An Independent Investigation into the Care and Treatment of Mr R

February 2012

A report for NHS London
Undertaken by Niche Health & Social Care Consulting

NHS London

Contents

1.0 INTRODUCTION

Niche Health & Social Care Consulting was commissioned by NHS London, the Strategic Health Authority for London, to conduct an Independent Investigation to examine the care and treatment of Mr R. Under Department of Health Guidance[1] Strategic Health Authorities (SHA) are required to undertake an independent investigation:

"*When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event."*

When it is necessary to comply with the State's obligation under Article 2 of the European Convention on Human Rights. Whenever a state agent is or may be responsible for a death, there is an obligation for the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.

Where the SHA determines that an adverse event warrants independent investigation. For example, if there is concern that an event may represent significant systematic failure, such as a cluster of suicides."

2.0 PURPOSE AND SCOPE OF INVESTIGATION

Independent Investigations should increase public confidence in statutory mental health service providers. The purpose of this investigation is not only to investigate the care and treatment of Mr R, but to put into context the care and treatment that he received up to his absconsion from mental health services and subsequent conviction for the murder of Mr Q and whether or not that could have been prevented, and to establish whether any lessons can be learned for the future.

3.0 SUMMARY OF THE INCIDENT

Mr R was admitted to the Tony Hillis Unit (THU), a specialist Medium Secure Unit in Lambeth in December 2007 to receive treatment for antisocial and borderline personality disorder. He was detained under Section 47/49 of the Mental Health Act 1983. The Tony Hillis Unit is part of South London and Maudsley NHS Foundation Trust.

This was his second admission to the unit. His first admission in 2005 had ended on the 27th October 2005 when he absconded from King's College Hospital whilst waiting for an ambulance to return him to the THU. He had been assessed following

[1] HSG (94)27, amended in 2005.

complaints of chest pain. On this occasion he had handed himself into police on the 7th November, and was admitted to The Spinney, an independent medium secure unit in Greater Manchester, on the 10th November, before being returned to prison on the 22nd December 2005.

Mr R was convicted of Rape, False Imprisonment and Robbery in May 1996 and was sentenced to life imprisonment on 21st June 1996. Prior to this conviction, he had convictions for a series of other crimes, including Unlawful Sexual Intercourse with a girl under 16 years which made him a Schedule 1 Offender.

Mr R had a history of heart disease which required surgery in 2003 and on the 10th February 2008 was admitted with complaints of chest pain to Trundle Ward, King's College Hospital (KCH) after being seen (under escort) in the Emergency Department. He was discharged back to the THU on the 13th February, but complained of further chest pains the next day. Attending Paramedics did not establish signs of significant concern, but advised transfer to KCH for further testing. He was admitted to Oliver Ward, a General Medical Ward on the ground floor of KCH in the early hours of 15th February. He refused the prescribed Glyceryl Trinitrate infusion for angina. After further tests, he was informed that he would be discharged and returned to THU at 1100 hrs. He became agitated and requested a specialist second opinion on his condition and fitness for discharge. The specialist opinion returned the same decision. He used the mobile phone supplied by the Tony Hillis Unit to make and receive phone calls whilst his discharge arrangements were being completed. It is not known to whom these phone calls were made.

Mr R walked out of the hospital shortly after 1400 hrs. The police were called via a 999 call at 1424 hrs from a junior doctor on Oliver Ward. His whereabouts were not known until he was apprehended in Great Yarmouth on the 17th April 2008 by armed police and charged with absconding from lawful custody. He was remanded to HMP Bedford, and in September 2008 was sentenced to 18 months in prison for his escape from lawful custody. He was later charged with the murder of Mr Q, a pensioner, after an associate of Mr R informed the police that Mr R had confessed to the killing. He was convicted of murder in Norwich Crown Court in June 2009 and was sentenced to life imprisonment on 25th September 2009.

During the trial in Norwich Crown Court, the jury had been told that Mr R stole Mr Q's television to raise money for drugs before killing him to prevent him speaking to police. Between his absconsion on February the 15th and his recapture on April 17th 2008, Mr R is thought to have travelled to the Republic of Ireland and back to Great Yarmouth. Mr R used a belt to throttle Mr Q at his flat, having met him twice before the killing.

4.0 CONDOLENCES TO THE FAMILY OF MR Q

The Investigation Team would like to offer their deepest sympathies to the family and friends of Mr Q. It is our sincere wish that this report provides no further pain and distress but addresses any outstanding issues and questions raised by his relatives regarding the care and treatment of Mr R up to the point of his absconsion from King's College Hospital.

5.0 ACKNOWLEDGEMENT OF PARTICIPANTS

This was a complex multi-agency investigation involving people from 11 statutory organisations, and we would especially like to acknowledge the helpful contributions of staff members from South London and Maudsley NHS Foundation Trust, King's College Hospital NHS Foundation Trust, the Metropolitan and Norfolk Police, Croydon Health Services NHS Trust, Inner London Probation service, HM Prison Service, Lambeth PCT, London Specialised Commissioning Group, the Department of Health, and the Ministry of Justice.

In particular we would like to especially thank the Assistant Director Patient Safety and Serious Incident/Board Level Inquiry Coordinator at South London and Maudsley NHS Foundation Trust for their valuable and unstinting assistance.

We would also like to thank The Spinney medium secure unit, Greater Manchester and Broadmoor Hospital medical records department for their help in obtaining clinical records.

6.0 TERMS OF REFERENCE

NHS London has commissioned this independent investigation with the full co-operation of South London and Maudsley NHS Foundation Trust ('the Trust') and Lambeth PCT.

It is commissioned in accordance with guidance published by the Department of Health in circular 'HSG (94) 27: The discharge of mentally disordered people and their continuing care in the community' and the updated paragraphs 33 – 36 issued in June 2005.

6.1 Background

Mr R was under the care of the forensic service in the Trust, and temporarily an in-patient in Oliver Ward at King's College Hospital when he absconded. After his return to prison he was charged with the murder of a pensioner in Great Yarmouth.

6.2 Terms of Reference

The aim of the independent investigation is to evaluate the mental health care and treatment of Mr R and to identify any contributory factors to the homicide and to learn appropriate lessons. The investigation will be undertaken by a team of people with the relevant expertise, approved by NHS London. If more specialist advice, such as legal implications etc, is required this will be negotiated separately with NHS London. The work will include a review of key issues identified and focus on learning lessons. Where appropriate recommendations based on best practice in mental health care will be made.

The investigation team will:

1. *Investigate and review the mental health care and treatment provided by the Trust to Mr R from his first contact to the time of the offence and the suitability of that care in view of Mr R's assessed health and clinical diagnosis.*
2. *Complete a chronology of the events to assist in the identification of any care and service delivery problems leading up to the incident[2].*
3. *Examine the extent and adequacy of collaboration and communication between the health and criminal justice agencies that were involved with Mr R.*
4. *Assess the adequacy of risk assessment and management processes in relation to Mr R and actions consequent upon the assessments(s).*
5. *Examine the nursing and medical leadership and management associated with Mr R's care and treatment.*
6. *Review the extent to which Trust services adhered to statutory obligations, relevant national guidance and local operation policies including the Mental Health Act 1983 and amendments in the Mental Health Act 2007.*
7. *Review the Trust's internal investigation and assess the adequacy of its findings and recommendations and the progress made in their implementation.*
8. *Make clear, sustainable and targeted recommendations based on the contributory factors or root causes of the events leading up to the homicide and aimed at ensuring that any lessons are learned, acted upon and shared.*
9. *To ensure that any action plan and recommendations take full account of the progress that the Trust and other agencies involved in Mr R's care have made since the completion of the internal investigation report.*
10. *To consider such other matters relating to this case as the public interest may require.*

[2] In this investigation the 'incident' referred to and the subject of this investigation is the absconsion from Trundle Ward, King's College Hospital on the 15th February 2008. The investigation team have limited themselves to the care and treatment of Mr R up to the point of absconsion, because subsequent events are not certain until he was recaptured in Great Yarmouth, and also because the police investigation dealing with the murder of Mr Q has been completed, resulting in the conviction of Mr R.

11. *To provide a written report including recommendations specific to the care and treatment of Mr R to NHS London and the agencies that were involved in his health and social care.*

6.3 Approach

The investigation team will provide the necessary services to ensure the effective co-ordination and delivery of the independent investigation.
The investigation team will conduct its work in private and will take as its starting point the Trust internal investigation supplemented as necessary by access to source documents and interviews with key staff as determined by the team.

As well as key staff, the investigation team is encouraged to engage actively with the relatives of the victim and Mr R so as to help ensure that as far as possible, the investigation is informed by a thorough understanding of the incident from the perspective of those directly affected, and will provide appropriate support to relatives throughout the investigation process.

The investigation team will follow established good practice in the conduct of interviews, for example, offering the opportunity for interviewees to be accompanied and be able to comment of the factual accuracy of their transcript of evidence.

If the investigation team identify a serious cause for concern, this will immediately be notified to NHS London.

6.4 Publication

The outcome of the investigation will be made public. NHS London will determine the nature and form of publication. The decision on publication will take into account the views of the chair of the investigation team, those directly involved in the incident and other interested parties. The published report will comply with the NHS London anonymisation policy.

6.5 Timescales

The investigation team will complete its investigation within six months of starting work. The six months will start once the team is appointed in full, written consent has been received for the release of Mr R's records and sufficient documents are available to the team for interviews to start. The chair of the investigation team and the investigation manager will discuss any delay to the timetable with NHS London and will also identify and report any difficulties with meeting any of the terms of reference to NHS London. A monthly progress report will be provided to NHS London along with a bi-monthly detailed update report suitable for all stakeholders.

7.0 THE INDEPENDENT INVESTIGATION TEAM

This Investigation was undertaken by the following team of healthcare professionals who are independent of the healthcare services provided by South London and Maudsley NHS Foundation Trust:

Dr Geoff Roberts	Chair of the investigation team, HMAD Coroner Cheshire, Director of Geoff Roberts Associates Ltd
Mr Nick Moor	Investigation Manager and Report Author, Director of Niche Health & Social Care Consulting Ltd
Ms Cathe Gaskell	Independent Nurse Consultant, Director of The Results Company
Dr Sherine Mikhail	Consultant Forensic Psychiatrist

Independent legal advice to the investigation team

Ms Kiran Bhogal	Partner, Weightmans Solicitor

8.0 INVESTIGATION METHODOLOGY

This investigation follows National Guidance[3]. The investigation commenced on the 4th April 2011.

8.1 Communication with Victims Family

As far as we were able to ascertain, Mr Q has no living relatives in this country. We were made aware of a sibling living in the United States by Norfolk Police, and we have corresponded with them over the course of the investigation. The sibling indicated while they considered the matter closed, they were willing to discuss any aspect of the case if it would be of help to the investigation.

8.2 Consent

Consent to access his medical records was not provided by Mr R. Therefore 'Caldicott Consent' was obtained by NHS London from the South London and Maudsley NHS Foundation Trust[4].

[3] National Patient Safety Agency. "*Good Practice Guide for Independent Investigations of Serious Patient Safety Incidents in Mental Health*" (2008)

[4] Where consent is not available personal data can be processed pursuant to section 31 of the Data Protection Act (1998) (in the public interest) and Article 8(2) of the European Convention on Human Rights, incorporated into the Human Rights Act (1998) (where disclosure is in accordance with the law and is necessary in a democratic society for public safety, for the protection and of the rights and freedom of others).

8.3 Communication with the Perpetrator and the Perpetrator's Family

Mr R declined to participate in this investigation. We attempted to contact him on three separate occasions in writing via solicitors and through HM Prison Service.

No contact details of next of kin were recorded in the ePJS electronic notes. Despite writing to Merseyside Probation Trust where Mr R had had previous contact, we were unable to establish contact with Mr R's family and so, at the request of the Strategic Health Authority, have not pursued this further.

8.4 Witnesses called by the Investigation Team

The team interviewed the staff involved making reference to the National Patient Safety Agency *Investigation Interview guidance.*[5] The list of staff titles of those interviewed is detailed in the appendices. Niche Health & Social Care Consulting adheres to the Salmon Principles[6] in all investigations. The investigation team had access to the police statements via the Metropolitan Police, taken at the time of the absconsion in 2008. The investigation team considered all those statements and other information supplied by the police in so far as they were relevant to the care and treatment of Mr R and this investigation.

Thirty people who had been involved with the care and treatment of Mr R or the management and commissioning of the Dangerous and Severe Personality Disorder (DSPD) pilot service were invited for interview in this investigation. Three of these were the Agency nurses involved in the escort on the morning of the 15th February 2008; of these one explicitly refused to attend and the other two did not attend for interview. We are disappointed that these three did not attend for interview. This falls far short of any professional accountability. They no doubt may have had valuable information to help this investigation. One further person invited had moved on and the investigation team were unable to contact them. Twenty six people were interviewed. Every interview was recorded and transcribed and all the interviewees had the opportunity to check the factual accuracy of the transcripts and to add to or clarify what they had said.

