

An independent investigation of the care and
treatment of a person using the services of
5 Boroughs Partnership NHS Trust

Undertaken by Consequence UK Ltd
Ref 2006 3391

March 2012

This is the report of an independent investigation commissioned by North West SHA (NHS North West) to conform with the statutory requirement outlined in the Department of Health (DH) guidance "*Independent investigation of adverse events in mental health services*", issued in June 2005. The guidance replaces paragraphs 33-36 in HSG (94)27 (LASSL (94)4), concerning the conduct of independent inquiries into mental health services.

The requirement is for an independent investigation of the care and services offered to mental health service users involved in adverse events, defined as including the commission of homicide, where there has been contact with specialist mental health services in the six months prior to the event.

The Independent Investigation Team members were:

- Maria Dineen, Director of Consequence UK Ltd
- Mr Justin O'Brien Head of Patient Safety, South West London and St George's Mental Health Trust.

Acknowledgements

The Independent Team wishes to thank Mr SU (the mental health service user whose care and treatment is the subject of this report) for meeting with it and sharing the circumstances of the incident that occurred and the antecedents to it.

CONTENTS

Section	Title	Page
	Executive Summary	4
1.0	Introduction	10
2.0	Chronology	12
3.0	The independent assessment of the then 5 Boroughs Partnership NHS Trust's internal investigation	22
	3.1 The findings of the Trust's report	22
	3.2 Positive Practice identified	25
	3.3 The conclusion	26
	3.4 Recommendations made by the then 5 Boroughs Partnership NHS Trust	27
4.0	Conclusions of the Independent Team	35
5.0	Recommendations of the Independent Team	36

EXECUTIVE SUMMARY

Incident overview

On 7 June 2006, while under the influence of alcohol, Mr SU (aged 39) and a friend became involved in an altercation with a third male at his home. A consequence of the altercation was the death of this individual. Mr SU received a life sentence as a consequence of his actions.

On 19 January 2011, at the HMP in which Mr SU was serving his sentence, Mr SU told an Associate Director of North West Strategic Health Authority and the Director of Consequence UK Ltd (CUK) that he did not believe he would have acted as he did had it not been for his alcohol misuse.

Purpose of the investigation

Prior to the incident that occurred, it had been determined that Mr SU was not suffering from any severe and enduring mental illness. The conviction of Mr SU and his disposal at court with a custodial sentence also confirms that there was no mental health component to the incident that occurred. This means that it is arguable that this case does not fall within the boundaries of HSG (94)27, or the intent of this guidance. However, because it had come to the attention of NHS North West as a legacy case, a decision was made to commission an independent retrospective analysis of the clinical records held by the then 5 Boroughs Partnership NHS Trust, to provide an assurance regarding the appropriateness of Mr SU's care and treatment. The purpose of the retrospective analysis was also to independently confirm to NHS North West the predictability and/or preventability of the incident, based on information the then 5 Boroughs Partnership NHS Trust knew, or reasonably should have known, at the time.

Conclusion of the Independent Team

As a result of our analysis of Mr SU's mental health records, his GP records and the then 5 Boroughs Partnership NHS Trust's internal investigation report, the Independent Team's conclusions are that:

- The incident in which Mr SU was involved was not preventable by different clinical care and treatment.
- The life-style of Mr SU meant that he was vulnerable to being involved in a serious incident as a consequence of this, and had been so in the past. However, it was not within the power of the then 5 Boroughs Partnership NHS Trust to control these aspects of Mr SU's life. Mr SU did not take advantage of the opportunities offered to him to address his addictions. This was his right and his choice.
- Overall, the care and treatment of Mr SU was reasonable.
 - He was offered the support of substance misuse services, which he chose not to accept.
 - He was provided with a hospital-based detoxification.
 - He was seen by the alcohol liaison nurse on more than one occasion.

- At least one doctor tried to explore with him how he (Mr SU) could exit the chaos in which he was living, and how mental health services could help him.
 - Mr SU was provided with appropriate anti-depressant therapy and enabled to remain an in-patient to allow time for him to arrange accommodation when he was homeless.
- Although there were aspects of documentation that could and should have been better, the Independent Team did not identify any factor that could have been so improved as to make a difference to what happened on 7 June 2006.

The only specific factor that the Independent Team considers should and could have been better in terms of Mr SU's care management was the care planning for him in 2006 in relation to his addiction. Furthermore, there should have been a clear effort to demonstrate the provision of information to his then partner and brother about the support available to them in the local community to assist them in coming to terms with Mr SU's addiction. This was not evident.

Finally, although the Independent Team concludes that there is no justification for pursuing further independent investigation of Mr SU's care and treatment, and it agrees with the main findings of the Trust's own internal investigation report, it is the opinion of the Independent Team that the Trust's report did not indicate an investigation process in line with the National Patient Safety Agency's model of incident investigation, implemented in 2003. A 5 Boroughs Partnership Foundation NHS Trust investigation report formulated in 2011 demonstrated to the Independent Investigation Team that the Trust now has an investigation approach and report template that shows a much improved level compliance with the National Patient Agency's standards.

Recommendations

The Independent Team has six recommendations for 5 Boroughs Partnership Foundation NHS Trust.

Recommendation 1

Where service users with substance misuse problems are engaged for assessment and/or treatment delivery by general adult services, rather than specialist dual diagnosis services, it is important that a thorough exploration of the service user's substance misuse is undertaken. The Independent Team recognises that this can be challenging and some service users will not want to divulge this honestly.

The clinical records of such a service user should clearly show the exploration of substance misuse. The following headings are a suggestion of the key questions that may support the effective recording of a clinician's exploration of this issue:

- How does the service user feel about his/her substance misuse? (Does he/she accept there is a problem, for example?)

- ❑ How has the service user's substance misuse affected him/her (continue to affect him/her)? (For example, getting into fights, loss of job, loss of home, loss of relationships, loss of self-esteem, feels angry, sad, etc.)
- ❑ What, if anything, does the service user want to do about his/her substance misuse?
- ❑ What help/support does the service user feel that he/she needs to address his/her substance misuse?

In cases where a service user expresses a wish to address the substance misuse problem, the clinical record should also set out:

- ❑ What information has been provided to the service user about statutory addictions services, voluntary addictions services and self-help groups in his/her local community.
- ❑ Whether or not the service user has been supported in referring him or herself to the local substance misuse service.
- ❑ Whether or not a referral to the Dual Diagnosis Service is appropriate; and, if yes, whether such a referral has been actioned.
- ❑ What the ongoing care plan for the service user is in relation to his/her substance misuse, and how it is to be reviewed.

In cases where the service user does not wish to discuss his/her substance misuse problem, or accept any help or support in relation to this, a clear record should be made to this effect.

The Independent Team recommends that review of the clinical records and care plans of service users with addictions is given specific attention via the team managers' regular records audit activity and also via periodic specifically targeted retrospective audit activity. For example, this could be managed via a peer review audit process facilitated by staff trained in dual diagnosis, or specialist addictions staff.

Recommendation 2

This recommendation has been separated into two distinct components.

Part 1

To deliver Recommendation 1, 5 Boroughs Partnership Foundation NHS Trust must ensure that its staff working in general adult mental health services are informed about and understand:

- ❑ addictive behaviour;
- ❑ what compels a service user to remain active in his/her addiction;
- ❑ what factors can motivate a substance misuser, including alcohol misuse, to change; and
- ❑ the range of statutory, voluntary and self-help opportunities available to support service users who wish to address their addiction, including those organisations that provide support in achieving complete abstinence from it, where this is the goal of the service user.

It is the experience of the Independent Team, as a consequence of undertaking HSG (94)27 investigations, that the knowledge and understanding of mental health staff (not working in specialist addiction services) can be variable in relation to substance misuse and addictive behaviour.

In the first instance, the Trust may wish to conduct a knowledge-based assessment using a simple web-based questionnaire tool such as Survey Monkey. The Independent Team suggests that the question content could be formulated with the input of statutory addictions services, voluntary addictions services, and with the input of service users with addictions who have either achieved a good level of control or have achieved abstinence. As an 'expert patient group', addicts should be engaged in the formulation of a meaningful survey tool whose purpose is to test knowledge and understanding of front-line staff.

Part 2

If 5 Boroughs Partnership Foundation NHS Trust finds, as a consequence of its assessment, that the skills and knowledge of staff around addictions management is not as robust as it would like, and an education programme is considered as a solution to this, 5 Boroughs Partnership Foundation NHS Trust may wish to liaise with neighbouring Mersey Care Trust, whose Dual Diagnosis Service currently delivers three awareness-raising training events a year for Mersey Care staff. In addition to drawing on its in-house expertise, the training events offered draw on the wide range of expertise available in its local communities, including:

- established charities working in substance misuse;
- established self-help organisations such as Narcotics Anonymous and Alcoholics Anonymous; and
- established carer organisations and self-help groups.

If not already established, 5 Boroughs Partnership Foundation NHS Trust may wish to offer a similar education opportunity in its organisation.

