HASCAS

Health & Social Care Advisory Service

An independent investigation into the care and treatment of Mr M

A Report for

NHS East of England

June 2010

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CHAIRMAN'S PREFACE

The Independent Investigation in this case was asked to examine a set of circumstances that are associated with two tragic deaths and the Mental Health Services provided by the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust and the Hertfordshire Partnership NHS Trust.

The methodology undertaken by the Investigation Panel necessarily revisits the circumstances and events in great detail causing all of those involved to revisit and re-examine often difficult and disturbing experiences. We wish to acknowledge this, as well as the discomfort caused by the process itself.

The Investigation underlines the importance of ensuring that the process is conducted in order to learn from the incident, improve the services to individuals and to minimise risk to service users and others. The overriding impetus for the Investigation and commissioning bodies is to ensure that there is a comprehensive effort to support the delivery of this objective. It is also the responsibility of the Mental Health Trusts involved in Mr M's care to ensure that any lessons to be learnt in this process are embedded into practice.

Those who attended for interview to provide evidence were asked to give an account of their roles, and provide information about clinical and managerial practice. They have all done so in accordance with expectations and with a frank openness for which they must be commended.

We are grateful to all those who gave evidence directly, who have supported those providing the evidence, and who have granted access to facilities and individuals throughout this process.

This has allowed the Investigation to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

My grateful thanks are also extended to the Independent Panel of experts who so diligently examined the documentation, participated in the interviews, considered the evidence and contributed to the report.

Condolences to the Family

The Investigation Panel would like to take this opportunity to publicly offer their condolences to the family of Mr M and his father. The help and constant concern of Mrs M and her daughter to ensure that the Investigation Panel had access to all the issues relating to Mr M's care and treatment was much appreciated. Their determination to remain part of this process at a time when they were personally in a fragile and distressed emotional state has to be applauded.

EXECUTIVE SUMMARY

The Incident

Mr M, a service user at the Orchard Unit in Luton, was granted leave under Section 17 of the Mental Health Act 1983 for a week from Tuesday 14 March to Tuesday 21 March 2006 in the care of his father at his home in Southend. Mr M and his father had very briefly returned to the Orchard Unit on the evening of Saturday 18 March to collect some of Mr M's belongings including some of his books. This was the last contact the staff at the Orchard Unit had with Mr M.

The Section 17 Leave ended at 21.00 on the evening of 21 March, and it was noted that Mr M had not returned to the Unit as required under the conditions of his leave. The nurse on duty phoned the RMO to ask whether he should let the Police know that Mr M was missing, having tried unsuccessfully to phone his father to check why Mr M had not returned. The decision was made to wait until the following morning as Mr M had been late returning from leave before.

On the morning of 22 March Mr M had not returned to the Orchard Unit and the staff had been unable to contact his father by phone. Mrs M, his mother, had rung the Orchard Unit to ask if the staff knew of her son's whereabouts as she had failed to raise either him or her husband on their phones. Mrs M decided she would go to her husband's address and found the Police were there. Upon entering the house the bodies of Mr M and his father were found inside. At the subsequent post mortem Mr M (father) was found to have died due to a knife wound in his back which had punctured his aorta, and his son was found dead due to strangulation.

Following the Police examination of the house where Mr M and his father had been found and the results of the two post mortems the Police decided not to seek any third party in connection with the deaths.

The Investigation Process

In accordance with the Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust (BL Trust) Policy and Procedure for Reporting Adverse Incidents (March 2005) an Internal Investigation was set up under the chairmanship of a Private Consultant and Non-Executive Director of a PCT as the lay chair. The report of the Internal Investigation was completed in January 2007. The Report highlighted that the incident could not have been predicted but that the Orchard Unit and the BL Trust should implement a set of recommendations covering issues concerning:

- the East of England Strategic Health Authority establishing an Independent Investigation into the incident;
- the Care Programme Approach and risk assessment and management;
- issues concerning the liaison arrangements between the BL Trust and the Hertfordshire Partnership Trust where a client lives in one area and is receiving inpatient services in another;
- comprehensive treatment plans for service users;
- assessments for carers;
- Section 17 Leave arrangements and requirements;
- the keeping of accurate records.

As the incident concerned a patient in receipt of mental health services and homicide was suspected the East of England Strategic Health Authority commissioned an Independent Investigation under the NHS Guidance HSG(94)27 as revised in June 2005. Following a national tender process the Health and Social Care Advisory Service (HASCAS) was selected to undertake the Independent Investigation.