In addition to this, the investigation team met or corresponded with eight other people to help us understand better the circumstances around the nature of the arrest of Mr R in Great Yarmouth, the application of the Mental Health Act in 2008 within the Trust, commissioning arrangements for the Dangerous and Severe Personality Disorder pilot, and work taken to implement the action plan arising from the Trust Internal Investigation and Board Level Inquiry since the incident.

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[5] National Patient Safety Agency, National Reporting and Learning Service. *"Root Cause Analysis Investigation Tools: Investigation Interview guidance"* (2008)

[6] The '*Salmon Process'* is used by a public Inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1996 Royal Commission on Tribunals of Inquiry whose report, amongst other things, set out principles of fairness to which public inquiries should seek to adhere.

8.5 Investigation Team Meetings

The investigation team met on a total of nine occasions:

April 8th 2011	Initial investigation team meeting
May 12th 2011	Site visit to Tony Hillis Unit, Maudsley Hospital; Oliver Ward, King's College Hospital; Wadden Ward, River House, Bethlem Royal Hospital
June 10th 2011	Interview day
June 16th 2011	Interview day
June 17th 2011	Interview day
June 23rd 2011	Interview day
June 24th 2011	Interview day
August 25th 2011	Interview day
November 25th 2011	Meeting with South London and Maudsley NHS Foundation Trust Board

Throughout the investigation, the investigation team were in regular communication with each other and worked on specific areas of the investigation relevant to their areas of expertise.

8.6 Root Cause Analysis

This report was written with reference to the National Patient Safety Agency (NPSA) guidance[7]. The methodology used to analyse the information gathered was by the use of Root Cause Analysis (RCA). Root Cause Analysis is a retrospective multi-disciplinary approach designed to identify the sequence of events that led to an incident. It is a systematic way of conducting an investigation that looks beyond individuals and seeks to understand the underlying system features and the environmental context in which the incident happened[8]. The Fish Bone analysis was used to assist in identifying the influencing factors which led to the incident. This is presented in Section 17.

The Trust's Serious Untoward Incident report was benchmarked against the National Patient Safety Agency's '*investigation credibility & thoroughness criteria*'[9] and the results analysed.

[7] National Patient Safety Agency. "*Good Practice Guide for Independent Investigations of Serious Patient Safety Incidents in Mental Health*" (2008)
[8] National Patient Safety Agency. "*Good Practice Guide for Independent Investigations of Serious Patient Safety Incidents in Mental Health*", p38, (2008)
[9] National Patient Safety Agency. "*RCA investigation: evaluation, checklist, tracking and learning log*" (2008) <http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60183&type=full&servicetype=Attachment>

9.0 SOURCES OF INFORMATION

The investigation team considered a vast and diverse range of information during the course of the investigation. This included (but is not limited to) the clinical records for Mr R held by South London and Maudsley NHS Foundation Trust and the Spinney Medium Secure Unit (Independent Psychiatric Hospital in Greater Manchester), the Trust's internal investigation report[10], Board Level Inquiry[11] and Review of Incident[12] interview notes, police witness statements, current and past South London and Maudsley NHS Foundation Trust policies and procedures and internal performance management information.

The investigation team consulted policies, strategy documents and circulars on the Dangerous and Severe Personality Programme, Medium Secure Care, and the management of risk from the Department of Health. It took into account the recommendations of the Fallon Inquiry regarding the management of Forensic Personality Disorder services[13]. In addition, the investigation team referred to journal articles on the management of risk, absconding and the care of people with dangerous and severe personality disorders. A complete bibliography is provided in the appendices.

[10] *Investigation Report into the Absconding of a Schedule 1 Offender on 15 February 2008, Whilst on Emergency Admission into King's College Hospital from a Trust Medium Secure Unit*
[11] Board Level Inquiry Mr R; 28th June 2008
[12] Review of incident involving Mr R; March 2008
[13] His Honour Peter Fallon QC, Professor Robert Bluglass CBE, Professor Brian Edwards CBE, Mr Granville Daniels (1999) "*Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital";* The Stationary Office.<http://www.archive.official-documents.co.uk/document/cm41/4194/4194.htm>

10. CHRONOLOGY

Background and early life

The following information has been gleaned from clinical notes, assessments and reports from Mr R's clinical records.

Mr R was born on the 21st of December 1971 in Liverpool. His mother became pregnant with him allegedly following a rape. His father was of African Caribbean origin. His mother remarried before his birth and he was treated very badly by his stepfather and subjected to frequent beatings. His mother suffered from long term mental health problems. Her illness and the abuse from his stepfather resulted in Mr R spending extended periods of time in Local Authority care. He told staff in prison he was assessed by a child psychologist and also for a special school on account of his behaviour. Although he was the only black member of the family, the family suffered persistent racial abuse from local people which required them to move on several occasions.

Mr R has a history of drug abuse, admitting to using cannabis from age 14, and heroin, amphetamines, ecstasy and LSD from the age of 22. He admitted that by the age of 23 he was using as much crack cocaine as he could afford. He admitted to using steroids when working as a doorman.

He has seven siblings, two of whom are known to have had serious involvement with the criminal justice system; one brother had been convicted of murder.

He regularly truanted from school and left at the age of 14 with no qualifications. His goal was to earn a living in the music business. His longest period of continuous employment was just under a year during which he worked as a doorman. Outside that brief period, he held only low grade and short term work as a labourer or busking.

He is reported to have had three major relationships in his life. He has a child from an earlier relationship, but he has had no contact with the child since the child was 2 years old. He had a brief marriage in 1995, and had a second child by this marriage, which he claimed to have not seen. His wife and child left the country in 1996. It is not known if they are divorced. He met his recent girlfriend of over 10 years when she worked for a prisoner befriending charity. She was described as his partner and girlfriend up to his second absconsion in 2008.

Criminal History

Prison service reports and clinical notes indicate that he had a history of non-convicted violence from an early age. He has a substantial list of previous convictions including burglary, theft and many other non-convicted charges. In 1989 he received

15 months youth custody for blackmail and was released in 1990. In September 1991, he received a 57 month sentence for offences of robbery, carrying an imitation firearm with intent to resist arrest and for Unlawful Sexual Intercourse with a girl under 16 years and was sent to youth custody again.

During his time in youth custody he absconded from his community service volunteer project. He returned to the Young Offenders Institute and set fire to the car of a female psychologist[14]. In a later interview he went on to say that she was "*inconsiderate*" in psychological groups and that "*she got a lot of stuff out and never put back*". He added that had he seen her he would have shot her[15].

In May 1996 he was convicted of Rape, False Imprisonment and Robbery and sentenced to life imprisonment on 21st June 1996. Mr R had threatened the male and female victims with a bayonet, as he believed the female victim had told his partner of his continued drug use. He later reported that he had used the rape as a punishment and way of having power over the victims. He then stole money from them. After the rape took place, Mr R drove around with the victims to buy crack cocaine. Despite being stopped twice that day (once for motoring matters, and once for an accident for which Mr R was arrested and taken to the police station), the victims did not disclose what was happening to the police. Police records note that Mr R had threatened the victims to prevent them disclosing what had happened. On his release from the police station, Mr R permitted the female victim to go home. The next day, she informed her brother of the incident. The police were called, and Mr R was subsequently arrested and convicted.

In September 1996 he was noted to have developed sexually aggressive feelings towards a female psychologist in HMP Brixton which was recorded on his Inmate Medical Record. Apparently he is reported to have told the psychologist who was wearing 'skimpy clothing' that "*if I were you I wouldn't come on the wing like that, someone may rape you"*[16]*.*

In 1998 he was adjudicated[17] for repeated threats against a female teacher in prison. There is no record he had assaulted this female member of staff whilst in prison.

[14] In an HM Prison Service Psychology Report it is stated that he left the prison without permission for a period of one year, and that although he was involved in the incident and present at the time of the firebombing, he stated he did not know who the car belonged to.

[15] Source: Confidential Psychiatric Report from Broadmoor Hospital Authority 31st January 1997

[16] Source: Structured Assessment of Risk and Need, Sex Offender Treatment Programme reports; September 2006 – July 2007. HM Prison Service

[17] Adjudication is the process of disciplinary hearings held within the prison system. They occur when there has been a breach of prison rules by prisoners, and the outcome can be a range of sanctions against the prisoner. Breaches of prison rules specifically refer to behaviours defined within Rule 51, The Prison Rules (1999). Statutory Instrument 1999 No. 728.

Medical and Psychiatric History

Mr R claimed that in 1989[18], he took an overdose of Prothiaden (an anti-depressant) which resulted in an admission to Sefton General Hospital and two outpatient appointments but did not remain in contact with the service.

In 1995 he saw a drug counsellor at the Scutari Psychiatric outpatient clinic at St Thomas' Hospital for a period of two months at the direction of an Inner London court.

He had a history of self harm which included cutting his arms with razors. This behaviour appeared to have ceased in 1996 after he apparently promised his mother that he would stop.

In June 1996, Mr R was assessed by a Forensic Psychiatrist for a pre-sentencing report[19] following his conviction for Rape, False Imprisonment and Robbery. He was diagnosed with both personality disorder and psychopathic disorder. At the time of the diagnosis it was thought that he was potentially treatable but would require a prolonged assessment and that the treatment for his personality disorder would need to be carried out under conditions of maximum security. It was felt that without appropriate treatment he would remain a danger to the public for the foreseeable future.

Mr R was referred to Broadmoor Hospital for assessment for transfer and was interviewed by Consultant Forensic Psychiatrist 2 from Broadmoor Hospital in early January 1997. He was not thought to have a mental illness. It was felt that he didn't warrant transfer to a maximum security hospital, but if there was to be sustained and consistent change in his desire to seek treatment, he could be reassessed with a view to a future possible transfer under the Mental Health Act 1983[20].

He was reassessed in March 1999 by the same Forensic Psychiatrist[21]and the recommendation was that he continues to receive treatment within the prison system. There was thought to be no clear advantage to transfer to Hospital. Moreover, there was a waiting list for transfer to Broadmoor that included patients in more urgent need of treatment than Mr R. However, it was noted that he would be reassessed if he were to encounter serious difficulties whilst in the treatment programme or develop a mental illness. He was diagnosed with Hepatitis C in 1998.

In 2003 he suffered a full cardiac arrest whilst in HMP Grendon. He was resuscitated and the resulting heart condition necessitated insertion of a stent and left him with cardiac problems requiring ongoing medical monitoring.

[18] Source: Psychiatric Report by Forensic Consultant Psychiatrist 1, 1996 and Post Sentence Report, December 1997, Inner London Probation Service.
[19] Psychiatric Report prepared by Consultant Forensic Psychiatrist 1 from North West London Forensic Service
[20] Broadmoor Hospital Psychiatric Report 31/01/1997
[21] Broadmoor Hospital Psychiatric Report 16/03/1999

Because of his physical health problems, Mr R was later transferred to HMP Albany due to its close proximity to a general hospital. There he underwent further treatment for substance misuse and anger management. However, treatment options at the prison were limited and he was aware that he would not be considered for parole until he had completed enough treatment.

January 2005

Mr R was referred to Forensic Intensive Psychological Treatment Service (FIPTS) at Tony Hillis Unit, Lambeth Hospital by the Mental Health In-reach Team at HMP Albany

21st March 2005

Mr R was assessed by Specialist Registrar 1 in HMP Albany

5th April 2005

Mr R assessed by Dr E, Clinical Psychologist and the Practice Development Nurse. Both this assessment and the previous assessment on the 21st of March recommended admission for a three month period of further assessment. Following discussion in the multi-disciplinary referrals meeting, it was agreed that Mr R be admitted[22].

29th June 2005

Mr R transferred from HMP Albany under S47/49 of the Mental Health Act 1983 to the Tony Hillis Unit, FIPTS, at Lambeth Hospital. He was escorted by four wardens. At that point in time he had served 9 years of his prison sentence and had been referred to the unit for treatment of his personality disorder and to reduce his risk of violence.

Early August 2005

Mr R was reviewed by the cardiology team at St Thomas' Hospital and had a repeat angiogram. The tests revealed a patent stent and clear arteries. He was given a clean bill of health and told he could live life as normal. Mr R was reported to be shocked at the news as it meant he could exercise without restriction. He began a fitness programme with the sports therapist.

In September he was introduced to the Violence Reduction Programme (VRP) by the psychosocial therapist and given the manual to read. It was reported he was unhappy about the delays in starting the programme and complained that he had been promised VRP but the promise had not been delivered. It was noted that although there were no episodes of physical violence, he could be intimidating at times and was very confrontational. He was often involved in altercations and had verbally aggressive outbursts and flashes of anger.

[22] Letter from Specialist Registrar 1

Mr R continued to attend the appropriate sessions, but during a ward round, shortly after a confrontation he was observed to be splitting[23] and distorting discussions he had had with staff, appeared controlling and to be externalising blame.

11th October 2005

He is noted to have been complaining of chest pains during the night and was escorted to A&E at King's College Hospital but returned to THU after tests.

15th October 2005

Complained again of chest pains during the night and was escorted to A&E at King's College Hospital. On this occasion he was admitted overnight for a full cardiac assessment. The results were normal and Mr R was returned to THU the following day with the advice to pursue cardiac rehabilitation.