Recommendation 3

Where it is known to mental health and primary care services that a service user has a substance misuse problem and there are closely involved carers/relatives, primary care and mental health services must provide those individuals with information about where they can source support for themselves.

Information should at least be available on the following obvious contenders:

- Addaction
- Action on Addiction
- Families Anonymous – for families of drug addicts (including alcohol)
- Al-Anon – for families and friends of those with an alcohol problem.

An internet search supplemented by telephone contact should reveal the range of charities and self-help groups in the North West who provide support for families.

An optimal approach would be to develop a self-help information leaflet or booklet for families/carers, or an information pack containing key pieces of already-published literature that may be useful to the family/carer.

Recommendation 4

The Trust's own recommendation about the clear documentation of staff in attendance at ward rounds needs to be revisited so that 5 Boroughs Partnership Foundation NHS Trust can show that the identified absence of necessary documentation has been successfully addressed.

The Independent Team suggests that the periodic assessment of the clear identification of Trust staff, and multi-agency representatives present at ward rounds and CM/HT team meetings, is incorporated into its standardised documentation audit processes.

Recommendation 5

The Trust's own investigation made a recommendation about the clear documentation of the physical examination undertaken of a service user at assessments. The Trust needs to provide assurance on the reliability with which the medical physical examination is now recorded in the service user's clinical records.

Recommendation 6

Although 5 Boroughs Partnership Foundation Trust has improved its approach to the conduct of serious untoward incidents, and the structure its investigation report template the Trust needs to continue on its improvement path so that:

- The terms of reference used for each investigation is appropriately targeted to the needs of the investigation. A generic term of reference does not achieve this.
- Staff tasked with leading serious untoward incidents understand the importance of attending to the detail of:
 - the investigation tools and techniques appropriate for the investigation in hand;
 - usage of systems/human factors frameworks and how they can be applied;
 - undertaking the systems/contributory factors analysis on a problem by problem basis, where significant lapses in care or treatment have been identified;
 - Stating plainly where care and treatment met the expected local and/or national standards
- Trust investigators understand that for some incidents such as suicide and homicide, the purpose of the investigation is not to identify the 'root

causes' of 'the incident', but to identify the 'root causes' of any significant/material lapse in the care and treatment afforded the service user. Once this has been determined Trust investigators can then consider the question of causality. (I.e. but for the lapses in care and treatment would the incident still have occurred?)

- ❑ All recommendations are formulated so that they meet S.M.A.R.T criteria.
- ❑ Investigation reports that clearly set out:
 - an executive summary;
 - why an investigation was commissioned and its purpose;
 - terms of reference;
 - investigation limitations;
 - findings in relation to i) where standards were met, ii) significant lapses in standards and the contributory factors to these lapses, iii) root causes (most significant contributory factors) to any significant lapses in care and treatment;
 - service user and family/carer involvement;
 - conclusions;
 - recommendations; and
 - relevant appendices.

1.0 INTRODUCTION

Consequence UK Ltd (CUK) was commissioned by NHS North West Strategic Health Authority to undertake an independent review of the care and treatment of Mr SU in line with the requirements of HSG (94)27.

On 7 June 2006, while under the influence of alcohol, Mr SU (aged 39) and a friend became involved in an altercation with a third male at his home. A consequence of the altercation was the death of this individual. On 19 January 2011, at the HMP in which Mr SU was serving his sentence, he told an Associate Director of North West Strategic Health Authority and the Director of Consequence UK Ltd (CUK) that he did not believe he would have acted as he did had it not been for his alcohol misuse. Mr SU also revealed that most of the difficulties he had encountered, including previous custodial sentences, had occurred as a consequence of alcohol.

Mr SU received a life sentence as a consequence of his actions.

Because there was no evidence that Mr SU suffered from a treatable mental health disorder, and because there is no evidence that the incident that occurred was influenced by the presence of a treatable mental health disorder, the then NHS North West Strategic Health Authority and Consequence UK Ltd agreed that the most proportionate approach to the independent and retrospective analysis of Mr SU's care and treatment was to:

- conduct an initial assessment of Mr SU's clinical records in the antecedent period leading to the incident to determine whether his care and treatment met the required national and local standards; and
- conduct an analysis of the Trust's own internal investigation report to determine its reasonableness and completeness.

It was considered that the outcome of these activities would determine the need, or not, for further independent investigation into Mr SU's care and treatment.

NHS North West Strategic Health Authority and Consequence UK agreed that this approach:

- was in keeping with the requirements of HSG (94)27;
- was proportionate to the circumstances of the incident; and
- represented reasonable usage of public monies.

An initial advisory report was delivered to North West Strategic Health Authority in August 2011. The time delay between meeting Mr SU in January 2011 and the delivery of the advisory report was because Consequence UK had been commissioned by NHS North West to review a number of legacy cases on its behalf. These cases were prioritised on the basis of the severity of the incidents that occurred.

Following its assessment of the advisory report, NHS North West Strategic Health Authority initially considered that publication of the report was not

necessary. However, in February 2012, it decided that, for completeness and in the interests of openness, publication of the findings and recommendations of the independent analysis of Mr SU's care and treatment and the internal investigation conducted by the then 5 Boroughs Partnership NHS Trust was necessary.

This report therefore sets out:

- The chronology of Mr SU's contacts with mental health services with commentary by the Independent Team where appropriate.
- The Independent Team's analysis of the then 5 Boroughs Partnership NHS Trust's own investigation, including its conclusions and recommendations.
- The conclusions and recommendations of the Independent Team.

2.0 THE CHRONOLOGY

Set out below is a comprehensive record of Mr SU's contacts with the mental health service provided by the then 5 Boroughs Partnership NHS Trust, drawing where appropriate from Mr SU's GP records.

Where considered appropriate, the Independent Team has added reflective commentary about Mr SU's care and treatment. This is clearly marked throughout.

Date and time	Chronology
28/12/1986	Mr SU was admitted informally to Leigh Infirmary via A&E department after self-harm to his wrist. Also had suicidal thoughts. He was diagnosed with reactive depression. His assessment records also noted that Mr SU had been feeling low for the previous 6 months and that his sleep was poor. He was noted to have reported living alone because father would have nothing to do with him. He was also noted to have reported that the reasons why he cut his wrist were boredom and unhappiness.
2/1/1987	Mr SU was discharged from hospital. At this time he was not started on any medication and no follow-up was arranged for him.
There is no record of Mr SU having any contact with mental health or A&E services between January 1987 and July 1991.	
10/7/1991	Mr SU attended to see his GP. This was precipitated by the death of his grandmother the previous week. He was noted to report not sleeping as a consequence of this loss. Mr SU's GP prescribed Temazepam.
There is no record of Mr SU having any contact with mental health or A&E services between July 1991 and October 1999.	
26/10/1999	Mr SU was admitted to the local general hospital. His clinical records show that a car had hit Mr SU when he was on a motor-bike. He was unharmed, but he was kept in for over-night observation, but discharged the next day with no follow-up. The records noted that Mr SU smelt of alcohol on assessment, having reportedly consumed a small number of glasses of whisky.
October 1999 – January 2001	No contact with mental health services.

Date and time	Chronology
3/1/2001	<p>Mr SU was admitted to the mental health unit in the general hospital in Bolton. He had been referred from A&E following a self-inflicted stab wound to his chest using a potato knife.</p> <p>The clinical records noted that Mr SU stated that he needed help. The records show that he was tearful and distressed on admission. His father had died 18 months earlier and he was reportedly grieving over his death. Mr SU is also reported to have said that he had arguments with his girlfriend (of four months), who he reported as texting him telling him to kill himself. He also admitted to self-harm attempts over the last four years.</p>
3/1/2001 continued	<p>He also told staff he had been drinking from the age of 13 years and used cannabis each day. The clinical record shows that at approximately 30 hours into his admission it was observed he was experiencing delirium tremors and required chlordiazepoxide prescribed on a reducing regime along with thiamine and vitamin B.</p> <p>Independent Team's comment: This was appropriate treatment for Mr SU.</p>
9/1/2001	<p>The clinical record noted that, six days after his admission, Mr SU was discharged at his own request and against medical advice.</p> <p>The clinical record noted that Mr SU decided he wanted to return home with his girlfriend. At this time Mr SU's diagnosis was Alcohol Dependence, with emotionally unstable personality disorder. He was offered an outpatient appointment with the alcohol services and follow-up with a community mental health team. The medical discharge included the following information:</p> <ul style="list-style-type: none"> □ that Mr SU had been in his then relationship for 4 months; □ that Mr SU had divorced from his wife two and a half years previously, having been married for five years; and □ Mr SU had four children, two from his marriage and two from another relationship.
15/1/2001	<p>An appointment for the alcohol team was booked for Mr SU. The GP records note that Mr SU had an appointment for "<i>this Friday</i>". The GP records also mention the alcohol team during the week of 23 January 2001.</p>
26/1/2001	<p>A letter of invitation was sent to Mr SU by the substance misuse service. This letter was sent by the then consultant psychiatrist in addictions services, inviting Mr SU to make contact with the service to book an appointment. It was clearly stated in the letter that Mr SU needed to make contact with the service to arrange the appointment and that, if they did not hear from him within two weeks, it would then be assumed that he did not want this.</p>