The Investigation was given Terms of Reference proposed by the Strategic Health Authority and amended by HASCAS and the mother and daughter of Mr M. The final terms of reference were:

Stage 1

Following the review of clinical notes and other documentary evidence:

- review the Trust's Internal Investigation and assess the adequacy of its findings, recommendations and action plan

- review the progress that the Trust has made in implementing the action plan
- agree with the Strategic Health Authority any areas (beyond those listed below) that require further consideration

Stage 2

- review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of his alleged offence
- compile a comprehensive chronology of events leading up to the alleged homicide and establish the circumstances of the incident itself
- review the appropriateness of the treatment, care and supervision of the mental health service user in the light of any identified health and social care needs, this will include (but not be restricted to)
    - medication
    - assessment of decisions taken and their validity
    - cultural factors which affected the needs of the service user
    - staff responses to service user's concerns
    - range of treatments/interventions considered
    - social care
    - reliability of the case notes and other documentation
- review the adequacy of risk assessments, including specifically the risk of the service user harming himself or others – to include the training staff had received in risk assessment
- comment on the adequacy of the communication between the various agencies involved with the service user
- examine the effectiveness of the service user's care plan including the involvement of the service user and his family
- review and assess compliance with local policies (including the handling of complaints), national guidance and statutory obligations including the appropriate use of the Mental Health Act regarding admission, discharge and the granting of leave
- consider any other matters arising during the course of the investigation which are relevant to the occurrence of the incident or might prevent a recurrence
- provide a written report to the Strategic Health Authority that includes measurable and sustainable recommendations

The Independent Investigation Panel comprised:

- Lynda Winchcombe (Panel Chair) Independent Consultant
- Tina Coldham — Service User Consultant
- Jane Cronin-Davis — Occupational Therapist/Senior Lecturer
- Professor David Kingdon — Consultant Psychiatrist
- Rachel Munton — Executive Director of Nursing
- Ian Allured — Project Manager (HASCAS)

9. FINDINGS AND RECOMMENDATIONS

The Investigation Panel did find some areas where policies and procedures were not fully adhered to by the staff of the Orchard Unit. It is the Investigation Panel's view that this incident was not predictable or preventable. The reasons for this are that there was no evidence that Mr M had previously been violent towards any member of his family. The information available to staff gave no indication that Mr M was contemplating any violent act towards his father.

The following section sets out the Investigation Panel's recommendations. It is understood that both BL Trust and the HP Trust have implemented the recommendations of the Internal Investigation and this should be remembered when considering the recommendations which follow. These do not appear in priority order but the Investigation Panel consider that those concerning the Care Programme Approach, the range of therapeutic interventions available on the Orchard Unit, staff supervision and the other recommendations regarding Section 17 Leave under the MHA were critical as indeed is Recommendation 25 relating to staff safety.

The recommendations mainly relate to The BL Trust but where they also apply to the HP Trust this is specified within the text close to the recommendation.

Recommendation 1

It is recommended that:

The staff at the Orchard Unit should receive mandatory training in diversity every three years. In addition, given the diversity within the Unit and within Luton, sessions from different cultures should be held regularly to highlight the 'must do' and 'must not do' actions to help the service user within the Unit.

The above recommendation is specifically for the BL Trust but the HP Trust may find it useful and appropriate to consider for their services.

Recommendation 2

It is recommended that:

The Orchard Unit examines the expertise and range of psychological interventions it can provide and remedy areas where deficits exist. They should ensure that these are assertively promoted for service users. This should be done consistently and be tailored to the interests of the individual. An audit of the interventions available should be undertaken and a list of staff from all disciplines able to deliver particular therapies at the necessary levels of expertise produced.

Recommendation 3

It is recommended that:

The suitably experienced Occupational Therapy staff should use relevant interests and occupations of service users in order to facilitate professional therapeutic relationships.

Recommendation 4

It is recommended that:

The clinical files must be clearly ordered in such a way that CPA notes and Ward Meeting notes are distinct, and that the latest risk assessment is displayed prominently in the file as is the latest care plan.

Recommendation 5

It is recommended that:

A member of staff should be made responsible for ensuring that all details of a patient are collated and a full history is compiled and displayed in the case record. Records from other units or services where a patient has received care should be sought and included in the 'case history'.