26th October 2005

While discussing the VRP with Dr E, Clinical Psychologist and VRP lead Clinician, Mr R became enraged at a comment he perceived to be an insult and threatened to hit Dr E. Later that same night, at around midnight, he asked to see the duty doctor, complaining of chest pains and associated sweating and vomiting. He was sent to A&E at King's College Hospital with two escorts by an ambulance. He did not wait to be examined and instead signed a self discharge disclaimer.

27th October 2005

While waiting for transport back to THU, Mr R absconded in the early hours of the morning ("the first absconsion").

7th November 2005

Mr R turned himself in to the police in Manchester. There were no reports of him having committed any crimes during the time he was absent from the unit. Shortly after turning himself in, he complained of chest pain and was escorted by officers to Manchester Royal Infirmary for assessment.

9th November 2005

In a discharge summary letter to the Home Office, Consultant Forensic Psychiatrist 3 (Mr R's Responsible Medical Officer or RMO) noted that on two previous occasions Mr R had experienced chest pains following being challenged. He stated that there was a concern within the FIPT service that the VRP was a programme that involved patients being challenged and therefore if Mr R was to participate in this programme, it would need to take place in conditions of high security.

10th November 2005

Mr R was admitted to the Spinney Medium Secure Unit in Greater Manchester.

[23] From the Concise Medical Dictionary: 'splitting' is a defence mechanism by which people deal with an emotional conflict by viewing some people as all good and others as all bad: they fail to integrate themselves or other people into complex but coherent images

20th December 2005

Mr R was assessed at the Spinney Medium Secure Unit, Atherton, Greater Manchester by a team ("the multi-disciplinary team") from FIPTS[24]. Mr R stated that while he had faked chest pain in order to go to hospital, he had not intended to abscond. He said that he felt humiliated before his partner during his interview with Dr E on the day he had absconded. The assessing Specialist Registrar observed that he appeared very affected by the lack of support from his family (his mother had contacted the Police) and by the fact that many of his peers were either dead or in prison. Mr R claimed that he had reached something of a turning point in his life through the realisation that his previous antisocial lifestyle was no longer an option for him. He acknowledged that he had to complete offending behaviour work in order to progress and retain any possibility of a normal life in the future.

Given his recent absconsion and his particular personality pathology (e.g. the prominence of deceitfulness and impression management identified in his PCL-R[25] assessment) the multi-disciplinary team agreed to review his suitability for admission to the THU following evidence of behavioural change to support his stated intention to engage. He was returned to prison with the recommendation that he complete the Enhanced Thinking Skills ("ETS") programme and to be reviewed after completion. Mr R remained on the FIPTS referral list as a patient with ongoing contact and was discussed on a weekly basis in the FIPTS referral meeting. Over the coming year, he also wrote to Specialist Registrar 1, and persuaded his girlfriend to correspond on his behalf, to ask for an update regarding his possible readmission to the THU.

22nd December 2005

Mr R returned to prison.

3rd July 2006

Mr R completed the ETS programme, and received excellent feedback from the facilitators. His progress was discussed in the FIPTS referral meeting and in view of the Home Office's recommendation that changes to the physical security of the Unit should be made before he could return and the likely timescale given for these changes to take place, the team recommended that Mr R complete the Core Sexual Offender Treatment Programme (SOTP).

28th July 2006

Mr R was assessed by a Chartered Forensic Psychologist, whose report recommended that should he be assessed suitable, Mr R should first participate in and successfully complete the Core SOTP during which the group facilitators would be able to make recommendations regarding the most appropriate means of addressing further issues relating to violence.

[24] Assessment team comprising of Specialist Registrar 1, Practice Development Nurse and Dr E (Clinical Psychologist and VRP Lead Clinician)

[25] Psychopathy Checklist-Revised (PCL-R) is the psycho-diagnostic tool commonly used to assess psychopathy

23rd August 2007

Specialist Registrar 1 had become Consultant Forensic Psychiatrist (4) on the unit and would become Mr R's Responsible Medical Officer. He attended Mr R's SOTP Post Programme Progress Review at HMP Albany with Community Psychiatric Nurse 1. Again he received very positive feedback on his engagement and progress.

It was recommended that Mr R be transferred to THU so that the focus of treatment might be shifted to his personality pathology. After discussing his progress in the FIPTS referral meeting, it was decided that he would be offered admission for a three month assessment once the recommended changes to the physical security of the building had been completed. Following his completion of the ETS programme, a provisional decision was made to readmit him pending implementation of the recommendations made by the Home Office and Ministry of Justice following his absconsion in October 2005.

Comment:

In much of the information and correspondence following the second absconsion, including the Internal Investigation, the Board Level Inquiry and the internal review[26], there is frequent mention of requirements placed on the service by the Home Office (the responsibility now lies with the Ministry of Justice) in order for Mr R to be readmitted to the THU. The MoJ holds no evidence of any conditions placed upon FIPT service in order to readmit Mr R to the Tony Hillis Unit. Mr R's case file contains no correspondence between the MoJ and the Trust from 3rd November 2005 up to the 4th of December 2007, when the Secretary of State directed his transfer from prison back to the THU under warrant (see Appendices). This is corroborated within the interview with Consultant Forensic Psychiatrist 4.

The investigation team have therefore concluded that the conditions referred to are therefore more likely to do with the general security requirements of a medium secure unit and referred to as general requirements as identified in *'Best Practice Guidance: Specification for adult medium-secure services' (2007).*[27]

When the Clinical Co-ordinator from the THU confirmed that the requisite security conditions had been met, arrangements were made to transfer Mr R to the THU. In the intervening period, Mr R was reviewed in HMP Albany where he had kept up his progress and had completed the Core SOTP. The Clinical Director, Consultant Forensic Psychiatrist 3, participated in the meeting and was supportive of the decision to readmit Mr R to the THU.

[26] See footnotes 10, 11, and 12 for the titles of three documents considered as Internal Investigation, Board Level Inquiry, and Internal Review

[27] Department of Health and Health Offender Partnerships. "*Best Practice Guidance: Specification for adult medium-secure services*" (2007)

3rd December

A handwritten file entry in the MoJ Caseworker file notes a phone conversation with the Deputy Ward Manager from the THU and an assurance that "*should Mr R become ill and require outside hospital treatment he will be taken out handcuffed".*

Comment:

Though aspects of this conversation were recalled by the Deputy Ward Manager and it was agreed a conversation did take place, the assurance given about handcuffs was denied and the investigation team have not been able to corroborate the noted conversation.

4th December 2007

MoJ issued a warrant for Mr R's transfer to THU.[28]

6th December 2007

Mr R was admitted to THU from HMP Albany under S47/49 of the Mental Health Act 1983 to receive treatment for a personality disorder. This was his second admission. He settled in quickly saying he was glad to be back and apologising for absconding previously. He became involved in groups and engaged in treatment plans but was soon noted to be pushing boundaries.

10th December 2007

When Mr R was admitted to the THU, a meeting of senior medical, psychology, nursing and occupational therapy staff was called to review the Forensic Medical Emergency Policy, to assess his absconsion risk and to develop an absconsion risk management plan for him. The consequences of his absconding were considered; it was noted that he had not offended while absent without leave in 2005 and that the Structured Assessment of Risk and Need (SARN) had given him a score of moderate risk of reoffending. Because of the positive factors mitigating absconsion, the team concluded that he was at moderate risk of absconsion.

Comment:

Throughout this investigation and the Trust's internal investigation, reference is made of the *'Structured Assessment of Risk and Need'* (SARN), using the Risk Matrix 2000 which assessed him as being at medium risk of sexual reoffending. This assessment was completed on 21st September 2006.

However upon completion of the SOTP, the SOTP was incorporated into a wider Structured Assessment of Risk and Need (Sexual Offending) date 9th August 2007. This clearly identifies that although Mr R was assessed as being medium risk for sexual reoffending, he was assessed as <u>high risk</u> <u>for future violent reconviction</u> and <u>high risk for combined risk of future violent or sexual reconviction</u>. This was not noted or reflected in subsequent actions.

[28] Ministry of Justice 'Transfer Direction In Respect Of Person Serving a Sentence', MoJ reference MNP 2/14542, SLAM notes, Volume 2.

The investigation team also noted that the Procedure for the Management of Medical Emergencies in Medium & Low Secure Services initiated on 22nd February after Mr R's second admission has general categories of low medium or high risk of absconsion, violence or self harm as part of the risk assessment section. These should not be combined, as the risk of absconsion is quite separate to the risk of harm.

However, the investigation team notes that the updated policy '*Policy for Patient Leave of Absence, Conveyance & Escorting in Medium & Low Secure Services*' (dated May 2009) is a much clearer and thorough document as it contains more detailed and comprehensive procedures to be carried out before escorting a patient to other services, and the risks of harm and absconsion are separated.

As Mr R had stated that he had faked his chest pain prior to his previous absconsion, a medical plan was devised to manage the complaints of chest pains by Mr R. The plan was circulated to all duty doctors covering THU. A nursing care plan was also written outlining the procedure should Mr R complain of chest pain. In addition, a recent photograph of Mr R was placed on the file and a list of those to be contacted in the event of him complaining of chest pain was updated. The investigation is aware from correspondence and interviews that such a meeting took place.

31st December 2007

Mr R's progress on VRP was discussed during a ward round and he asked if he could have a parole hearing in 2009.

1st January 2008

Mr R complained of chest pains and was seen by the doctor on duty. He was advised to use GTN (Spray) should he experience further pain. Mr R refused to provide a urine specimen for a random Urine Drug Screen (UDS) as he said he had smoked cannabis in prison and therefore it would be positive.

11th January 2008

He refused to provide a Urine Drug Screen (UDS) and became very confrontational with the staff concerned (Registered Mental Nurse (RMN) 1), refusing to let them supervise him. In his review by the SHO the following week he admitted that he knew it would be positive and that his previous excuse would not be plausible.

14th January 2008

Mr R spoke with another member of staff regarding his altercation with RMN 1. He stated that he wanted to resolve the situation, but the member of staff was not willing. He complained that the unit was not supporting him.

15th January 2008

The caseworker from the MoJ wrote to Mr R, informing him of the provisions of the Mental Health Act 1983 under which he was being detained in hospital, the effect of those provisions and his rights of application to the Mental Health Review Tribunal.

17th January 2008

Mr R spoke with Deputy Ward Manager 1, wanting to talk about the UDS incident with RMN 1. He stated the nurse had invaded his personal space and that had brought back memories of his childhood. He did not want to try to speak with the nurse concerned and try to resolve the issue, as the nurse had left it too long. He went on to say "*I hate the guy I want to punch his face in*". In the end, he met with the nurse concerned under the mediation of the Deputy Ward Manager 1, and they parted in a civil manner.

Early February 2008

Mr R seemed to settle down but maintained he needed therapy for Post Traumatic Stress Disorder (PTSD). He attended his music and cooking groups and chaired the community meetings. He continued to get angry quickly and often complained that the staff were not supporting him, expressing concern that he would have to go back to prison and disagreeing with his diagnoses.

7thFebruary 2008 2030 hrs

Mr R reported that he had an "issue" with a Registered Mental Nurse (RMN 1) who had asked him for the UDS.

9th February 2008

Mr R complained of chest pains at 2110 hrs. He vomited in front of staff and was seen by the duty Senior House Officer. They then discussed the situation with Consultant Forensic Psychiatrist 4 (Mr R's RMO) who recommended an emergency admission to Accident and Emergency department (A&E) at King's College Hospital with two nurse escorts and advised the staff to inform the police and KCH security. King's College Hospital A&E were contacted and they advised of the transfer under blue light ambulance. The Sister was informed that Mr R was a high risk offender and she is noted to have said she would inform security. The Home Office duty officer was also informed of the transfer. Following admission to A&E, Mr R was examined by a cardiologist who was of the opinion that he should be hospitalised for a minimum of 5 days.

10th February 2008

At 0722 hrs Mr R was transferred to Trundel Ward 2nd Floor Cheyne Wing where he was to be kept under close observation by 1 Registered Mental Nurse (RMN) and 1 Health Care Assistant (HCA), escorts provided by the THU.

13th February 2008

Mr R was discharged back to Tony Hillis Unit

14th February 2008

In the early hours of the morning, Mr R complained of central chest tightness radiating to his left arm with associated nausea and feeling 'hot'. He was given oxygen and staff called for an emergency ambulance. His RMO and the Home Office were informed. He was to be accompanied by 2 members of staff (the escorting

nurses) with a brief referral letter to King's College Hospital A&E Department. According to the notes, the A&E Department were informed and expecting him and knew the police and Home Office needed to be informed in the event of him absconding. Upon arrival at THU, the paramedics did not find anything serious but advised a precautionary transfer to A&E for tests given his previous history.

He was admitted overnight to Oliver Ward ("the ward") at King's College Hospital. Nursing staff confirmed that he refused to take the prescribed GTN infusion. Mr R reportedly spent much time in other areas of the hospital; the canteen, shops and the smoking cabin in front of the Hambledon wing.

Comment
Mr R was a patient detained under Sections 47/49 of the Mental Health Act 1983. This meant his movements and contact with the public were intended to be restricted by the Home Office. It appears these restrictions were not enforced whilst in King's College Hospital, as he was allowed unrestricted access to visitors, the canteen and the smoking area of King's College Hospital.