Date and time	Chronology
<p>Independent Team's comment: The information contained in the letter to Mr SU from the addictions service was appropriate. For addictions services to be successful, there has to be a level of self-motivation in the service user to address their addiction. The first step in this process is that a service user is often expected to make his/her own appointment. With regards to the follow-up of Mr SU by the community mental health team, there was no record of what, if any, contact community mental health services made with Mr SU. Because of the ten-year gap between this care contact and the independent investigation process, coupled with the five-year gap between this care episode and the incident, the Independent Team determined that trying to gain an insight as to what happened with regards to the community mental health team was unlikely to be revealing. Furthermore, the Independent Team does not consider events of 2001 to have any connectivity to the events of 2006.</p>	
8/3/2001	<p>Mr SU was admitted to in-patient psychiatric services from the A&E department with ideas of suicide and alcoholic behaviour. The clinical records show that Mr SU reported consuming one bottle of spirits and that he had been involved in an argument with his girlfriend. The records also show that Mr SU reported threatening her and then nearly killing her. The records noted that the police brought Mr SU into the A&E department. It was also reported at this time that Mr SU had a prior history of domestic violence towards his "ex-wife" when drunk. The clinical record noted that, the day prior to this hospital attendance, Mr SU had been in court for criminal damage.</p>
15/3/2001	<p>Mr SU was discharged following his completion of a medical detoxification regime. The content of the clinical records suggests that staff considered that Mr SU manipulated admission to hospital and that he had a turbulent relationship with his girlfriend.</p>
19/3/2001	<p>Mr SU was seen at his GP surgery with his partner. The GP records noted that Mr SU was angry that he had been discharged from the in-patient psychiatric ward without his depression and anger problems being addressed. The GP record noted that Mr SU was offered 3 Librium tablets and that he had a psychiatric follow-up appointment the following day (20 March). It was also noted that Mr SU and his girlfriend felt he should be re-admitted to hospital. The records show that Mr SU's GP informed him that he (the GP) would fax a letter to the consultant psychiatrist in addictions service so that he was aware of the feelings of Mr SU and his girlfriend.</p>
<p>Independent Team's comment: There was no evidence in the mental health record or the GP record of Mr SU's partner or brother being advised, or provided with information about self-help groups in the community, where they could have become more informed about addictive behaviours and where they may have found the support they needed to assist them in dealing with the impact of Mr SU's addiction on their lives.</p>	

Date and time	Chronology
20/3/2001	<p>Mr SU was seen in outpatients by a consultant psychiatrist in substance misuse.</p> <p>The records of this appointment noted that Mr SU experienced withdrawal sweats and shakes when he stopped drinking. They also noted that Mr SU had been unemployed since 1989. The appointment record also revealed that a history of aggressive outbursts inter-related with alcohol was noted. The diagnosis Alcohol Dependence Syndrome was confirmed, alongside mental behavioural disorder due to the use of alcohol, along with emotional unstable personality disorder compounded by unresolved grief and turbulent relationships.</p> <p>The plan agreed was to commence carbamazepine, consider psychology and a rehabilitation residential placement for Mr SU.</p> <p>A further planned admission to the in-patient psychiatric ward was also to be considered.</p>
<p>Independent Team's comment: This contact with Mr SU constituted very good practice and confirms that the mental health services provided by the then 5 Boroughs Partnership NHS Trust were willing to support Mr SU in achieving recovery from his substance misuse at this time.</p>	
5/4/2001	<p>Mr SU was seen on the medical assessment unit at the general hospital in Bolton by the duty psychiatrist.</p> <p>The assessment took place following an argument between Mr SU and his girlfriend, who threatened to leave him. Mr SU then took a 28-tablet overdose of carbamazepine. The clinical records report that Mr SU stated that he did not want to kill himself and that he did not realise the risk associated with the tablets he took. The records also noted that Mr SU had been drinking between three and five litres of cider daily (between 24 units and 40 units of alcohol daily).</p> <p>The subsequent letter to Mr SU's GP stated that Mr SU was seen by the alcohol liaison nurse while in A&E. No medical treatment as such was required by Mr SU, and, following psychiatric review, Mr SU was discharged home.</p>
<p>Independent Team's comment: The letter to the GP from mental health services was of very good quality and set out clearly Mr SU's presenting complaint, his past history, his relationships, his alcohol history and forensic history.</p>	
19/6/2001	<p>Mr SU did not attend for his appointment with the consultant psychiatrist in substance misuse. (Note: the letter inviting him to this appointment was sent on 2 February 2001.)</p>
29/6/2001	<p>Mr SU did not attend his outpatient appointment with the local Alcohol Team. A letter was sent to him advising that if they did not hear from him in two weeks his file would be closed. The letter advised that he could self-refer at any time.</p>
2/7/2001	<p>The consultant psychiatrist in addictions wrote to Mr SU's GP advising that Mr SU will be sent an 'opt-in' appointment in view of his non-contact with services. This letter put the responsibility of making contact with addictions services with Mr SU.</p>

Date and time	Chronology
7/7/2001	Mr SU was discharged from the alcohol drug team after failing to attend previously arranged appointments. The hand-written letter states that Mr SU was also seen by the psychiatric liaison nurse on 10 July 2001, and that he gave this nurse a false address. The letter also says: <i>"It appears that he is not ready to address his alcohol problem. His file has been closed accordingly."</i>
Independent Team's comment: The follow-up of Mr SU by a consultant psychiatrist in addictions and by the local community substance misuse team represented very good care and treatment. Mr SU was given good opportunity to engage with the service that could assist him in addressing his dominant problem. The decision to close his file, whilst leaving an 'open door' should Mr SU make contact with the team, was entirely reasonable.	
5/7/2001	Emergency admission of Mr SU to the local general hospital. Mr SU was experiencing bouts of haematemesis with abdominal pain. He was admitted to hospital for six days for observation and then discharged on 11/7/2001 with a 4-week follow-up appointment.
26/9/2001	Mr SU was seen in outpatients as planned. Mr SU reported that he continued to experience gastro-intestinal problems, but reported to the medical staff that he had cut down his alcohol intake. He also reported that he was living in a hostel and was now estranged from his girlfriend, due to his drinking problems.
28/1/2002	Mr SU did not attend at this follow-up with the gastro-intestinal team.
February 2002 – August 2002	It appears that Mr SU had no contact with services.
14/8/2002	Mr SU was seen by his new GP. The GP records noted that Mr SU was a new patient to the practice. It was also noted that Mr SU had been alcohol-free for one year, and was in a new relationship. His gastric symptoms, however, were noted to continue and the need for further endoscopic examination was queried. He was prescribed rabeprazole 10mg daily to help with his dyspepsia. A letter was sent to the local gastro-intestinal service about the need for further endoscopic examination.
30/8/2002	Correspondence was received from a solicitor acting on behalf of Mr SU. Mr SU was due to be sentenced on 9 September, following an allegation of assault. A medical report was therefore requested. At this time Mr SU had been on Dothiepin (an anti-depressant) 75mg for the last 2 years.
31/8/2002 – 31/3/2003	There is no evidence of contact between Mr SU and services. However, there was a 2002 medical report prepared for Mr SU's solicitors in preparation for a pending court case. This report confirmed to Mr SU's solicitors that: <ul style="list-style-type: none"> - Mr SU had a history of drinking to excess; - That he self-reported being alcohol-free for one year.

Date and time	Chronology
1/4/2003	<p>Mr SU was seen by a duty senior house officer in A&E after slashing his wrists and drinking strong alcohol. The clinical records say that Mr SU reported that his actions were a cry for help. It was also noted that when he slashed his wrists he called for an ambulance. After the assessment, Mr SU was discharged home with no prescribed medication. The senior house officer who undertook the assessment noted that Mr SU was low risk with regards to deliberate completed suicide, but at moderate risk of accidental suicide.</p> <p>The doctor suggested to Mr SU's GP, in the discharge letter, that counselling/psychology treatment might be worthwhile for Mr SU.</p>
30/5/2003	<p>Mr SU was sentenced to a three-and-a-half-year custodial sentence for grievous bodily harm. He served 22 months of this sentence. When he was released in 2005, he was 'on licence'. This meant that there were conditions associated with his release back into the community, the breach of which could result in him again being detained in prison.</p>
6/3/2005	<p>Mr SU was admitted to A&E following an overdose of Dothiepin (a tricyclic anti-depressant).</p> <p>On this occasion, the overdose resulted in Mr SU being admitted to intensive care with a Glasgow Coma score of three.¹ He had taken an overdose of 14 Dothiepin tablets and heroin.</p>
7/3/2005	<p>A referral letter was sent from Mr SU's GP to the community psychiatric nurse service requesting follow-up for him.</p> <p>The GP referral letter noted that Mr SU had been released from prison that week. The letter also stated that Mr SU's Dothiepin was stopped three weeks earlier and that his symptoms had increased, i.e. depression and alcohol use. The GP also reported recommencing Mr SU on anti-depressants. (Note: it appears that this letter from the GP overlapped with Mr SU's admission to hospital.)</p>
8/3/2006	<p>Mr SU was discharged from hospital.</p> <p>Prior to discharge, Mr SU was seen by the psychiatric liaison nurse.</p>
13/3/2006	<p>Mr SU is again in A&E.</p> <p>On this occasion, the clinical records show that Mr SU was awaiting transfer to the mental health unit for an assessment of his mental state. The precipitator to this admission was his apparent suicide risk. Following an assessment by the duty psychiatrist at 1.20am on 14/3/2006, Mr SU was admitted to the in-patient unit and placed on 30-minute (level 2) observations.</p>

¹ The **Glasgow Coma Scale** or **GCS** is a neurological scale that aims to give a reliable, objective way of recording the conscious state of a person for initial as well as subsequent assessment. A patient is assessed against the criteria of the scale, and the resulting points give a patient score between 3 (indicating deep unconsciousness) and either 14 (original scale) or 15 (the more widely used modified or revised scale).

