Assertive Outreach Team in relation to role clarity and responsibilities.	The specific work with Assertive Outreach Team due to be completed in April 2011
Communication		
Record Keeping	A single record system in place following the full implementation of RiO Electronic Patient Record System in January 2011.	None
Transition	Admission, Transfer and Discharge policy reviewed by Adult Mental Health Directorate (AMH) to take account of specific recommendations. These were audited 6 months after the policy review and as a result, all staff were reminded of the changes to policy, which would be audited again in 6 months.	None

Recommendation Theme	Action Undertaken	Outstanding Actions
Liaison with Police	Recommendations concerning police involvement in the discharge of patients who they were involved with prior to admission, now included in revised Memorandum of Understanding between Hampshire Constabulary and HPFT.	None
	HPFT Protocol, responding to criminal behaviour in Mental Health Services reviewed to include thresholds for reporting incidents of violence to the police. Review will also include reference to information sharing between the Police and HPFT. New policy, Procedure for the Pursuance of Sanctions Following Alleged Criminal Activity.	None
	Revised Information Sharing Protocol Approved by Criminal Justice Forum in February 2011.	None
Response to the Forensic Psychiatry Report		
	Protocol for obtaining second opinions reviewed to include the need that the Senior Clinician requesting the report should be responsible for ensuring that it is actioned.	None

Monitoring of Action Plan

The detailed Action Plan was agreed by the Clincal Governance and Risk Committee on 13 January 2010. It was updated on 22 April 2010, 17 June 2010, 26 August 2010 and 26 January 2011. Each updated version of the Action Plan was subsequently reviewed by the Assurance Committee on behalf of the Trust Board.

Summary

All but one of the actions arising from the 36 Recommendations in the internal CIR and from the independent SHA review of the CIR have been completed. The one outstanding action is due to be completed by the end of April 2011 and this will be monitored by the Patient Safety Group of HPFT.

Huw Stone
Medical Director
23 February 2011