It was later reported that he had access to the mobile phones that were meant for the escorting nurses to use to contact the THU for advice on his handling. Records indicate that he made 20 calls to his partner while at King's College Hospital. According to the escorts he was informed of his imminent discharge at 1100 hrs on the 15th February. He became very agitated and argumentative and requested a specialist and second opinion on his condition and fitness for discharge. He was seen by the Cardiologist at around 1245 hrs, who confirmed he was to be discharged. Between 1100 hrs and 1300 hrs he used the THU supplied mobile phone four times; making two calls to his partner and receiving two from his partner. Mr R reportedly went in and out of the ward to use the smoking cabin three times. On the third occasion he met and conversed with a lady he claimed was the wife of a man he knew from prison.

Escorting nurses reported that after this lady left the smoking cabin, he walked away from the Hospital towards Caldecott Road and then onto Cold Harbour Lane and absconded ("the second absconsion"). They initially stated that they had challenged him but he threatened them and told them to stay away. They stated that they did not give chase as they did not consider restraint to be possible. They reported that they telephoned 999 and were put through to the Brixton police.

However, the subsequent police investigation and CCTV footage contradict the statements of the escorting nurses. The CCTV footage shows Mr R walking unaccompanied down a hospital corridor at 1409 hrs. Telephone records show that the call to 999 was made at 1424 hrs by a junior doctor working on Oliver Ward, and not the escorting nurses.

Comment
The scheduling of Agency nurses to provide escort for Mr R was clearly a factor in his absconsion. Particularly as it was quite clear that Agency nurses were not given access to appropriate induction training and supervision.

This is further underlined by the fact that the escort nurses statements did not correspond with events as identified by the police investigation. It should be noted that one of the escort nurses has subsequently written to the Trust and admitted to fabricating their version of events in their earlier statement to the internal review.

However, the use of Agency and Bank nurses had become common practice on THU, and the underlying problem of significantly high turnover of nursing staff and inadequate consistent clinical leadership within a unit that did not fully implement proper governance processes, whilst preparing to transfer the unit to another site, lie at the real root causes of this incident.

17th April 2008
Mr R was apprehended in Norfolk. He was later questioned about the murder of Mr Q and was subsequently arrested and charged with his murder.

Consultant Forensic Psychiatrist 4 wrote to the Ministry of Justice notifying them that, in his view, Mr R could no longer be provided with effective treatment within a hospital setting and to request that he be returned to prison.

22nd April 2008
Ministry of Justice issued a warrant of remission to return Mr R to prison.[29]

11.0 REVIEW OF THE MENTAL HEALTH CARE AND TREATMENT PROVIDED BY THE TRUST TO MR R FROM HIS FIRST CONTACT TO THE TIME OF THE OFFENCE AND THE SUITABILITY OF THAT CARE IN VIEW OF MR R'S ASSESSED HEALTH AND CLINICAL DIAGNOSIS.

The investigation team heard and reviewed written evidence that Mr R had a primary diagnosis of a Personality Disorder with a co-morbid substance misuse disorder and possible post-traumatic stress disorder.

Personality disorder is a recognised mental disorder, but an underdeveloped area of mental health care. It affects many people in society, most of whom do not commit offences. For some, however, it significantly contributes to offending and risk related behaviours. Approximately two-thirds of prisoners meet the criteria for at least one type of personality disorder[30].

[29] MoJ warrant of remission-SLAM notes volume 2,page 3
[30] Stewart, D. "*The problems and needs of newly sentenced prisoners: results from a national survey*", Ministry of Justice Research. Series 16/08. London: Ministry of Justice (2008)
Singleton, N., Meltzer, H. and Gatward, R. "*Psychiatric morbidity among prisoners in England and Wales*", The Stationery Office, London (1998)

For a relatively small number, in its more severe forms, it can be linked to a serious risk of harm to others. These offenders have highly complex psychological needs that create challenges for staff in the NHS and National Offender Management Service (NOMS) in terms of management, treatment and maintaining a safe working environment.

Personality disorder was not much recognised in the 20th century, but this changed after the British government made considerable sums of money available for public protection of 'dangerous people with personality disorder' (now known as Dangerous and Severe Personality Disorder, or DSPD) following the murder of Lin Russell by Michael Stone in 1996.

The National Personality Disorder Development Programme[31] was introduced and ran from 2002 to 2011. It was launched with the publication of "*No Longer a Diagnosis of Exclusion*" to support service development and "*Breaking the Cycle of Rejection*" to set a framework for training and workforce development. According to the programme, people with dangerous and severe personality disorder test boundaries, break rules, challenge authority, have failed in other interventions and persistently re-offend in harmful ways.

In 2004 the THU was set up to run a Dangerous and Severe Personality Disorder (DSPD) programme in line with the pilot services developed under the umbrella of the joint Health Partnership DSPD Programme between the MoJ and DoH. It was known (and is currently known at River House) as FIPTS (Forensic Intensive Psychological Treatment Service). In keeping with the spirit of the DSPD programme it was set up as a research and evaluation programme looking into the treatment of DSPD individuals i.e. a pilot with research as a core part of its remit, and a new service providing treatment for DSPD individuals.

The investigation team heard evidence that patients admitted to the programme were assessed via clinical interview for eligibility and using standardised instruments such as the HCR-20 and PCL-R. On admission they underwent a further 3 month period of assessment using a "minimum dataset", comprising review, updating and completion of risk assessments tools, namely the HCR-20, VRS, Risk Matrix 2000, Static 99, SARN and IPDE. This period was also used as a test of engagement by the patient and motivation to sustain engagement.

These assessments are in line with the recommendations of the April 2008 *'Planning & Delivery Guide for Forensic Personality Disorder, Medium secure and Community Pilot Services'*. In light of his primary diagnosis, and high risk of violence, Mr R was appropriately placed in a DSPD programme, and the programme at the THU was set up to provide the relevant actuarial and structured risk assessment processes. Processes were in place to review his clinical progress via the PTT and ward round meetings (notwithstanding some of the deficiencies in the running of these meetings

[31] Source: National Personality Disorder Programme; <http://www.personalitydisorder.org.uk/about/>

as outlined below). Therapy programmes were available such as the VRP, sex offender group therapy, and therapies to address substance misuse and post-traumatic stress, including individual therapy. There was a community FIPTS service for continuity of care had Mr R successfully progressed to the community from secure in-patient care.

12.0 REVIEW OF THE EXTENT AND ADEQUACY OF COLLABORATION AND COMMUNICATION BETWEEN THE HEALTH AND CRIMINAL JUSTICE AGENCIES

12.1 Commissioning

The Forensic Intensive Psychological Treatment Service (FIPTS) was commissioned as a pilot in April 2004 as part of the national Dangerous and Severe Personality Disorder (DSPD) Programme. The Tony Hillis Unit (now Waddon Ward) is part of the national DSPD programme, which is a unique Department of Health and Ministry of Justice scheme to develop innovative models of service delivery to high risk offenders with a diagnosis of Personality Disorder. The intention of the Programme is to provide such individuals with a therapeutic programme which works with them to reduce recidivism and risk in the future. There are two other similar medium secure units (one other in London and one in Newcastle). There are also pilot projects within the High Secure service and the prison service.

Dangerous offenders whose offending is linked to severe forms of personality disorder present complex challenges to criminal justice and health systems, in terms of meeting mental health needs and for resettlement.

Initial funding came via the national programme, with a high degree of 'hands on' oversight from the national programme. At the time of Mr R's first and second absconsion, oversight and performance management of the DSPD service in THU was retained by the national programme. In April 2008, this commissioning and oversight responsibility was transferred to the London Specialised Commissioning Group, and funding devolved down to local PCTs.

Comment
Despite the regular and in-depth communication and performance management occurring between the commissioners (the national DSPD Programme, London Specialised Commissioning Group and initially Lambeth PCT) and the Trust regarding the Forensic Intensive Psychological Treatment Service (FIPTS), the investigation team formed the view that the picture of the THU, with a very high vacancy rate of nursing staff (and other professions including Psychology and Occupational Therapy), with some key clinical leaders experiencing severe stress and burnout, and key nursing posts being 'acted up to' by lower grade staff, was missed by these external commissioning agencies who could have influenced the decision to admit further patients to the THU.

It is possible that this was because the THU was part of the wider FIPT service, and performance management information regarding the unit and the high vacancy levels was diluted in the wider service information which included a community service with a much more stable team.

Despite several papers on performance management and a Service Level Agreement for the unit, these were clustered tightly around the period 2008, when commissioning responsibility transferred to NHS Lambeth, although a degree of oversight was provided by both London Specialised Commissioning Group and the DSPD Pilot. However, since then, which organisation has responsibility for commissioning, performance management and oversight of the service remains unclear.

Recommendation 1. Commissioning Roles
We recommend that within 3 months of the publication of this report, NHS Lambeth, London Specialised Commissioning Group, and the national DSPD Programme clarify roles and responsibilities for the funding, performance management, oversight and commissioning of this service.

12.2 The extent and adequacy of collaboration and communication between healthcare agencies

Despite the earlier internal investigation following the 2005 absconsion[32] recommending that the THU establish a working relationship with King's College Security service this did not happen. The requirement to communicate the nature of risk for Mr R at the time of second absconsion had been devolved to lower grade nursing staff working on the THU at the time. There were no clear processes for planning and preparing for such an occasion.

The internal investigation recommended that in the updated action plan, the Trust "*Use the work developed between King's and SIaM as the basis for discussions with other acute hospital providers.*[33]" The updated action plan recommends that "*Discussions to take place with Mayday Hospital to develop a similar protocol between the Medium Secure Services and Mayday Hospital – To be completed by the end of February 2009*"

The investigation team have seen evidence that communication and planning between King's College Hospital and South London and Maudsley NHS Foundation increased substantially after Mr R absconded on 15th February 2008. This has been borne out by witness statements, minutes of joint agency meetings and development of policies and procedures.

[32] Local Management Inquiry - Part 1: Date of Incident 27/10/05 Incident Form Number: 65188
[33] Referring to the earlier point regarding the development of Grab Packs.

Although the Trust reports sound working relationships with Mayday Hospital (a part of Croydon Health Service NHS Trust) staff on the ground, these do need to be strengthened at a senior level on an ongoing basis. However, the Trust reports that most transfers for acute healthcare from River House are still to King's College, despite the move to the Bethlem Royal site.

Recommendation 2. Joint working to manage medical emergencies for high risk patients
We recommend that the South London and Maudsley NHS Foundation Trust and Croydon Health Services NHS Trust meet, immediately, to establish sound and collaborative working relationships at a senior operational level, to develop clear, shared, agreed and understood policies for the management of medical emergencies for medium secure patients. These procedures to be tested and reviewed on an ongoing basis to establish safe working.

The investigation team noted that much of the focus of the internal post incident investigations and review had been on the transfer of high risk patients, not the need for continued security whilst they receive in-patient care. Mr R absconded twice, on both occasions whilst waiting for transport to take him back to the unit, not whilst in transit. It is important therefore that future plans incorporate the need for continued security whilst receiving in-patient care and awaiting transfer back to secure care, and not just on transfer.

Recommendation 3. Use of Restraint
Future planning to manage risk needs to consider the need for ongoing physical restraint whilst patients receive treatment in acute hospital, not just during transit. The investigation team note this has now in fact been incorporated in the Trust Policy for Patient Leave of Absence, Conveyance & Escorting in Medium & Low Secure Services.

12.3 The extent & adequacy of collaboration and communication between healthcare agencies, and the Police

Prior to Mr R absconding on 15th February 2008, the Trust relied upon the local police to provide the necessary security, without evidence of their involvement in planning such arrangements. In the 10th February admission, when police support was requested for transfer of Mr R, the Police CAD[34] system recorded discussion that the security arrangements were the responsibility of the prison service, as the patient was a transferred prisoner. In all such events, security arrangements are the responsibility of the NHS Trust providing mental health care to the transferred prisoner.

[34] CAD – Computer Aided Despatch

On the second admission to King's College Hospital on 14th February the Police were called at 0521 hrs and attended A&E at 0606 hrs. Mr R was described as a risk for absconding, and a high risk patient by the nurses in the CAD system records.
After Mr R absconded, and the police were called via 999, communication between the police and the Trust increased significantly. Police were given accurate descriptions, and diligently investigated all reports of sightings. The absconsion was widely reported in the local and national press including the BBC.

The investigation team have seen evidence that communication and planning between Lambeth Borough Police and South London and Maudsley NHS Foundation Trust increased substantially after Mr R absconded on 15th February 2008. This has been borne out by witness statements, minutes of joint agency meetings and development of policies and procedures.

We are also aware of good working relationships between Bromley Police and Bethlem Royal Hospital.

12.4 The extent & adequacy of collaboration & communication between healthcare & criminal justice agencies (MoJ liaison)

The investigation team formed the view that there were misunderstandings between the Home Office and the THU regarding the use of handcuffs during transfer for medical appointments outside the secure perimeter of the THU. A telephone conversation between the Home Office and the THU led the Home Office to believe and document in their records that an assurance to use handcuffs was provided in the event of a medical emergency involving Mr R

Comment
It is the responsibility of the Home Office to seek assurances in writing from the RMO about the use of handcuffs, and to ensure that they are satisfied that the level of security and security measures in place in a hospital are suitable before issuing a transfer direction from prison to hospital. This is noted in Recommendation 1.