Date and time	Chronology
	<p>Independent Team's comment: The clinical record made by the duty psychiatrist was of good quality. It noted that Mr SU reported hearing voices after drinking, and that his problems commenced after his father disclosed to him that his step-mum was not his real mum, as he had believed she was. The clinical record noted that Mr SU was not happy with his upbringing. He felt that it had 'made him' have a bad reputation in the community. He was also noted to be 'fed up' with his family's attitude towards him. The recent overdose of Dothiepin was also noted. The assessment record also noted that Mr SU had no friends and that his last friend died from an alcohol-related problem. It also noted that Mr SU believed he <i>"was strong and nothing could touch him"</i>. No formal thought disorders were identified and there was no obvious plan for self-harm. The record also noted that Mr SU had no thought of causing harm to others.</p>
14/3/2006	<p>A care co-ordination risk screen was undertaken with Mr SU. The clinical records noted that Mr SU was homeless and living with his brother. The record also noted that Mr SU had been sentenced to imprisonment in 2003 for actual bodily harm; he had cut a man's throat. Mr SU was noted as stating he did not have friends and that he heard voices telling him to kill himself.</p>
14/3/2006	<p>At 04.30hrs Mr SU left the ward. It transpired that Mr SU went to his brother's home. It was his brother who contacted paramedic services so that Mr SU could be returned to hospital. The clinical records show that, on return to his brother's home, Mr SU secreted a knife on his person, reportedly with the intention of harming himself. He was prevented from doing so by his brother. The record also noted that Mr SU again disclosed that he heard voices telling him to kill himself.</p>
15/3/2006	<p>In-patient ward round. This ward round was led by the senior house officer on duty. Mr SU received a full physical examination, which revealed no significant problems, other than Mr SU's psoriasis, for which an aqueous cream (E45) was recommended. A full blood screen was also requested, including liver function tests. Mr SU's nursing observation level was also reviewed and reduced from 'Level 2' to 'Level 1' or 'general' observations.</p>
	<p>Independent Team's comment: The nursing records largely report that Mr SU behaved appropriately on the ward, with no evidence of psychotic symptoms. There were, however, a number of episodes noted where Mr SU had taken time off the ward and returned smelling of alcohol and he tested positive for benzodiazepines.</p> <p>On 18 March, a care plan for Mr SU was documented within the daily progress record. This identified Mr SU's lowness of mood and the medication plan; that Mr SU was homeless and that he had contacted the council regarding accommodation, and was awaiting a property. It also identified that Mr SU was aware of the short admission afforded him.</p> <p>The care plan did not include any discussion with Mr SU regarding his relationship with alcohol and drugs and how he felt about his substance misuse. Furthermore, there was no documentary evidence to show that nursing staff tried to explore this area with him. A review of the formal care plan of the same date showed that it did not list Mr SU's substance misuse as a specific problem for him.</p>

Date and time	Description of event
23/3/2006	<p>Mr SU was absent without leave.</p> <p>Mr SU had been on an agreed leave period, but did not return to the ward as had been agreed. In line with the Trust's protocols at the time, the absconder procedure was activated.</p> <p>It was also noted in the clinical record that Mr SU's brother was concerned that his brother could not come back to live with him because of the problems Mr SU's alcohol consumption caused.</p>
28/3/2006	<p>Mr SU was discharged from in-patient services.</p> <p>The records noted that allocation of a care co-ordinator to Mr SU was to be arranged. A note on the risk screening form, effective care co-ordination, also stated that Mr SU had been discharged from the unit as the consultant psychiatrist assessed him as not being depressed.</p> <p>With regards to his accommodation, the records show that Mr SU's brother agreed for him to stay one night only. Thereafter, Mr SU needed to find alternative accommodation.</p> <p>The nursing records state that the consultant psychiatrist did not consider Mr SU to be suffering from a mental illness at the time of discharge.</p>
<p>Independent Team's comment: When the Independent Team visited Mr SU in prison, he was not receiving any care and treatment from prison health or mental health in-reach services. Mr SU told the Independent Team that all of his problems had been caused by his substance misuse.</p>	
30/3/2006	<p>The community mental health team records note that Mr SU had been discharged and that the required 7-day follow-up was required.</p>
4/4/2006	<p>The community mental health team records show that telephone contact with Mr SU was attempted.</p> <p>There was no reply and no answerphone facility.</p>
5/4/2006	<p>The community mental health team records show that the 7-day follow-up visit to assess Mr SU was attempted.</p> <p>The address provided was that for Mr SU's brother. The community mental health team contacted the number provided and spoke with Mr SU's brother. He is noted to have told the mental health staff that Mr SU was not living with him and that he had not seen him since the previous evening. He also informed the mental health staff that Mr SU went on "walk about" and that Mr SU had an appointment with the Citizens Advice Bureau regarding accommodation. The plan, as far as the brother was aware, was for Mr SU to be located in the Bolton area. Mr SU's brother had no contact details for Mr SU and did not know when he would next be in touch with him.</p> <p>As a consequence of this discussion, and the lack of opportunity to locate Mr SU, a decision was made by the community mental health team that this contact would be recognised as the 7-day follow-up in the absence of being able to locate Mr SU himself.</p>

Date and time	Chronology
5/4/2006	A further attempt was made to telephone Mr SU. This was not successful. Consequently, on 6 April, at the community mental health team allocation meeting, it was agreed by those present that the team's duty regarding the 7-day follow-up had been discharged.
9/4/2006	<p>Mr SU was admitted to hospital via section 136 of the Mental Health Act. The clinical records show that Mr SU was again threatening to harm himself with a knife. It was also noted that he wanted to be put in prison; the inference being that this was where he felt safe.</p> <p>Mr SU was admitted on to an in-patient psychiatric ward for ongoing observations. These were determined at 30-minute intervals.</p>
<p>Independent Team's comment: The records show that the medical assessment conducted was thorough. The assessment noted a range of triggers for Mr SU's thoughts of self-harm. These included a lack of access to his family, no access to his children, disturbed sleep, drug and alcohol abuse, feelings of wanting to end his life.</p> <p>The clinical record shows that the senior house officer (SHO) asked Mr SU: "<i>How he thinks he can get out of this vicious circle, and how services could help him?</i>" Mr SU's response was noted as being that he saw the only way was being in prison, where he felt safe. It was "<i>like home</i>".</p> <p>The clinical record shows that Mr SU's forensic history was accounted and recorded. The record also noted that Mr SU had received prison sentences 10 times in the past, the most significant in May 2003, when he received a 3½-year sentence for cutting a man's throat in a fight. He remained on licence at the time of this assessment.</p> <p>The clinical record also showed that the senior house officer noted that Mr SU was 'High Risk' for a range of social and behavioural reasons and offered him a short-term admission. Mr SU agreed to this on an 'informal' basis.</p> <p>The clinical record confirms that ward rules with regards to drugs and alcohol were explained to Mr SU.</p>	
11/4/2006	<p>After two days, a decision was made to discharge Mr SU. The plan was the follow-up of Mr SU by his local community mental health team, and for him to self-refer to the substance misuse service. The addressing of this issue was considered central to Mr SU's recovery.</p> <p>Mr SU's medication was to continue, as Citalopram 20mg daily.</p> <p>In the records it was also noted that Mr SU stated that he had endured enough of everything and felt safer in prison. He also admitted that in a previous admission he had used the hospital because he had nowhere else to go and he accepted that this was not the right thing to do.</p>

Date and time	Chronology
11/4/2006 continued	The medical record also states that Mr SU was again instructed to contact the alcohol services for help. At the time of discharge, the plan was for Mr SU to stay with his brother.
	Independent Team's comment: During the above admission, two risk screening documents were completed and an initial core assessment was partially completed. Neither of the documents was dated. However, in terms of content the risk screening forms contained appropriate information and, where a risk factor was identified, further qualitative/descriptive information was provided. This constitutes expected and good practice. Furthermore, where information was not known, it was stated clearly. Both risk forms identified Mr SU as of medium risk to others as a consequence of his life-style choices. This risk was accurately determined and was not within the power of mental health services to change.
20/4/2006	Mr SU did not attend at the community mental health team base for his 7-day follow-up. It was noted in the community mental health team 'diary sheet' that Mr SU had no mental illness and was not on CPA.
28/4/2006	Mr SU's case was discussed in the community mental health team allocation meeting and his case closed.
7/6/2006	The Incident occurred. Mr SU was charged, along with a co-defendant, of murder.