Recommendation 6

It is recommended that:

All nursing staff should have training in the assessment and management of risk. This must include how to identify the risk level an individual presents with evidence to confirm the level assessed, and to check this against any other current risk assessment made by the clinical team.

Recommendation 7 (Relevant for both BL Trust and HP Trust)

It is recommended that:

The assessment should not only examine risks to others, but also the risk to the service user, including risk of self harm, self neglect and social exclusion and isolation.

Recommendation 8

It is recommended that:

The respective roles and responsibilities should be clarified to assist in boundary issues and the relationships between the professionals.

Recommendation 9

It is recommended that:

The BL Trust sets up a system that documents the arrangements when a named Nurse is absent and ensures that the patient is aware of these.

Recommendation 10

It is recommended that:

Staff must ensure that when patients are granted leave under S17 MHA the address of all places they will be staying are known, verified and that this is documented in clinical records.

Recommendation 11

It is recommended that:

When a patient or the person in whose care they have been granted leave requests an extension by phone staff must question how the leave has been, and seek reasons for the extension, and try to ascertain the patient's mental state.

Recommendation 12

It is recommended that:

When a patient returns from leave staff must ask how the leave was, and seek information from the patient and the person caring for them. It is vital to obtain as much information as possible and not take comments such as 'fine' as sufficient.

Recommendation 13

It is recommended that:

In cases such as Mr M's before leave is granted staff must have had experience of having escorted the patient on leave. This would have enabled them to have direct evidence of how the individual responds to being out of the hospital environment to inform their decision as to whether leave is granted.

Recommendation 14

It is recommended that:

Where leave is granted at a distance from the local Trust staff should try to assess the suitability of the leave address and put plans in place for assistance should the leave break down or the patient suffer relapse. Contact with the local services for the leave address should be considered to alert them to a possible call for help, together with a plan as to how help from the Orchard Unit can be mobilised.

Recommendation 15

It is recommended that:

Where a patient acts strangely by refusing to go on leave when they have usually done so, staff must investigate the reason for this and stop leave until they are satisfied that there is nothing seriously untoward to account for the patient's refusal.

Recommendation 16

It is recommended that:

When a patient does not return from leave at the designated time the Absent Without Leave Policy must be invoked immediately if no other information can be gained.

The Investigation Panel consider that for Recommendations 10 to 16 both Trusts examine their current practices regarding Section 17 Leave MHA.

Recommendation 17

It is recommended that:

The carers of patients should be offered an assessment of their needs and any help that they may require in order to fulfil their caring role.

Recommendation 18

It is recommended that:

The out of hours duty rota for cover to the Orchard Unit should be part of the general duty rota for the psychiatric services within the BL Trust, both now and in the future. The medical staff of the unit should participate in the on call duty rota for the whole Trust in line with their medical colleagues.

Recommendation 19

It is recommended that:

The management of the Orchard Unit and the BL Trust must ensure that staff gain a varied experience of mental health work; relevant training; have opportunities to visit other units and to practice in different units. The purpose is to expose them to new ideas and other accepted good practice in the provision of mental health care and treatment.

Recommendation 20

It is recommended that:

All members of the multidisciplinary team in inpatient units and working in the community must have regular access to professional supervision relevant to their own discipline and the process is audited on a regular basis as part of the Clinical Governance reporting process.

Recommendation 21

It is recommended that:

The management of the Orchard Unit in liaison with Trust senior management should agree a clear and effective admission and discharge policy for the Orchard Unit.

Recommendation 22

It is recommended that:

This work should include a review of the role of the two wards, Orchard 1 and 2, to determine whether they should have clear and distinct roles, and not, as present, deliver essentially the same service.

Recommendation 23

It is recommended that:

The Orchard Unit Management Team should consider the environment, including the provision of furniture which is difficult to move; and the consistent use of non-breakable crockery and cutlery to reduce patient and staff injury.

Recommendation 24

It is recommended that:

The Orchard Unit and the Community Teams with which it works must ensure that all relevant information about service users is shared, particularly with regard to any risks an individual may pose to themselves and other people especially where a weapon has been used. Such incidents must be included with a revised risk assessment of the service user.

Recommendation 25

It is recommended that in future the BL Trust should ensure that any Internal Investigation after a serious untoward incident is given a clear timeframe within which to work and that the root cause analysis and reasons for all decisions are clearly stated.

It is acknowledged that the BL Trust has reviewed its procedure for Internal Investigations and now follows the Department of Health Guidelines to use the National Patient Safety Agency model.