Recommendation 4. Communication between Ministry of Justice and Forensic Services
Any future discussions and requirements regarding restrictions placed on prisoners subject to detention under Part III of the Mental Health Act between the Ministry of Justice and Forensic Services should be followed up in writing by the Ministry of Justice.

The Ministry of Justice should correspond in writing with RMOs (RCs) in relation to any aspect of a patient's care, or to follow phone calls with written documentation confirming a conversation, to avoid misunderstandings and discrepancies in care.

13.0 REVIEW OF THE ADEQUACY OF RISK ASSESSMENT AND MANAGEMENT PROCESSES

13.1 Decision to admit a second time

The decision to admit Mr R to the THU in 2005 and 2007 overlooked documented historical information indicating that Mr R had previously absconded from HMYOI Feltham. There was a failure to corroborate and clarify this information further, and to incorporate it into the Historical, Clinical Risk-20 assessments (HCR-20) in 2008. Our interviews revealed that the absconsion from HMYOI Feltham appears to have taken place during a period of community leave from the prison to attend a community service volunteer project, and is reported to have been associated with firebombing of a prison psychologist's car.

Comment
Had this information been extracted from the historical records and examined for accuracy and detail, it might have cast a very different light on his absconsion risk (assessed as moderate in 2007), the risk of offending during an abscond (the team were assured by his apparent lack of offending during his 2005 abscond to feel confident of his risk manageability on readmission in 2007), and his suitability for admission to a medium secure unit in 2008 given a history, by then, of potentially 2 previous absconds.

Recommendation 5. Assessment of patients and use of previous records
We recommend that efforts are always made to obtain all past medical records on patients receiving in-patient treatment. The importance of obtaining past records to reduce the risk of serious incidents repeating should be reinforced.

The timing of Mr R's admission to the THU in 2007 is concerning:

- he was admitted during a period of significant staff shortages that affected both the nursing and psychology disciplines.
- he had missed the opportunity to commence the Violence Reduction Programme (VRP) and would be subject to a delay in starting the next rotation of this, and
- his admission predated a planned move to new, more secure, premises at River House.

Comment
These events appear not to have been factored into the decision to admit Mr R in 2007 and assessed in terms of their likelihood of influencing Mr R's compliance with treatment and manageability. The investigation team heard evidence that his case attracted a considerable amount of discussion, thought and anxiety prior to admission, which combined with previous treatment failure and an abscond in 2005 should have led to a decision to admit once the move had taken place.

Recommendation 6. Timing of future admissions
We recommend that there is multi-disciplinary and management input into the timing of admissions to a service about to undergo a period of significant change. It is better to delay admission than risk a serious incident occurring due to staff pressures to manage the change and increased anxiety caused to patients who are still settling into a new environment and are likely to be unsettled in their mental health.

13.2 Risk assessment

Mr R was subject to a variety of risk assessment tools in preparation for and during his admission in 2007. These included the Risk Matrix 2000, Structured Assessment of Risk and Need, Static-99, and HCR-20. These tools variously assessed his risk of sexual and/or violent offending and reconviction. He was variously assessed as moderate, moderate-high, or high.

The use of them is in keeping with the spirit of the DSPD programme, to support the development and delivery of new services for those who present a high risk of committing serious violent or sexual offences as a result of a severe personality disorder with research as a core part of its remit.

Comment
In day to day clinical practice, particularly in emergency situations, the interpretation of these tools may not serve as a useful guide for risk management by less experienced or less academic staff. There was a lack of effective communication of risks to staff and therefore a lack of understanding of the risks. This is of particular significance in relation to escorting staff who require a clear understanding of the risks to guide their day to day assessment and management of these patients outside the confines of medium security.

Recommendation 7. Risk Assessment
We recommend that the grab pack highlights the nature and level of risk presented by a patient in simplified terms as a guide to appreciating the risk.

13.4 Clinical Risk Management

There are significant similarities between the circumstances surrounding Mr R's absconds in 2005 and 2008. On both occasions, Mr R had presented as increasingly challenging, confrontational, and dissatisfied with his treatment as time passed in the programme. On both occasions he complained of delays in starting of the VRP. On both occasions he twice complained of chest pains with short intervals between each complaint and was admitted on each occasion to KCH. On both occasions, his absconds occurred during the second admission to KCH, when left in the care of only 1 of 2 escorting members of staff and whilst awaiting transport back to the THU.

Comment
His potential to use his physical health to engineer an absconsion was recognised in 2005, but the exact circumstances that might warn of an increased risk of absconsion had not been dissected and absorbed from the 2005 admission. A replication of circumstances predating his abscond in 2008, might have led to a review of the abscond risk from moderate to the default position of high. Lessons had not been adequately learned.

We repeat the earlier Recommendation 5. Assessment of patients and use of previous records.
We recommend that efforts are always made to obtain all past medical records on patients receiving in-patient treatment. The importance of obtaining past records to reduce the risk of serious incidents repeating should be reinforced.

14.0 REVIEW OF THE NURSING AND MEDICAL LEADERSHIP AND MANAGEMENT

14.1 Review of Medical Roles & involvement in Senior Management; & Leadership

Mr R was admitted to the THU in 2005 and 2007 under S47/49 MHA 1983. The Responsible Medical Officer (RMO) on both admissions was a role assumed by a Consultant Forensic Psychiatrist.

Comment
The RMO (and now RC) carries overall responsibility and is in charge of the treatment plan.

In 2005 a multi-disciplinary assessment of Mr R's suitability for admission to the THU, was carried out by senior medical, psychology and nursing staff who recommended admission for a 3 month period of further assessment. Following discussion in the multi-disciplinary referrals meeting, it was agreed to admit Mr R. Following his abscond, he was reassessed at The Spinney by senior medical, psychology and nursing staff from the THU and recommendations were made to review his suitability for readmission only after he had demonstrated evidence of behavioural change to support his stated intention to engage.

The multi-disciplinary and senior nature of the assessments in 2005 and the decision-making following his abscond demonstrate good clinical practice and leadership in care. However, there is an important omission of a Social Work role to corroborate Mr R's account of events and contacts during his abscond if plans were underway to support an eventual readmission to the THU.

Recommendation 8. Social Work
We recommend that Social Workers play an active role in liaising with external agencies, including family members and criminal justice agencies, to collect and corroborate information which could be extremely important in risk assessment and management. This should be directed by the RMO (RC) and agreed by the multi-disciplinary team.

In order to facilitate readmission, contact with the prison was maintained to monitor Mr R's progress in treatment within the prison therapy programmes. His progress was discussed at the multi-disciplinary referrals meetings at the THU and recommendations for further treatment within the prison were made following senior management advice on the need for changes to the physical security of the THU recommended by the Home Office and the likely timescale for these changes to take place.

Good Practice
Liaison between the prison and senior management at the THU demonstrates good practice in communication.

There is a great deal of ambiguity as to whether there was multi-disciplinary agreement at the THU to Mr R's readmission in 2007, in contrast to his admission in 2005. We heard evidence that nursing staff felt resigned to Mr R's readmission, and we also saw evidence that senior nurses and other clinicians had been involved in pre admission assessments.

Recommendation 9. Multi-disciplinary assessment for new patients
We recommend that all admissions, whether they are new or re-admissions, be subject to a multi-disciplinary assessment prior to admission. A medical assessment is key to ascertaining diagnosis and suitability for treatment, but a nursing assessment is necessary to advise and prepare staff for manageability within a ward environment. In the case of a population of patients with a personality disorder, a psychology assessment is also recommended. All assessments should involve the preparation of a written report, and the outcomes of the assessment discussed to agree a final common pathway.

We heard evidence from several sources that a well-attended meeting was convened in 2007 to create an absconsion risk management plan for Mr R, in light of his previous abscond and history of cardiac problems which might necessitate emergency medical transfer for treatment.

Comment
Given the importance of this issue to Mr R's care and treatment, the absence of minutes or documentation of this in Mr R's ePJS and its availability for all clinical staff involved in his care is a significant omission.

Recommendation 10. Multi-disciplinary assessment, meetings and planning of admissions

Where such multi-disciplinary meetings take place in future, minutes should be produced and should include agreed actions and a formally agreed plan that should be distributed to all members of the clinical team.

We recommend that notes of such meetings recording clinical decisions are entered contemporaneously into ePJS.

The care and treatment of patients at the THU was formally assessed and monitored through the Primary Treatment Team (PTT) and Ward Round meetings, alternating on a fortnightly basis. The intention was that they served separate functions – the ward round for decision-making and the PTT for co-ordinating the completion of the minimum data set. However in reality they seemed to overlap and merge at points. There was a vague distinction between the functions of the 2 meetings, and no consistent, or senior medical representation in the PTT. Better co-ordination and leadership of the 2 meetings could have improved co-ordination and management of clinical care, and improved a review of risk assessment and management.

Recommendation 11. Multi-disciplinary Review

We recommend that all new admissions which are undergoing assessment for a time-limited period, which we understood to be 3 months, are subject to weekly multi-disciplinary review.

There is clear documentation of the RMO's advice in 2008 regarding the escorting arrangements to KCH during Mr R's admission there on 10th February 2008. It is less clear whether similar leadership in advising on transfer arrangements to KCH was demonstrated on Mr R's readmission on 14th February 2008. There is no medical guidance evident on the use of smoking breaks, visitors, contacts with the public or freedom of movement within KCH, and there was a failure to complete Section 17 leave forms at the earliest possible opportunity following the transfer. Specifically there is no documentation to remind staff that awareness should now be raised of the risk that Mr R might be using his physical health in a perverse way to plan an absconsion, and Mr R's physical complaints did not prompt a review of written documentation of the outcome of the absconsion risk management plan discussed in 2007 (this might have raised an alert that the documentation was missing).

Comment

This represents an omission in clinical leadership and medical responsibilities. A flow chart to advise on the ward response to cardiac pain experienced by Mr R was a step in the right direction, but of limited benefit as in all likelihood an expert review of his complaints would be considered desirable. We have discussed this in more depth in the later section on Section 17 Leave.

14.2 Nursing Leadership

It was noted by the investigation team that nursing leadership of the THU was severely fragmented with a number of managers and acting managers attempting to manage the ward between 2005 and 2008, with a substantive Ward Manager who was on extended sick leave from 2007 - 2008 and an acting manager who was in post for nearly 12 months until the second abscond.

At this point a senior manager who had previously been in the service was 'parachuted' into it and the acting manager (Deputy Ward Manager 1) was removed immediately and returned to a more junior substantive position. In 2011, the ward has again an Acting Ward Manager, who has held this role for nearly 12 months.

Staff working in the service between 2005 and 2008, describe a very difficult workplace without the structures that could reasonably be expected to be constituted to promote good practice, such as regular clinical supervision, access to relevant training, regular clinical meetings to discuss patient care with the MDT and consistent peer supervision. Nurses in particular expressed feeling disempowered within the team with the other team members undertaking therapeutic roles with patients whilst the nursing team perceived itself to be relegated to a custodial role within the service. There was no clear escalation process for raising operational concerns and it was not transparent to staff who they could contact to raise concerns about clinical safety and risk based on shortfalls in staffing and resources.

Comment
Consistent and supported leadership is essential in this area and should be a priority to stabilise the service and Ward Manager's role and ensure the patients receive continuity of treatment. The practice of long periods of 'acting up' by junior staff does not provide the stability required[35].

Nurses within the organisation must be aware that they can raise professional issues concerning unsafe working practices and be supported when unacceptable levels of risk are exposed within operations.

Recommendation 12. Nursing Leadership
Nursing leadership and historically high churn rates within the nursing team is a known risk to the Trust for this service. A contingency plan should be in place for managing the risks incurred when senior positions in the team are vacant to ensure stability on the unit.

The practice of long periods of acting up does not provide real continuity for the team nor the post holder. The Trust should recruit and appoint a substantive Ward Manager for Waddon Ward immediately.

[35] Warren, McAuley et al. "*A review of treatments for severe personality disorders*". Home Office Online Report.(Home Office March 2003)

Supervision, mentorship opportunities and appropriate training for managers must be resourced that are specific to this client group to prevent staff burnout[36].

The full involvement of the nursing staff in the assessment, treatment planning and provision of therapeutic interventions must be monitored and audited on an ongoing basis to ensure that it is embedded and continues.

Admissions should be carefully monitored and risk assessments completed to ensure the service has capacity and is functioning at safe levels for current patients as well as new individuals without permanent nursing leadership. If necessary, alternative arrangements for admission should be made to ensure service continuity and patient care.

14.3 Recruitment and Retention

Through staff interviews and performance information, the investigation team established that vacancies were at a level that was likely to have compromised the service functioning for a period of years rather than months but particularly between 2006 and 2008. The conclusions drawn were that the retention was given less weight than recruitment. A cycle of recruitment drives were held during this two year period and these had varying success in attracting candidates but senior managers advised the investigation team that candidates started to withdraw and drop out during induction. This appeared to be a continuous cycle that went on for months, if not years, in the service.