OVERALL OPINION OF THE INDEPENDENT TEAM REGARDING MR SU'S CARE AND TREATMENT

On the basis of its analysis of Mr SU's care and treatment by the then 5 Boroughs Partnership NHS Trust, the Independent Team is of the opinion that Mr SU's care and treatment by the then 5 Boroughs Partnership NHS Trust was reasonable and that there was no significant lapse in the service offered to him. Furthermore, it is the opinion of the Independent Team that there was nothing about Mr SU's care and treatment that could have been done differently that would have averted the incident that occurred in June 2006.

It is not within the power of specialist mental health services or addiction services to force persons suffering from an addiction to address this.

As a consequence of the assessment of Mr SU's clinical records, the Independent Team can see no rationale for a full independent investigation of Mr SU's care and treatment. Further investigation is unlikely to elicit any materially different conclusion than that achieved by the review of Mr SU's clinical records.

3.0 THE INDEPENDENT ASSESSMENT OF THE THEN 5 BOROUGH PARTNERSHIP NHS TRUST'S INTERNAL INVESTIGATION

The purpose of the independent analysis of the then 5 Borough Partnership NHS Trust's internal investigation into Mr SU's care and treatment was to determine whether:

- ❑ the opinions of the Independent Team and the Trust's appointed investigation team were the same regarding the preventability of the incident;
- ❑ the opinions of the Independent Team and the Trust's appointed investigation team were the same regarding the reasonableness and appropriateness of Mr SU's care and treatment; and
- ❑ in the opinion of the Independent Team, the Trust's investigation report was proof of a sufficiently robust investigation following an incident of such severity.

Following its assessment of the 5 Borough Partnership NHS Trust internal investigation report, it is the overall opinion of the Independent Team that the Trust's report does show a reasonable retrospective analysis of Mr SU's care and treatment. The construct of the Trust's investigation could, however, have been made more robust with the inclusion of a consultant psychiatrist as a specialist adviser to the investigative lead. This may have facilitated a more detailed analysis of Mr SU's care and treatment.

The specific observations of the Independent Team in relation to the following components of the then 5 Borough Partnership NHS Trust's internal investigation report are headlined as follows:

- ❑ The Findings Section
- ❑ Feedback on Positive Practice
- ❑ The Conclusion of the internal investigation
- ❑ Recommendations made.

The observations of the Independent Team are made using the content of the Trust's investigation report, supplemented by the interview transcripts made of staff interviews undertaken during the Trust's internal investigation team.

3.1 Findings (the analysis on page 7 of the Trust's report)

The analysis section of the Trust's report is presented as a narrative which is not particularly conducive to determining which elements are a recounting of chronological fact, and what constituted the Trust's investigation team's analysis of information gathered during the investigation process.

It is expected that the 'findings section' of an investigation report sets out an investigation team's analysis of what was acceptable and unacceptable in relation to care and treatment delivered to a service user. Where care and treatment have been found to have fallen below expected standards, it is assumed that an investigation report will set out clearly how and why these lapses occurred. The investigation guidance provided by the National Patient

Safety Agency suggests that such lapses should be termed 'care management problems'. Furthermore, the National Patient Safety Agency recommends the analysis of such identified problems using its human factors framework. This requires investigators to develop an understanding of practice/care lapses in the context of a practitioner's interaction with the environment in which care and treatment is delivered. This includes:

- ❑ Work-place design;
- ❑ the practitioner's skills and knowledge;
- ❑ the practitioner's appreciation of 'the rules', or policy and procedural expectations;
- ❑ team-working relationships and culture;
- ❑ communication issues; and
- ❑ clinical and managerial leadership.

The then 5 Boroughs Partnership NHS Trust's internal investigation report contained very little analysis, or commentary, regarding the appropriateness or otherwise of Mr SU's care and treatment. The content of its 'analysis section' is dominated by a re-presentation of chronological fact. At the time the report was written, this approach was not uncommon across all sectors of the NHS.

The Independent Team does note that the authors of the internal investigation report did identify the following care and clinical practice issues that it considered could have been improved in relation to the service afforded Mr SU. These were:

- ❑ That the reference to Mr SU reporting voices (when drinking) and the duty psychiatrist's notation of "*? Auditory Hallucinations*" was not qualified at the time.
- ❑ That Mr SU's consultant psychiatrist was not available to attend a scheduled ward round due to a prescheduled hospital appointment.
- ❑ That in Leigh CMHT the 'ward round message book' was not signed.
- ❑ That, on 17 March 2006, it was not possible to determine whether Mr SU had permission to leave the ward.
- ❑ That there was no clear indication of Mr SU's CPA status at the end of March 2006.
- ❑ That, on 5 April 2006, the CM/HT classed the contact the team managed to achieve with Mr SU's brother as constituting the 7-day follow-up, and that this could not have been classed as such because the CM/HT did not see Mr SU.

However, it is the contention of the Independent Team that none of the above constituted a significant 'care management problem' that could be causally linked to the incident that occurred, or constituted a significant threat to the delivery of an effective mental health service to Mr SU. Consequently, it is reasonable that the Trust's investigation team did not set out a detailed analysis of the above issues, using a human factors framework such as that recommended by the National Patient Safety Agency.

However, because the authors of the Trust's report stated that they interviewed staff engaged in the care and treatment of Mr SU and that they facilitated a team review with all stakeholders, the Independent Team would have expected the Trust's investigation team to have set out in its report some commentary with respect to staff's perspectives regarding:

- ❑ The presence of auditory hallucinations during Mr SU's in-patient episode. (We know from the clinical records that no such signs were identified.)
- ❑ Staff's recall regarding the CPA level for Mr SU.
- ❑ Whether or not Mr SU was free to come and go from the ward, and what the normal practice was on the ward with regards to notating agreed leave periods for informal patients.
- ❑ Why the community mental health team made a decision on 5 April 2006 to class the telephone contact with Mr SU's brother as meeting the 7-day discharge criteria for Mr SU, even though they had not been successful in making contact with Mr SU.

All of the above observations made by the Trust's investigation team should have been explained in greater detail than was achieved in its internal investigation report. The purpose of conducting an investigation is to explore and understand issues that are not clear from an appraisal of the clinical records. It is imperative that the understanding achieved is clearly presented in the subsequent investigation report.

3.1.1 Gaps Identified by the Independent Team in the Trust's analysis of Mr SU's care and treatment

There were two main issues that the Independent Team believes should have been commented on in the Trust's investigation report. Both relate to Mr SU's addiction to alcohol.

The first issue was Mr SU's in-patient episode in March 2006. The care plan documented was appropriately detailed in every respect, except for Mr SU's substance misuse. As this was his dominant problem, it was, the Independent Team considers, a significant omission, but not one that was, on the balance of probabilities, likely to have impacted on the subsequent course of events or Mr SU's engagement with statutory and/or voluntary substance misuse services, or self-help groups such as Narcotics Anonymous or Alcoholics Anonymous.

Nevertheless, there are many service users such as Mr SU, and it is essential that general adult in-patient and community mental health staff have a grounded appreciation of addictive behaviours and know how to:

- ❑ undertake a baseline assessment of a service user's substance misuse;
- ❑ engage in front-line activities such as motivational interviewing, where a service user expresses a desire to address his/her addiction; and
- ❑ refer a service user to specialist substance misuse services and/or voluntary services and self-help groups in the community.

Furthermore, the in-patient wards should have information packs for service users to read and/or take away. Ideally, such information packs would include personal anecdotes contributed from those in recovery achieved via engagement with statutory services, voluntary services and self-help groups.

Such exploration and information may not have made a material impact with Mr SU, but may provide an opportunity for recovery for another service user. Given the increasing incidence of addiction in England, good quality inspirational information should be routinely available to service users across all adult services.

The other factor the Independent Team identified that was not addressed in the Trust's internal investigation report was the lack of information provided to the partner of Mr SU by primary care and mental health services. Both services were aware of the domestic abuse issues and that Mr SU's addiction was a contributory factor to this. Families and carers of addicts, including alcohol, are often unsupported and do not know where to get help. Specialist mental health services are ideally placed to enable them to be more aware of support opportunities in their local community. It is the experience of the Independent Team that this information is infrequently provided to families and/or carers.

3.2 Positive Practice (page 10 of the Trust's report)

The Trust's investigation noted three episodes of good practice. These were as follows:

1. *“Following Mr SU's admission, the reviewers wish to note that documentation on admission by Staff Nurse M was of a very high standard.*
2. *The reviewers also wish to comment on the high standard of the entries made by Staff Nurse B, all relating to care plans and evaluating the same.*
3. *In this instance, the CMHT pursued follow-up of Mr SU as they wished to ensure the same was completed, even though Mr SU was not subject to CPA or 7-day follow-up.”*

It is the opinion of the Independent Team that there was a greater range of good practice episodes to be made about Mr SU's care and treatment.