It was not evident to the investigation team that a wide number of solutions were applied to this issue. Information about staff (leavers) interviews, if they were held by HR, was not presented to the investigation team as being fed into the recruitment process.

A strategy for improving Retention and Recruitment specific to the THU and River House would have been a likely solution for the safe operating of the service but has not yet been presented to the investigation team, despite this problem being widely known in the operations team and by senior management during this period. Poor retention led to the high use of Agency staff and it has been reported between 30-55% vacancy levels were held on this unit. No correlation appears to have been made to the need to reduce patient numbers to ensure consistency of service and to consolidate the staff group in this timeframe. Staff reported to the investigation team the great stress they worked under due to the vacancies in the team and the need to work alongside high numbers of Agency staff. This is likely to have had an impact on the therapeutic relationships with patients. Staff from a range of disciplines reported to the investigation team the significant stress within the service

[36] Ministry of Justice and Department of Health. "*Working with personality disordered offenders – A practitioners guide".* (January 2011)

affecting their abilities to complete tasks on the unit and that a number of them looked for alternate positions during their time in the service.

Senior management highlighted the issue of capacity and capabilities in the unit in the Terms of Reference of *the Internal Interim Investigation report on the Mr R abscond 2008.* The high vacancy factor was noted in the following words *"Explore the leadership and management capacity and capabilities in the unit"* and the actions highlighted post investigation:

1) *Recruit to current vacancies on Waddon Ward (formerly Tony Hillis Unit) including Team Leader post.*

2) *Review skill mix on Waddon Ward to reflect needs of client group who are mainly prisoners with life sentences*.

Comment
In the light of the longstanding issues with recruitment and the recognition of the impact on the service performance, these recommendations were neither robust nor comprehensive enough to provide reassurance of the gravity with which the situation was now being taken by senior management within the Trust.

Recommendation 13. Recruitment and Retention
A robust strategy for monitoring the Recruitment and Retention of all staff in the FIPT Service, especially Waddon Ward, should be produced and monitored monthly and include the involvement of the MDT. This strategy should include meaningful feedback from staff that leave the service and must be fed back into the service via Clinical Governance and other performance management meetings. A threshold should be agreed and set on the maximum vacancy levels of staff to be held by the team on Waddon Ward. If breached, these should ensure extra resources be provided and admissions stopped until the team is stabilised. Links with other similar services must be forged to develop strategies for staff support. Staff should be polled annually on their experience of working within the FIPT Service and concerns noted and acted upon by senior staff. Leaver's questionnaires should be fully utilised by management to examine why high management turnover has occurred and possible solutions to end the cycle.

15.0 REVIEW OF THE EXTENT TO WHICH TRUST SERVICES ADHERED TO STATUTORY OBLIGATIONS, RELEVANT NATIONAL GUIDANCE AND LOCAL OPERATION POLICIES INCLUDING THE MENTAL HEALTH ACT 1983 AND AMENDMENTS IN THE MENTAL HEALTH ACT 2007.

15.1 Use of the Mental Health Act

The Mental Health Act 1983 was in force at the time of Mr R's admissions in 2005 and 2007. It is intended to provide safeguards for the patient and public in the considerations required for the care and treatment of patients. There were some serious shortfalls in the practical application of the Act in Mr R's case.

Mr R was transferred to the Tony Hillis Unit from prison with the permission of the Home Secretary, under Section 49 of the Act, for treatment of his Dangerous and Severe Personality Disorder (DSPD). This meant that he was a patient subject to restrictions under the Act, which should have been applied during his stay on the unit.

15.2 Section 17 Leave

A patient who is detained under the Act may be granted leave of absence as part of their treatment programme under Section 17 of the Act. This is a responsibility of the Responsible Medical Officer (RMO, now RC). In a medical emergency, as occurred in this case, Section 17 leave will be granted for treatment of the condition of a restricted patient by the Home Secretary. Nevertheless, the formal requirements of Section 17 are still necessary. A suitable leave form must be completed, including any restrictions on place and access to the public. This was not done in Mr R's case. No clearly defined and communicated restrictions were put into place to inform and guide the escorting nursing staff.

On the 10th February and 13th February 2008 when Mr R required urgent transfer for medical treatment, the RMO was consulted and the Home Office informed. However, a Section 17 leave form was not completed by the RMO on either occasion. There is no record of any restrictions that may have been discussed. This meant that the escorting nurses did not have access to the RMO's advice on any restrictions of freedom of association. During smoking breaks, (which were inadvisably allowed), Mr R freely talked to members of the public. According to the police, this allegedly included a young woman under the age of 16.

It appeared to the investigation team that the restrictions required under this section of the Act were not fully understood by all members of the care team.

Recommendation 14. Section 17 leave and Restricted Patients
That RMOs (now Responsible Clinicians, RCs) complete Section 17 leave forms when any detained patient is granted leave for any purpose. That a copy of the care plan, outlining appropriate measures to protect the public, be placed, for the guidance of the escorting nurses, in the 'grab pack[37]' which is now in place on the unit for the transfer of emergencies. That escorting nurses are made aware of this care plan and conditions. We recommend that for Restricted Patients, the limitations of Section 17 leave for any hospital treatment are clearly defined in the Care Plan in relation to the freedom of movement, contacts, and visitors a patient may have. That the use of Section 17 for restricted patients be routinely and regularly audited.

15.3 Relational Security

Security is the framework in which care and treatment can be provided. Patients and staff cannot purposefully participate in activities within the service unless they feel safe first. The relational security on the unit is based on the knowledge the staff have of a patient and of the environment and how that translates into care. Due to the staffing and leadership challenges on the THU this was a difficult balance to achieve as a culture of flux in staff members, ambiguity over boundary issues and changing nursing management styles affected and impacted on the environment.

Physical and procedural boundaries were being tested on the unit due to the nature of the patient group and exacerbated by the constant newness of team members. The nursing team in particular appeared to grapple with relational security expressing that they appeared to have more exposure to the patient group, but in more of a custodial role than therapeutic and this left them in the position of having to enforce ward rules.

Around the 2008 readmission of Mr R to THU a number of staff expressed to the investigation team they had reservations about his readmission but felt these were not heard and they had to accept other disciplines decision to admit him again. Relational security can be affected by one patient's admission to a service.

According to nursing staff interviewed Mr R was known to have a "difficult to manage" reputation. However, he was escorted in hospital by staff who were either junior in the team (health care support workers) and or were not permanent members of the nursing team. This is despite the unit being well staffed on the day

[37] Grab Packs have been developed since the Mr R incident. Grab Packs contain high level information, a photograph and description of the patient, and a summary of their care requirements and their assessed risks, to be used in an emergency situation, literally 'grabbed' to accompany a patient requiring urgent transfer.

of the abscond, according to the weekly rota and verification by staff present at the time.

A decision was made to send Agency staff versus permanent staff to provide escort. Agency staff who worked on THU on the day of the second absconsion were claimed to be very experienced in setting boundaries but they were diverted to River House to review security measures before the pending ward move. The conclusion being that optimal relational security was overlooked on the day of the absconsion by choosing to use Agency nurses for the escort to King's College Hospital.

Comment
Patients with the forensic and complex history of Mr R, with known challenging behaviours, should not have been delegated to the care of inexperienced staff from outside of the service. To this end relational security was significantly compromised.

Recommendation15. Relational Security
Training in relational security and boundary management be included within the induction package and all staff become familiar with the terminology and behaviours required to maintain a therapeutic and dynamic service environment[38].

This could be evidenced by better retention/reduction in sickness levels and a reduction in ward incidents. This needs to be clearly reinforced by reference to the Mental Health Act to ensure there is a clear understanding of the implications and requirements under Part III of the Act and the meaning of restriction within this.

15.4 Induction Process

The process for new and Agency staff joining the service at THU was reported to the investigation team as being severely fragmented and diluted between 2005 – 2008.

It was concluded that the induction process and introduction to the DSPD service and patients was inconsistently applied to any members of the team joining THU during this time frame. It had reportedly reduced both in the time spent on induction from 6 weeks to several days and the content had changed to consist of a more generic ward introduction.

This differed markedly from the plans at the DSPD service inception in 2003 when a six week induction programme was developed which included elements of working with patients with personality disorder and differing treatment regimes as well as building team working skills. The sheer volume of new staff and the high turnover appeared to have impacted upon the length of time new staff spent in induction, and also its quality. The reduced quality of the induction programme was exacerbated further by high staff turnover which meant that a majority of existing

[38] Department of Health. "*Your guide to relational security: See, Think, Act" (*2010)

staff were frequently new themselves to the service. It appears less investment was made by senior management into the new joiners experience during this time period.

This was in itself a likely contributor to the long periods of turnover within the service. Some staff reported being expected to induct themselves during this time frame.

Comment
Induction for new staff as well as Agency staff needs to be a consistent process that meets the needs of the service inclusive of security and health and safety issues but also includes wider service needs such as the awareness of training needed by staff joining the service to manage the complexity of the DSPD patient group they are to work with[39].

Staff should have a period of protected supernumerary status to allow them to adjust to the ward demands. No staff including Agency staff working in this service should ever be expected to induct themselves. Agency staff and or new staff being supplied with policies to read to explain ward processes does not comply with a reasonable expectation that staff understand fully their responsibilities and is therefore safe for them to work with DSPD patients.

Recommendation 16. Induction Process
Regular monitoring of the usefulness of the current 2 week induction process should be undertaken and feedback sought on any improvements required to ensure it is an evolving process and meets the needs of all staff that experience it. Supernumerary status must be preserved during induction for all staff. Agency staff Induction must be reviewed and ensured that it meets relational and procedural needs of the service.

15.5 Use of mobile phones on the THU

The Trust mobile phone held by escort staff was found by the police to have been accessed on 20 occasions by Mr R after his absconsion in February 2008. As the escort staff involved in the escort refused to attend for interview, the investigation team cannot verify the reasons for this.

A ward search in the THU following the absconsion resulted in a mobile phone, charger and SIM card (unregistered) being found in an unknown patients' rooms and handed to the police by Deputy Ward Manager 2.

[39] Home Office and Department of Health. *"Managing Dangerous People with Severe Personality Disorder: Proposals For Policy Development"* (July 1999)

The police also advised the investigation team that Mr R's partner's phone had been rung from staff mobiles (who were working on THU).

The investigation team asked the current acting Ward Manager to explain the current 2011 mobile phone policy for Waddon Ward. The investigation team was told patients have personal mobiles which are secured in lockers but they can access them when or if leaving the unit. Staff are not permitted to have mobile phones on the unit and these should be placed in staff lockers but the Ward Manager had observed staff with mobiles phones and these being used on the unit and had reminded them to remove them from the clinical areas. Despite the question being asked it is not clear whether medical staff fully comply with policy.

In conclusion it remains a risk that mobile phones are not automatically removed from all staff working on in-patient areas at reception. This contravenes Trust policy[40].

Due to the challenges DSPD patients bring to staff working with them of testing, demanding, belittling and confronting behaviours it would be possible for some staff to feel manipulated by patients into allowing them access to their personal mobile phones if they are brought into the clinical areas[41]. It is a concern to the investigation team that Mr R's usage of the Trust mobile phone of up to 20 calls is listed within the Trust's Interim *Investigation of the Absconsion of Mr R* Report – commissioned in March 2008; but no actions or recommendations are made on mobile phone usage despite it being a clear breach of Trust policy.

Without immediate stringent monitoring of patients, visitors and staff, illicit use of mobile phones could reoccur. In the future, other technologies will all also need to be considered.

Comment
Having clear guidelines that prohibit the use or possession of mobile phones within the clinical arena would eliminate the potential for staff to be induced to allow patients to use their phones. In the absence of being able to verify the reasons with the staff involved the investigation team have concluded that staff were induced by Mr R to let him use the phone in light of the Trust policy contravening such use.

Such guidelines should be monitored by the Ward Manager and any breaches by any member of the MDT considered a disciplinary measure. The use of the ward phone should be monitored to ensure safe and appropriate usage. The unit should be regularly searched to ensure prohibited materials are not present and risk is effectively monitored at all times.

[40] SLAM Policy: Working Draft Policy on the use if mobile phones by Patients. 2005
[41] Ministry of Justice and Department of Health. "*Working with personality disordered offenders – A practioners guide*" (January 2011)

In conclusion all staff should be reminded, and all steps taken, to ensure that mobile phones are not taken into clinical areas in River House.

Recommendations 17. Use of Mobile Phones
The Fallon Inquiry highlights concerns over communications usage and sets guidelines which should be adapted by River House to include mobile phone usage.

We recommend that it is essential to control and monitor the use of ward-based telephones carefully in order to prevent abuse, control fraud and prevent the introduction of prohibited substances and articles into the Hospital.

We recommend a revised policy on the use and restriction of access to mobile phones whilst in the unit, based on best practice and guidelines arising from the Fallon Inquiry, is developed, implemented, and regularly audited for implementation.

15.6 Boundaries

Staff described very clearly to the investigation team the constant challenges the patients presented in terms of complex behaviours and high levels of verbal aggression and belittling occurring from the second cohort of patients in 2004 until 2008 and leading up to the period of the second abscond by Mr R.

The increased presence of patients with complex personality disorder issues coupled with the staff team's high level of attrition, lack of supervision, lack of leadership and working in what has been referred to as "a potentially toxic client group" within the Trust's Internal Investigation[42] has led the investigation team to conclude that boundaries were difficult to both enforce and maintain over a period of some considerable time and potentially years. Some of this was due to the level of ambiguity within boundary setting from the clinical team who did not also demonstrate non negotiable boundaries.

One clear example was the behaviour of visitors on the unit. Staff described Mr R's partner as challenging in her behaviours and the issue of intimacy between her and Mr R causing management difficulties and the management advice given to staff could be viewed as arbitrary in nature. The policy regarding completion of the Visitors Book was suspected as not to have been properly adhered to in terms of signing in, and was not able to be found during the Trust's earlier investigations. There is also evidence of Mr R receiving visitors whilst in King's College Hospital. Again, proper management of visitors was a recommendation from the Fallon Inquiry.

[42] "Investigation Report into the Absconding of a Schedule 1 Offender on 15 February 2008, Whilst on Emergency Admission into King's College Hospital from a Trust Medium Secure Unit"

Mobile phone access has been highlighted as an area where a definitive boundary was needed to ensure that patients were not allowed access to, or used staff or unit mobile phones, as happened in this instance. Other examples of boundary transgressions were apparent in both Mr R's absconds in 2005 and 2008 in terms of his access to smoking areas and the general public whilst receiving emergency medical treatment at King's College Hospital. Staff did not appear to be clear about what was appropriate in terms of monitoring and restricting Mr R's movements and certainly were not in ear shot when he was taking breaks in 2008 when he was able to converse freely with the general public[43]. It is likely then that boundaries were not known or fully internalised by the clinical team in 2008. This is even more concerning when we consider the index offence, the nature of previous crimes, and the fact the Mr R was a restricted patient under the Mental Health Act 1983.

In 2011 with strengthened management systems, better escort policy arrangements and arrangements for consistent supervision there is an opportunity for boundary management to be reinforced and modelled effectively within a stable workforce.

However the investigation team noted that a current member of staff did not understand the phraseology "grooming" when working with this patient group and was not clear on what this may entail or indeed be alive to signs or behaviours of grooming. This suggests there is further work required to ensure staff are fully aware of the complexities that people with dangerous and severe personality disorders present with and to reinforce the need for bespoke training, induction and clinical supervision to include key elements relating to the specifics of managing this patient group.

Comment
The tools to support Boundary management such as induction, peer supervision, clinical and management supervision were inconsistently applied to nursing staff working within THU for a number of years. Staff reported a great many attempts being made to help them in their reflection and patient management, however few lasted more than a few months and reported inconsistent attendance in team groups.

Recommendation 18. Boundaries
Boundary management will remain an ongoing issue for staff working with DSPD patients and constant training in this area must be supplied and monitored for its effectiveness by the Trust. This training should commence in induction and be an ongoing feature in supervision and all clinical meetings so that grooming and coercion can be closely monitored between staff and patients. This must be monitored and resources developed to ensure that the skills being gained are held within the team. If clinical supervision/group supervision is suspended then senior managers must be alerted and act to replace resources in a timely manner.

[43] From information provided by the general public to the Metropolitan Police following the absconsion

16.0 REVIEW OF THE TRUST'S INTERNAL INVESTIGATION, THE ADEQUACY OF ITS FINDINGS AND RECOMMENDATIONS, AND THEIR IMPLEMENTATION

There is no doubting the seriousness with which the second absconsion of Mr R is viewed by all concerned and in particular by the Trust. It is significant that there were what amounts to three separate, although sometimes parallel, investigations following the absconsion of Mr R in 2008. The internal investigations, inquiry and review we are referring to are:

1. Report on the Investigation into the Absconding of a Schedule 1 Offender on 15 February 2008. Reference Number 74334, commissioned 18th February 2008 (the 'initial internal investigation')
2. Review of Incident involving Mr R, March 2008
3. Board Level Inquiry Mr R, 26th June 2008.

On the 21st February the Chief Executive also commissioned a wider review of security arrangements for 'Medium Secure Patients Outside MSU Boundaries'[44]. This subsequently became an appendix of the 'Review of the Incident Involving Mr R'.

However, the intention to ensure that the investigation(s) were conducted properly and all aspects were reviewed has meant that there are multiple sources of information, with no one single source of information and evidence of implementation of the action plan(s). This can both cause duplication of effort, and has the potential that important aspects get missed. As examples:

- the correct most recent and updated action plan was not provided to the investigation team until quite late in this investigation
- the investigation team were not provided with copies of the "Review of Incident Involving Mr R" until 5 months after commencement of the investigation.

We note that many of the findings of the Review of the Incident involving Mr R support the implementation of the action plan devised from the internal investigation and Board level Inquiry, and we noted the extensive and wide ranging nature of the review.

The initial internal investigation was commenced on February 18th 2008. That it was commissioned so soon after the absconsion is in itself an indication of how seriously the Trust viewed the incident.

However, guidance[45] recommends that the initial '72 hr' investigation is concerned with collating evidence and names of witnesses.

[44] "Options Paper on Security Arrangements for Medium Secure Patients Outside MSU Boundaries". 21st February 2008
[45] National Patient Safety Agency. "*Independent investigation of serious patient safety incidents in mental health services: Good practice guidance*" (February 2008)

By acting so precipitately there is a risk that later emerging findings get missed, such as:

- the finding of a mobile phone, charger and SIM card following a search of THU
- the contradiction between escort nurse statements, and events known to the police regarding notification of the police via a 999 call, and the area within the hospital Mr R absconded from.

There is no completion date on this investigation. Investigations should record the date they were completed.

Another aspect that was also missing was any indication that the family and relatives of the victim and the perpetrator were informed, or offered the opportunity to be informed of both the process and findings of the Trust investigation. In fact the Trust does not appear to have contact details for either Mr R's, or the victim's, next of kin, or to have made contact with them. This, in large part, may be because the investigation was commenced soon after the absconsion, before the murder of Mr Q was known. However, this was not the case for the Board Level Inquiry.

We had to obtain the contact details of the victim's family by going through Norfolk police.

Despite attempts at making contact with Mr R's next of kin, we were unable to do so. It is to our regret that we have been unable to make contact with Mr R's next of kin, because we were unable to find their contact details within the time allowed for the investigation.

It was also difficult contacting several of the potential witnesses for interview, as they were either Agency nurses or had subsequently left the organisation.

It would be helpful for future investigations following serious incidents, if all contact details for victim and perpetrators family/next of kin, and members of staff involved (especially if the incident involves either a suicide or homicide) were obtained in the initial 72 hour period, immediately post incident and kept on file as part of the investigation documentation. In this investigation much time and effort were expended in trying to contact relatives and staff members/witnesses who had subsequently left the organisation, or who were Agency nurses.

The investigation team note that one of the initial internal investigators was one of the managers of the service, who subsequently stepped down from the investigation. This is entirely appropriate. It is always preferable that investigations are conducted by people within the organisation who are trained in investigation and root cause analysis techniques, who are independent of the service involved, and who have dedicated time allocated for the purposed of investigation. In this instance this appears to have been the case.

The method of investigation identified was a root cause analysis[46]. The investigation team were told that the starting point for this was the seven pillars of Clinical Governance[47].

The Key Finding identified as an area of concern in the initial internal investigation, the "*evidence of an absence of effective systems to support staff to manage the emergency admission and an over reliance on Bank/Agency to carry out escort duties with no induction, handover, or structured support from the unit*" begins to identify the root cause of the absconsion.

However, a root cause of this incident lies in the failure to address the high turnover of staff and significantly high attrition rates of staff, which had been known to be happening for some time, of which over reliance on Bank/ Agency staff is a consequence.

The Board Level Inquiry mentions that Mr R spent time in River House, a high support hostel and a low support hostel. This is an error of fact. Mr R never went to River House, having been admitted to the Tony Hillis Unit. There is no record of him spending time in either a high or low support hostel. Nor should he have done, as he was a restricted patient, requiring the permission of the MoJ for any moves outside of the THU, and there is no record this was applied for or given.

Given the initial investigation, the value of the second 'Board Level Inquiry' is not immediately obvious, since although it makes new recommendations, these are not based on new facts arising (such as the contradiction between escort nurses statements and the events as noted by the police, and the finding of a mobile phone on the unit). It would be preferable for there to be one single internal investigation that provides clear coherent recommendations to the Trust Board for future action. NPSA guidance recommends a single internal investigation, usually completed within 90 days of the incident[48].

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[46]Source: NPSA Glossary. Root Causes/Causal Factors
The prime reason(s) why an incident occurred. A root cause is a fundamental contributory factor. Removal of these will either prevent, or reduce the chances of a similar type of incident from happening in similar circumstances in the future.

[47] Clinical governance was defined in the 1998 consultation document "A First Class Service: Quality in the New NHS" (p33) as:*'A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish"*
The Seven Pillars are:

- Audit
- Clinical effectiveness
- Risk management
- Patient/service user and public involvement
- Education and training
- Information management
- Staff management

[48] National Patient Safety Agency. "*Independent investigation of serious patient safety incidents in mental health services: Good practice guidance*" (February 2008). Internal NHS mental health trust investigation: using root cause analysis (RCA) or similar process to establish a chronology and identify underlying causes and any further action that needs to be taken. This would usually be completed within 90 days."

The investigations do touch upon the serious turnover of staff, the high use of Bank/ Agency nurses, the difficulties facing the nursing team the lack of substantive nursing leadership and (as identified in the Key Finding "*an absence of effective systems to support staff to manage the emergency admission and an over reliance on Bank/ Agency staff to carry out escort duties with no induction, handover or structured support from the unit*"). The subsequent action plan[49] has two Action Points touching upon these issues:

- *"Recruit to current vacancies on Waddon Ward (formerly Tony Hillis Unit) including Team Leader post"*.
- *"Review skill mix on Waddon Ward to reflect needs of client group who are mainly prisoners with life sentences"*

Although these are necessary, they are not sufficient to address the fundamental and underlying issues of high staff turnover, sickness and vacancy levels. Unless attention is paid to the underlying root cause, any gains from the above actions are likely to be short-lived.

It is noted in the initial internal investigation, there was a recommendation for a Service Review, which *"should include an analysis of the effectiveness of the current structure of the team. Clarity should be established in each disciplines role function level of responsibility and accountability or practice. Competence and capability of the workforce should meet the standards required. All Governance systems need to be established, reviewed, for effectiveness".* This is much closer to addressing the root cause issues.

However, it is not clear to the investigation team whether this action has been completed. It is omitted from the Action Plan currently in use.

There are further other omissions. The initial investigation identifies that the escort nurses called the police on 999 using the unit supplied mobile phone. However the police CAD (Computer Aided Despatch) log identifies that the police were called by a junior doctor from King's College Hospital.

The initial internal investigation does mention the access to and use of mobile phones whilst in KCH, but not that a mobile phone, charger and SIM card (though inactivated and not apparently used by Mr R) had been found on the THU following a search after he absconded. There is consequently no action plan to manage the access to and use of mobile phones.

The initial internal investigation also mentions lack of access to the ward Visitors Book for THU, though there is no corresponding action plan to review the management of visitors to the unit.

[49] Action plan of recommendations arising from the investigation into the circumstances of incident Mr R. Updated November 2010

Both access to phones and management of visitors accessing the unit are key recommendations in the Fallon Inquiry[50].

Within the notes on ePJS there are comments that lead the investigation team to conclude Mr R is likely to have used cannabis whilst on the Unit.

There is an entry in ePJS dated 08/02/2008 at 2025 hrs:

"(he) seemed in a fairly settled mood today and seemed to take the room search earlier today fairly well. He seemed particularly pleased with the discretion staff used when handling certain sensitive, but prohibited materials found in his room"

What these sensitive but prohibited materials are is not known. However the access to cannabis and prohibited materials, the inadequate management of visitors and access to mobile phones all paint a picture of a service with suboptimal security. This is not mentioned in the initial internal investigation, and consequently lacks a corresponding action plan.

When benchmarked against the NPSA Investigations Credibility Checklist, because of the above factors, the initial internal investigation scores 7 out of 10.

Recommendations 19. Future Investigations
We recommend that the Trust adopts the NPSA "*Good Practice Guide for Independent Investigations of Serious Patient Safety Incidents in Mental Health*", and provides one single robust investigation and action plan. That in future, in all such investigations, attempts are made to obtain the contact details and to contact both the victim and the perpetrators family/next of kin to explain the process and purpose of the investigation, and as appropriate the outcome. That the contact details of staff involved in the incident are kept on file as part of the investigation process for serious incidents (especially homicides and suicides) to aid future independent investigations That the Trust reviews security arrangements, use of mobile phones and management of visitors within Waddon Ward.

[50] His Honour Peter Fallon QC, Professor Robert Bluglass CBE, Professor Brian Edwards CBE, Mr Granville Daniels (January 1999) "*Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital"* VOLUME 1. The Stationery Office.<http://www.archive.official-documents.co.uk/document/cm41/4194/4194.htm>

16.1 Review of the implementation of the findings and recommendations from the internal investigation

It has been noted that the Trust action plan updated November 2010[51] shows that all actions are completed. The investigation team is conscious that many improvements have been made in the practice and security of patients and to the governance of Waddon Ward, the successor to the Tony Hillis Unit. These include the following areas of improvement.