For example:

- ❑ The duty psychiatrists, when Mr SU was admitted via A&E, all undertook thorough assessments and appropriately explored Mr SU's background. The clinical records suggest a good level of care and attention.
- ❑ In June 2001, Mr SU was offered assessment and support from a consultant psychiatrist in addictions and from the local addictions community team. This represented good practice.
- ❑ In March 2003, the duty SHO who assessed Mr SU noted specifically that he tried to explore with Mr SU whether he felt he could get out of the vicious cycle he was caught in and how mental health services could

help him with this. This represented a good level of care and concern for Mr SU.

3.3 Conclusion (page 10 of the Trust's report)

The conclusion section of a serious untoward incident report should set out the conclusion of the relevant investigation team in relation to:

- ❑ the terms of reference provided to the investigation team;
- ❑ the predictability of the incident; and
- ❑ the preventability of the incident.

Although the Trust's investigation report includes a conclusion, it does not state as clearly as it should the conclusion about the predictability and preventability of the incident that occurred in June 2007. The authors of the Trust report say: *"It appears to the reviews that Mr SU had no serious mental illness, and certainly not to the degree or nature requiring tertiary services. Mr SU admitted himself that he was using the health provision to assist him to solve his housing difficulties at the times of his admission. Mr SU did not present as a significant management problem when admitted to the in-patient unit, but did continue to abuse drugs and alcohol during his stay on the unit. The reviews will make recommendations around practice that have been highlighted during this investigation, but the deficits in care do not appear to have affected the outcome of this case."*

The Trust's investigators may have been hampered in the formulation of their conclusions as a consequence of the lack of a terms of reference for the investigation with which they were tasked. Nevertheless, wording along the lines below would have made the Trust's investigation team's conclusion more clear.

"As a consequence of the retrospective analysis of Mr SU's care and treatment, the reviewers conclude that:

- ❑ *They agree that Mr SU displayed no symptoms suggesting that he suffered from a treatable mental illness, or that he required the ongoing input of tertiary mental health services.*
- ❑ *There were no significant lapses in the care and treatment of Mr SU, the absence of which could have avoided the incident that subsequently occurred.*
- ❑ *Although it was identified that Mr SU was of medium risk to himself and others as a consequence of his addictions, it could not be predicted how this risk would manifest itself, when it would manifest, or the consequences of this should it manifest.*
- ❑ *It is therefore the overall conclusion of the Trust's review team that the incident in which Mr SU was involved was neither predictable nor preventable by any of the mental health professionals who had contact with Mr SU during the relevant antecedent period leading to the incident, i.e. that is between 2005 and 2007."*

The Trust's review team could then have gone on to say something like:

“Although the review team did not identify any serious/significant lapse in Mr SU’s care and treatment, it did identify a number of features that could have been improved and these are addressed in the recommendations made in the following section of this report.”

3.4 Recommendations made by the then 5 Boroughs Partnership NHS Trust investigation team

The then 5 Boroughs Partnership NHS Trust investigators made 13 recommendations as a consequence of their investigation. It is the perspective of the Independent Team that, in view of the absence of any serious lapses in the care and treatment of Mr SU, this seems to be a high number of recommendations to make.

In assessing the quality of the recommendations made, the Independent Team benchmarked them against SMART criteria. That is, whether the recommendations were:

- Specific
- Measurable
- Action orientated
- Relevant and realistic
- Timely and time bound.

The Independent Team also assessed the recommendations and subsequently approved Trust action plan in relation to their reliability attributes.

In healthcare, quality improvement and safety improvement interventions can frequently be grouped under the following headings, which give an indication of the reliability of the planned intervention(s) aimed at improving care and service delivery:

- Physical interventions. These are interventions that have designed out as far as possible the human interface and thus reduced as far as possible the opportunity for human error. An example of a Physical Intervention would be an electronic prescribing system that used forced fields and did not allow a prescription to be made without the completion of these fields.
- Natural Interventions: A natural intervention is one that uses naturally occurring elements such as time, distance and place. An example of a natural intervention is the offsite storage of clinical records with companies who specialise in the safe storage and retrieval of clinical records. Another example would be the WHO safer surgery initiative, where a time break pause is required immediately before the commencement of interventional treatment, to allow all present to make a final check that they have the right patient, are doing the right treatment, on the right body part, on the right side of the body.
- Human Action Interventions: Human action interventions rely on ‘telling’ individuals what they should be doing.

- ❑ Administrative Interventions: Administrative interventions include the development or revision of existing training/skills development programmes, the updating of policies and procedures, supervision of practice.

Each of the above groups is considered to have differing degrees of reliability; that is, each differs in the uniformity with which it performs the relevant task or process on a day-in and day-out basis.

- ❑ Physical interventions tend to be the most reliable, performing as intended. Physical interventions generally constitute highly reliable interventions. Unfortunately, scope for such intervention in mental health services is very limited.
- ❑ Natural interventions could be considered of medium reliability. The institution of activities such as time breaks creates space for clinical staff to identify an error or hazard before an incident occurs. There is scope for this type of intervention in mental health services. For example, using a two-tier (or person) checking system with a time break in between the checks made.
- ❑ Administrative interventions are weak in terms of reliability as they rely on humans to carry them out. Consequently, the checks and balances put into regularly test the effectiveness of these interventions and obtaining a good understanding of the contributory factors to any system deficit/non-performance are important in the development of more robust solutions.
- ❑ Human intervention, i.e. telling staff what they should be doing, is a very unreliable improvement intervention. Consequently, recommendations that are targeting human behaviour need to be given specific consideration, and understanding why staff are not performing as expected is essential to delivering an action plan of merit. Again, the ongoing audit process for testing the effectiveness of any human action intervention is essential to the success of any action plan focusing on human behaviour.

The Independent Team has set out its assessment on the 5 Boroughs Partnership NHS Trust recommendations and associated action plan based on the safety and reliability principles set out above.

Trust Recommendation 1. *“There was a lack of easily accessible information relating to the identification of CPA level following discharge. When a client is discharged from an in-patient unit, the Multi-Disciplinary Team (MDT), wherever practicable, should ensure the CPA level is discussed and agreed, and this is fully documented in the client’s main clinical notes.”*

Independent Team’s comment: This is a ‘Human Action’-orientated recommendation. Although the principle of what is stated here was correct, the recommendation is unlikely to have had any lasting impact on practice. It would have been better if the authors had recommended the issue to be further

explored in the next and subsequent CPA audits and then devised an action plan to determine why there is a lack of accessible information if the more extensive audit showed that the problem was an extensive one. This would have enabled 'the cause of the problem' to be identified and addressed.

The Trust's action plan states that this recommendation has been implemented, but it does not say how the impact of implementation was to be assessed.

Trust Recommendation 2. *"It was noted by the reviewers that the service of CR/HT covering clients admitted to the A&E department at RAEI saw a mental health nurse working for the CR/HT team. The reviewers recommend that, when there is annual leave or sickness, a formal agreement regarding the level of cover is agreed and implemented."*

Independent Team's comment: This is an administrative/human action-orientated recommendation. The Independent Team could not see the relevance of this recommendation in relation to the purpose of the investigation conducted by the Trust. However, it is commendable that the Trust did follow it through and the situation with CR/HT was clarified.

Trust Recommendation 3. *"It was stated in Mr SU's medical notes that the SHO believed that Mr SU might be experiencing ? auditory hallucinations. It is recommended that all staff quantify a statement with reasons for this opinion."*

Independent Team's comment: This is a human action-orientated recommendation. On reading the medical assessment to which this recommendation refers, the narrative makes clear why the SHO included " ? auditory hallucinations" at the relevant point on the assessment form. The service user had reported hearing voices when drinking. Although the Independent Team agrees that it is good practice to qualify such statements, it is not convinced that making the above recommendation was necessary in this particular case. If the Trust's investigators were particularly concerned about this element of practice, it would have been more productive to have included an assessment of the reliability of medical documentation with regards to the description of auditory in subsequent documentation audits and then to have devised a remedial plan if required.

The Trust's action plan devised as a consequence of this recommendation was not satisfactory. It said: *"SHO's must not write derogatory remarks (?) and must be specific about problems identified with supporting evidence to validate observations."* The Independent Team saw no evidence of inappropriate documentation by the medical staff involved in the care and treatment of Mr SU. Furthermore, it is precisely this type of action plan that often has little to no impact on the practice of the professionals it is targeting.

Trust Recommendation 4. *"The documentation during ward rounds did not state who attended the ward round. This caused added difficulty in reviewing this case."*

Independent Team's comment: The wording of this recommendation constitutes a statement and not a recommendation. It does not meet SMART criteria. Alternative wording could have been:

“The operational policy for in-patient services needs to make explicit the standards of record-keeping during ward rounds. Such standards should at least require the notation of those present and their job roles.”

This would have at least met the following criteria: Specific, and Action-orientated. The recommendation would have remained low in its performance reliability because policies rely on individuals following them. Consequently, ongoing audit initiatives by ward managers would be required to keep the issue alive.

Because maintaining a record of who was at a ward rounds remains relevant from a contemporary clinical management perspective, the Independent Team recommends that this issue is subjected to a one-off audit to determine the reliability with which the records of the 'ward round' identify the persons present on the round.

Trust Recommendation 5. *“There was a general theme regarding the accuracy of information. DH received several assessments from mental health services and on each occasion there were varying reports from him regarding history. It is recommended by the reviewers that, when a client self-reports information, this is clearly identified, and as soon as practicably possible, that this information is independently verified as accurate.”*

Independent Team's comment: There is no evidence that the issue of obtaining informant history and the reliability with which Mr SU's mental health team did this was explored during the Trust's internal investigation. It is a matter of good practice that there is a clear link between the findings of an investigation and the articulation of this in the investigation report and subsequent recommendations made. Best practice is that recommendations are designed to address the 'root causes' of care delivery and service delivery lapses. There is no evidence of the systemic analysis of the lapses identified by the Trust's investigators.

If the authors considered that the issue of gathering informant history merited a recommendation, it would have been preferable if it had been presented along similar lines to:

“The investigation team identified a lack of informant history gathered during the chronology of contacts with Mr SU. Although the investigation team appreciates the complexities of addictive behaviour, this issue does, the investigation team believes, merit further exploration to determine the frequency with which clinicians are seeking appropriate informant history as an integral part of the assessment process.

The investigation team therefore recommends that, during the next planned clinical records audit, specific attention is given to assessing the frequency with which:

- ❑ informant history is documented; and
- ❑ clinicians notate why no informant history has been gathered.

The latter is important as informant history is not always necessary and even when it is considered valuable some service users do not give their consent to approach carers and family members.

If the audit process reveals that insufficient efforts are being made to collect informant history, then adult mental health services can explore how best to improve practice and documentation in relation to this.”

Trust Recommendation 6. *“That many entries as an in-patient were written by a non-registered nursing staff and not staff nurses and no entry for 48 hours commented on Mr SU’s mental state. The reviewers recommend that consideration be given to a standard of documentation where a review of the care plan, and daily evaluation, occurs on all clients in any given 24-hour period.”*

Independent Team’s comment: Although human action-orientated, this is a pragmatic recommendation. The Trust’s subsequent action plan also shows that the issue has been incorporated into record-keeping training and that it is now a Trust standard that all entries by unqualified staff must be countersigned by a qualified member. This issue is monitored via a range of established audit mechanisms in the Trust.

Trust Recommendation 7. *“It was noted by the reviewers that a physical examination was not carried out on his first admission within 24 hours. There was no documentation to give explanation for this by the Locum SHO.”*

Independent Team’s comment: The above does not constitute a recommendation. It is an observation about Mr SU’s care management and should, if considered important, have been reported on in the main body of the investigation report. Furthermore, although physical examination is important, the above observation does not acknowledge that, subsequent to the involvement of a Locum doctor, Mr SU did receive a physical examination by another doctor. This perhaps indicates that the identified lapse in practice was an individual rather than a systemic problem. Generally speaking, it is not good practice to make system-wide recommendations based on a lapse in practice of an individual, unless further exploration of the lapse reveals that there is a systemic problem.

The then 5 Boroughs Partnership NHS Trust accepted the recommendation made and determined that SHOs must document where a physical examination is not possible and that all such examinations must occur within 24 hours.

Because this action plan is ‘human action-orientated’, the Trust now needs to show that this standard is known about, understood and is being met by its medical staff.

Trust Recommendation 8. *“That there are appropriate checks of all medical equipment, including the breathalyser, and that staff receive appropriate training on the use of all medical equipment used on their clinical area.”*

Independent Team’s comment: This recommendation was ‘administrative in nature’, i.e. requiring the implementation of a structured checking process for all clinical equipment in use. It was a relevant recommendation; however, the subsequent approved action plan did not address the recommendation. It said that all staff were to be trained in breathalyser use. It did not address the wider issue of ensuring that equipment is appropriately checked, and that staff know how to use all of the equipment in their work area.

Trust Recommendation 9. *“During both admissions, Mr SU was only seen once by his consultant psychiatrist and it appears that many of the ward rounds occurred without this individual present. The reviewer would recommend that clear guidance be given to Consultants around cover for ward rounds and access to a covering consultant be an option.”*

Independent Team’s comment: The above is another example of a clinical practice concern that was given insufficient attention in the main body of the Trust’s internal investigation report. This issue should not be articulated for the first time in the recommendation section of an investigation report.

The Trust’s investigation report does not set out any context for the lack of consultant presence on the ward rounds to which it refers. Neither does it set out what the established practice is for obtaining consultant input where required if the consultant to a service user is not available. An understanding of both of these issues would be necessary to determine the need for the above recommendation and how the recommendation needed to be directed.

The Trust’s approved action plan did not address the principle this recommendation appears to be raising. It focuses on the role and responsibility of individual ward staff to seek input from an alternative consultant psychiatrist. This intervention is human action-orientated, and thus not at all reliable. There appears to have been no recognition that the system for ensuring that appropriate cover is in place for consultant staff not available for work may have needed review. Furthermore, there appears to have been no recognition of the need to establish whether the concern raised by Recommendation 9 was an isolated incident, or whether non-availability of consultant cover was a frequent issue for adult in-patient services.

Trust Recommendation 10. *“The entry made by Mr SU’s consultant psychiatrist on 28th March 2006 regarding discharge and future planning, including follow-up and diagnosis, was minimal and below expected standard. The reviewers would recommend that guidance be given to all medical staff around documentation in the ward round and standards expected on discharge documentation.”*

Independent Team’s comment: The Trust’s investigators did not comment on this aspect of the consultant psychiatrist’s record-keeping in the main body of

the report. As with other recommendations made, where there is no clear linkage between the investigation's findings and recommendations, highlighting this issue in this manner was not appropriate or fair to the practitioner involved.

The Independent Team agrees that the consultant's writing was illegible and that this was not acceptable. However, this could have been reflected in a less person-focused and blame-orientated way. This type of practice issue lends itself to the use of the substitution test (see the NPSA's Incident Decision Tree) by an investigation team. It enables a perspective to be taken as to whether the element of practice identified as below par, in an individual practitioner, is in fact representative of the wider body of practitioners. In this case, a reasonable question would have been: *"to what extent is this consultant's handwriting representative of all 5 Boroughs Partnership NHS Trust's adult consultant psychiatrists?"* If a randomised sample of consultant records was reviewed and a significant percentage found to be illegible, then there would have been just cause for a recommendation targeting the documentation standards of medical staff. However, if the general standard of documentation and legibility was found to be good, then the issue would have become a specific professional improvement activity for Mr SU's consultant psychiatrist.

In this case, the Trust's own action plan only set out what doctors should do. It was therefore a low-reliability plan.

Trust Recommendation 11. *"Due to a lack of documentation in the medical notes around CPA level on discharge, there is lack of guidance to ward clerks and nursing staff when informing the CM/HT of discharge and requirements of 7-day follow-up. It is recommended in point 1 that clinical staff ensure documentation is completed around CPA level, but further guidance be given to nursing staff and administrative staff regarding action to take if no CPA level is documented."*

Independent Team's comment: The whole system of CPA has changed since this incident occurred. Service users are now either 'CPA' or non-'CPA'. The electronic record-keeping system *in situ* at 5 Boroughs Partnership Foundation NHS Trust requires the CPA status for all service users to be recorded. Compliance with this is regularly audited through CPA audit and also through supervision.

Trust Recommendation 12. *"It is requested by the reviewers that consideration be given to staff in the CM/HT ward rounds that all entries in the communication log have name and job title clearly printed with each entry."*

Independent Team's comment: This was a pragmatic recommendation similar to that made about ward rounds and in-patient areas.

Trust Recommendation 13. *"Mr SU left the ward during the day of 23rd March 2006 and staff reported Mr SU as AWOL. There is no documentation regarding any agreed leave. The reviews accept that Mr SU was an informal client, but feel there should be some discussion and documented agreement regarding leave recommended and times of return."*

Independent Team's comment: Although the above was not raised as a concern in the main body of the Trust's investigation report, the Independent Team considers that this was a pragmatic recommendation on the grounds of safety. When an in-patient is off the ward, the Trust retains clinical responsibility for the service user. This man had a history of deliberate self-harm and was considered of some risk to others when under the influence of illicit substances. Had an untoward incident occurred during a leave period, then the Trust would have been required to produce an appropriate assessment of Mr SU, including risk assessment, in support of the decision that he could leave the ward unimpeded. The appropriateness of the service user's 'voluntary' or 'informal status' would also have been examined in such a circumstance. The auditability of agreed leave time periods, including some evidence of staff's perspective of risk, seems to be sensible.

4.0 CONCLUSIONS OF THE INDEPENDENT TEAM

As a result of our analysis of Mr SU's mental health records, his GP records and the then 5 Boroughs Partnership NHS Trust's internal investigation report, the Independent Team's conclusions are that:

- The incident in which Mr SU was involved was not preventable by different clinical care and treatment.
- The life-style of Mr SU meant that he was vulnerable to being involved in a serious incident as a consequence of this, and had been so in the past. However, it was not within the power of the then 5 Boroughs Partnership NHS Trust to control these aspects of Mr SU's life. Mr SU did not take advantage of the opportunities offered to him to address his addictions. This was his right and his choice.
- Overall, the care and treatment of Mr SU was reasonable.
 - He was offered the support of substance misuse services which he chose not to accept.
 - He was provided with a hospital-based detoxification.
 - He was seen by the alcohol liaison nurse on more than one occasion.
 - At least one doctor tried to explore with him how he (Mr SU) could exit the chaos in which he was living, and how mental health services could help him.
 - Mr SU was provided with appropriate anti-depressant therapy and enabled to remain an in-patient to allow time for him to arrange accommodation when he was homeless.
- Although there were aspects of documentation that could and should have been better, the Independent Team did not identify any factor that could have been so improved as to make a difference to what happened on 7 June 2006.

The only specific factor that the Independent Team considers should and could have been better in terms of Mr SU's care management was the care planning for him in 2006 in relation to his addiction. Furthermore, there should have been a clear effort to demonstrate the provision of information to his then partner and brother about the support available to them in the local community to assist them in coming to terms with Mr SU's addiction. This was not evident.

Finally, although the Independent Team concludes that there is no justification for pursuing further independent investigation of Mr SU's care and treatment, and it agrees with the main findings of the Trust's own internal investigation report, it is the opinion of the Independent Team that the Trust's report did not indicate an investigation process in line with the National Patient Safety Agency's model of incident investigation, implemented in 2003. 5 Boroughs Partnership Foundation Trust has now developed its approach to the investigation of serious untoward incidents since 2003. A 5 Boroughs Partnership Foundation NHS Trust investigation report formulated in 2011 demonstrated to the Independent Investigation Team that the Trust now has an

investigation approach and report template that shows a much improved level compliance with the National Patient Agency's standards.

5.0 RECOMMENDATIONS

The Independent Team has a small number of recommendations for 5 Boroughs Partnership Foundation NHS Trust.

Recommendation 1

Where service users with substance misuse problems are engaged for assessment and/or treatment delivery by general adult services, rather than specialist dual-diagnosis services, it is important that a thorough exploration of the service user's substance misuse is undertaken, recognising that this can be challenging and some service users will not want to divulge this honestly.

The clinical records of such a service user should clearly show the exploration of substance misuse. The following is a suggestion of the key questions that may support the effective recording of a clinician's exploration of this issue:

- ❑ How does the service user feel about his/her substance misuse? (Does he/she accept there is a problem, for example?)
- ❑ How has the service user's substance misuse affected him/her (continue to affect him/her)? (For example, getting into fights, loss of job, loss of home, loss of relationships, loss of self-esteem, feels angry, sad, etc.)
- ❑ What, if anything, does the service user want to do about his/her substance misuse?
- ❑ What help/support does the service user feel that he/she needs to address his/her substance misuse?

In cases where a service user expresses a wish to address the substance misuse problem, the clinical record should also set out:

- ❑ What information has been provided to the service user about statutory addictions services, voluntary addictions services and self-help groups in his/her local community.
- ❑ Whether or not the service user has been supported in referring him or herself to the local substance misuse service.
- ❑ Whether or not a referral to the Dual Diagnosis Service is appropriate; and, if yes, whether such a referral has been actioned.
- ❑ What the ongoing care plan for the service user is in relation to his/her substance misuse, and how it is to be reviewed.

In cases where the service user does not wish to discuss his/her substance misuse problem, or accept any help or support in relation to this, a clear record should be made to this effect.

The Independent Team recommends that review of the clinical records and care plans of service users with addictions is given specific attention via the team managers' regular records audit activity and also via periodic specifically targeted retrospective audit activity. For example, this could be managed via a peer review audit process facilitated by staff trained in dual diagnosis, or specialist addictions staff.

Recommendation 2

This recommendation has been separated into two distinct components.

Part 1

To deliver Recommendation 1, 5 Boroughs Partnership NHS Trust must ensure that its staff working in general adult mental health services are informed about and understand:

- ❑ addictive behaviour;
- ❑ what compels a service user to remain active in his/her addiction;
- ❑ what factors can motivate a substance misuser, including alcohol misuse, to change; and
- ❑ the range of statutory, voluntary and self-help opportunities available to support service users who wish to address their addiction, including those organisations that provide support in achieving complete abstinence from it, where this is the goal of the service user.

It is the experience of the Independent Team, as a consequence of undertaking HSG (94)27 investigations, that the knowledge and understanding of mental health staff (not working in specialist addiction services) can be variable in relation to substance misuse and addictive behaviour.

In the first instance, the Trust may wish to conduct a knowledge-based assessment using a simple web-based questionnaire tool, such as Survey Monkey. The Independent Team suggests that the question content could be formulated with the input of statutory addictions services, voluntary addictions services and service users with addictions who have either achieved a good level of control or have achieved abstinence. As an 'expert patient group', addicts should be engaged in the formulation of a meaningful survey tool whose purpose is to test knowledge and understanding of front-line staff.

Part 2

If 5 Boroughs Partnership Foundation NHS Trust finds, as a consequence of its assessment of the skills and knowledge of staff around addictions management, is not as robust as it would like and an education programme is considered as a solution to this, 5 Boroughs Partnership Foundation NHS Trust may wish to liaise with neighbouring Mersey Care Trust, whose Dual Diagnosis Service currently delivers three awareness-raising training events a year for Mersey Care Staff. In addition to drawing on its in-house expertise, the training events offered draw on the wide range of expertise available in its local communities, including:

- ❑ established charities working in substance misuse;
- ❑ established self-help organisations such as Narcotics Anonymous and Alcoholics Anonymous; and
- ❑ established carer organisations and self-help groups.

If not already established, 5 Boroughs Partnership Foundation NHS Trust may wish to offer a similar education opportunity in its organisation.

Recommendation 3

Where it is known to mental health and primary care services that a service user has a substance misuse problem and there are closely involved carers/relatives, primary care and mental health services must provide those individuals with information about where they can source support for themselves.

Information should at least be available on the following obvious contenders:

- Addaction
- Action on Addiction
- Families Anonymous – for families of drug addicts (including alcohol)
- Al-Anon – for families and friends of those with an alcohol problem.

An internet search should reveal the range of charities and self-help groups in the North West who offer support for families.

An optimal approach would be to develop a self-help information leaflet or booklet for families/carers, or an information pack containing key pieces of literature that may be useful to the family/carer.

Recommendation 4

The Trust's own recommendation about the clear documentation of staff in attendance at ward rounds needs to be revisited so that 5 Boroughs Partnership Foundation NHS Trust can show that the identified absence of necessary documentation has been successfully addressed.

The Independent Team suggests that the periodic assessment of the clear identification of Trust staff, and multi-agency representatives present at ward rounds and CM/HT team meetings, is incorporated into its standardised documentation audit processes.

Recommendation 5

The Trust's own investigation made a recommendation about the clear documentation of the physical examination undertaken of a service user at assessments. The Trust needs to provide assurance on the reliability with which the medical physical examination is now recorded in the service user's clinical records.

Recommendation 6

Although 5 Boroughs Partnership Foundation Trust has improved its approach to the conduct of serious untoward incidents, and the structure its investigation report template the Trust needs to continue on its improvement path so that:

- The terms of reference used for each investigation is appropriately targeted to the needs of the investigation. A generic term of reference does not achieve this.

- ❑ Staff tasked with leading serious untoward incidents understand the importance of attending to the detail of:
 - the investigation tools and techniques appropriate for the investigation in hand;
 - usage of systems/human factors frameworks and how they can be applied;
 - undertaking the systems/contributory factors analysis on a problem by problem basis, where significant lapses in care or treatment have been identified;
 - Stating plainly where care and treatment met the expected local and/or national standards
- ❑ Trust investigators understand that for some incidents such as suicide and homicide, the purpose of the investigation is not to identify the 'root causes' of 'the incident', but to identify the 'root causes' of any significant/material lapse in the care and treatment afforded the service user. Once this has been determined Trust investigators can then consider the question of causality. (I.e. but for the lapses in care and treatment would the incident still have occurred?)
- ❑ All recommendations are formulated so that they meet S.M.A.R.T criteria.
- ❑ Investigation reports that clearly set out:
 - an executive summary;
 - why an investigation was commissioned and its purpose;
 - terms of reference;
 - investigation limitations;
 - findings in relation to i) where standards were met, ii) significant lapses in standards and the contributory factors to these lapses, iii) root causes (most significant contributory factors) to any significant lapses in case and treatment;
 - service user and family/carer involvement;
 - conclusions;
 - recommendations; and
 - relevant appendices.

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