Communication and meetings.

MDT meetings are now minuted and minutes circulated to the clinical team so that all clinical decisions and reasoning are disseminated and kept for future reference.

Pre-assessments of all new patients are MDT focused with a number of staff including nurses attending and meeting the patient and participating in assessment for suitability for admission.

Weekly and other Team meetings are held consistently and involve all of the wider clinical team including nursing. The whole staff group meet weekly, with an independent facilitator. There are reflective practice sessions for staff every day between 1400 hrs and 1500 hrs. There is a weekly community meeting attended by all staff and patients.

The unit now has dedicated administration support to ensure meetings are minuted and all correspondence and documentation is filled appropriately.

Team

Nursing recruitment has been prioritised and managed effectively since 2009 with the majority of posts filled by permanent staff. Vacancy rates across the year are recorded at less than 7% of establishment in 2010, with no vacancies in November 2011. Two new Psychologists have been recruited to previously vacant posts.

High nursing turnover has been managed down and the causes addressed. The use of Agency staff has significantly diminished. Staff skill mix is regularly reviewed by the MoJ and NHS Commissioners in quarterly performance management meetings.

Induction has been modified and lengthened to better prepare staff for the environment and patient group. Along with the Trust and River House induction process, there is a two week induction process for staff joining Waddon Ward. It has been extended to Bank nurses employed via NHS Professionals.

[51] Action plan of recommendations arising from the investigation into the circumstances of incident Mr R. Updated November 2010

Education and Training

Clinical and Management Supervision for nurses has been given a higher priority and is reported as consistently in use for all qualified staff.

Access to training has improved with staff now accessing DBT (Dialectical-behavioural therapy), Schema Therapy, and Solution Focussed Therapy courses and nurses encouraged to gain further skills to enhance practice and supported by the wider team to move from largely custodial roles.

There is a Personality Disorder Awareness training which staff undertake, and have been encouraged to complete up to Masters Degree level.

Security

Relational security has significantly improved with clearer boundaries both for patient admissions and for clinical reasons to remain in the unit. Patients who do not actively participate in treatment programmes and who present unacceptable risks are, based on a multi-disciplinary clinical team decision, returned to their admitting service.

Following a review of the FIPT Service, prisoners with a history of Personality Disorder who have no previous history of being managed in NHS facilities and who largely perceive themselves and behave as criminals rather than patients, are no longer admitted into an in-patient service as currently provided on Waddon Ward. This is supported by Option 1 in the *'Consultation on the Offender Personality Disorder Pathway Implementation Plan'* document published jointly by the Department of Health and the Ministry of Justice[52]. The investigation team wholeheartedly endorses this approach.

Risk assessments are now completed prior to any patient escort out of the service and are written by the MDT and peer reviewed and regularly updated.

A robust new policy *'Patient leave of Absence, Conveyance and Escorting in Medium and Low Secure Services'* was implemented by the Trust in 2008 and integrated into service usage which ensures a more consistent approach to patient leave and transfers in both in-patient areas and community services.

[52] Department of Health and Ministry of Justice. "*Consultation on the Offender Personality Disorder Pathway Implementation Plan"* (2011)
Option 1 – strategic change to re-model services on a pathway model.
This scenario uses the pathway approach described in paragraph 43. By disinvesting funding of the pilot DSPD units at Broadmoor, Rampton and the three Medium Secure services and organising these services differently we will be able to significantly increase treatment capacity, mostly in prisons. In addition, we will aim to provide additional psychological support (in prisons and the community) for those making progress, and strengthening oversight for those released from custody.

A new role of Security Lead has been devised who advises strategically on security training and induction and assessment of risks for any patients leaving the unit.

On each shift a designated member of staff takes the role of lead for security per ward and who ensures the physical boundaries are monitored and secure. The lead networks and arranges support for all clinical teams. This is recorded and factored into numbers and skill mix on the unit.

The investigation team is aware of the significant reduction in absconsions and attempted absconds from the Trust Medium Secure Services since 2008, and in particular the halving of absconsions and reduction of 80% the number of absconding incidents[53].

Each ward has a Relational Security group facilitated externally to help understand issues that arise and challenge staff.

Since 2010 Bromley Police have assigned a senior staff member to work alongside the Bethlem Royal Hospital (BRH) team to help identify areas where joint working and Police engagement might add benefit. The team has worked with the Trust to develop the Buddi protocol and test Police response to tagged clients returning late from leave. The team have worked with BRH staff on joint training for Police and hospital personnel in Buddi tracker incident response.

Most significantly the Trust has developed the Buddi system and protocol, working with an independent provider and the Police. The Buddi System provides a lightweight, discrete, GPS tracking system which is securely attached to the wearer. This enables the wearer to be tracked accurately, to within 50 metres should they go missing whilst on leave. It also provides a vibration alert for geographic/exclusion areas, and also alerts the wearer up to 30 minutes before leave is due to finish. Monitoring is available 24 hours a day and all year round.

High risk patients may be monitored in real time. The system records and time logs movements so it is possible to track someone's journey and timescale, at any point in their leave. The devices are tamper proof and alert the monitoring system of any attempt at removal.

Since initial piloting in April 2010, it is now fully implemented for the Medium Secure Service. There has been a significant drop in absconsions[54], in part due to Buddi, since 2010. The number of patient leave episodes has increased by 20%. Prior to its introduction 60% of leaves were escorted, and now 60% are unescorted.

The number of incidents occurring during leave from River House have more than halved since the introduction of the Buddi system. The percentage of "abscond" incidents (where a patient purposefully removes themselves from the supervision of

[53] Source: "*Learning from Absconding*" Report for Bromley Public Protection Scrutiny Committee, 4th April 2011
[54] Source: "*Learning from Absconding*" Report for Bromley Public Protection Scrutiny Committee, 4th April 2011

a nurse escort whilst out on leave) have almost halved, whilst the actual number of abscond incidents has reduced by 80%. This is an important achievement given that, whilst all patients with authorised leave are given leave as they are assessed as low risk, those patient who are escorted are less tested in a leave environment than those who have progressed to unescorted leave.

The use of the Buddi has enabled a more open conversation with clients about risk and their ability to be trusted and use their leave well. When the Trust presented leave statistics in March 2010 it was noted that in 12,285 leaves for the year the level of risk (of abscond or fail to return) was 0.5%. by the end of March 2011 it is estimated that leave levels for the year will have reached 22,719 leaves, with a risk rate of 0. 07%. This demonstrates a significant reduction in the number of patients absconding.

The other key element arising from Mr R absconding is the development of 'grab packs'. These are packs which contain brief high level information, including care plans, an explanation of the nature of risks, and recent patient photograph, that can be 'grabbed' in emergency to provide basic information to take on escort if required in emergency.

Other Good Practice Initiatives.

The Trust has identified a number of quality improvement initiatives in respect of its action plans arising out of this incident. These include:

- Clinical and Management Supervision is now clearly differentiated and this is supported by Audit findings.

- Forensic Induction package for new joiners is regularly audited and amended based on staff feedback.

- Relational security support has increased with internal and external facilitators in place per service.

- There is a Clinical Audit Prioritisation grid which highlights relevant areas for audit focus such as Risk Management and Multi professional Care planning.

- Positive patient experience is recorded and evidenced by a reduction in complaints and a positive patient survey.

- The directorate now has an annual 'workforce action plan' with initiatives to address vacancy levels, and to improve staff skills and competencies, induction, support, team development, and retention. Evidence of a variety of retention initiatives inclusive of keeping high performing staff with career development programmes and more tailored training.

- In-patient staff engagement surveys are taken as a benchmarking tool Trust wide, indicating comparable levels of staff satisfaction.

- Feedback from the Care Quality Commission (CQC) visits and their findings is published in the Trust's internal newsletters.

- The 'Basic to Excellence' Matrix which is a self and peer assessed balanced scorecard approach to scoring performance improvements in the service across the domains of Patient Engagement, Governance and Compliance, Quality, Improvement and Innovation, Workforce Capability, Financial Management, and Sustainability (of the service).

- The Trust has a contract with licenced independent sector security providers to transport and provide security to high risk patients, including the use of handcuffs.

Recommendation 20. Ongoing monitoring of implementation of Action Plans
The investigation team recommends that the successful implementation of these actions and initiatives is monitored, along with the implementation of this investigation's recommendations, by NHS London and commissioners of the service.

Recommendations not Implemented

However, the investigation team have identified that despite a specific action point arising from the Board Level Inquiry referring to establishing *"clear pathways and protocols for the admission treatment and management of forensic patients on acute wards*", no such pathways have been developed for the patients on Waddon Ward.

Although South London and Maudsley NHS Foundation Trust reports sound working relationships with Mayday Hospital staff on a case by case basis these need to be strengthened at a senior level in a more regular and documented forum so that it is not dependent on just good relationships between individuals. However, the Trust reports that most transfers for acute healthcare are still to King's College Hospital, despite the move to Bethlem Royal site.

Recommendation: Joint Working to manage medical emergencies for high risk patients.
We refer to the earlier recommendation 2 for the Trust and Croydon Health Services NHS Trust to develop these protocols as a matter of urgency.

The action point referring to recruitment arising from the initial internal investigation[55] is recorded as completed. However, the current Ward Manager on Waddon Ward had been in an acting role at the time of interview for 12 months.

Given that nursing leadership and acting roles was a factor in the high turnover of staff on THU, this is disappointing.

Recommendation: Recruitment and Retention
We refer to the earlier recommendation 13 to recruit and appoint a substantive Ward Manager for Waddon Ward immediately

[55] Recruit to current vacancies on Waddon Ward (formerly Tony Hillis Unit) including Team Leader post

17.0 ROOT CAUSE ANALYSIS

At the time of the second absconsion, there were a substantial number of policies in place, but some policies were not clear (the Section 17 leave Policy referring to Restricted Patients), formalised ('Procedure for the Management of Medical Emergencies n Medium and Law Secure Services dated 12th November 2007) or fully implemented (the Trust policy on Risk Assessment) on the Tony Hillis Unit. The care and service delivery problems with contributory factors are represented diagrammatically in the fishbone diagram below.

This analysis follows NPSA guidance. In essence, an attempt is made to identify root causes in organisational process, how those directly resulted in specific care and service delivery problems and how those led to the documented actual or potential effect on the outcome. The issues overleaf identify sub-optimal processes as identified by using this technique. These issues are are highlighted for organisational learning.

Fishbone Analysis

Serious Incident:
Mr R absconds, leading to the murder of Mr Q

Patient factors:
Clinical condition:
Complexity of the personality disorder and high degree of psychopathy
Cardiac problems
Social Factors:
Mr R's history of substance misuse
Interpersonal relationships:
History of 'splitting' and grooming, deceit and managing impressions

Individual (staff) factors:
Psychological Issues:
Stressful environment for nursing staff, predominantly involved in 'security' not 'therapy'.
Cognitive factors:
Not all team members' views carried equal weight

Task factors:
Guidelines, Policies and Procedures
S.17 leave, transfer and escort of patients and risk assessment policies not clear, not adhered to, not implemented appropriately, not up to date.
Decision Making Aids
Incomplete information of previous abscond, history of violence, lack of family history/ corroboration via Social Work

Working condition factors:
Design of physical environment
Inadequate physical security provision, including restraint
Staffing
Inappropriate skill mix (e.g. Lack of permanent substantive senior staff)
Too low staff to patient ratio on escort
Use of temporary staff
High staff turnover

Team factors:
Leadership
Ineffective clinical leadership - 'acting roles'.
Support and cultural factors
Lack of induction and support networks for staff, especially Bank/ Agency nurses
Inadequate inter-professional challenge

Education + Training Factors:
Competence
Lack of knowledge and skills (by agency nurses in particular) of Personality Disorder, and issues around grooming and splitting.
Inexperienced staff on escort
Supervision
Inadequate supervision
Lack of / inadequate mentorship
Availability / accessibility
Training needs analysis not conducted /acted upon - high turnover of nursing (and Psychology) staff
Lack of induction for agency nurses

Equipment + resources:
Handcuffs considered but blocked as 'not therapeutic'.
Access to mobile phones not restricted

Communication factors:
Written Communication
Records stored both in paper and on ePJS
Written information not circulated to all team members
Lack of effective communication to staff of risks (Alerts systems etc)
Failure to communicate adequately risks and plans to escort and KCH staff
Communication Management
Ineffective communication flow to staff completing escort and to KCH security staff
Over reliance on Police without underpinning relationship and understanding of needs

Organisational + strategic factors:
Organisational structure
Unit not adequately linked to organisational governance structure, policies not fully implemented or seen as 'inappropriate for unit'.
Inadequate commissioning/ performance management reporting
Externally imported risks
Transfer of unit from THU to Wadden Ward River House
Agency/ bank nursing staff with inadequate preparation for role
Safety culture
Inappropriate safety / efficiency / therapy balance
Insufficient attention to safety and security, history of absconds
Failure to learn from previous absconsion

18.0 CONCLUSIONS

Mr R had been involved with the criminal justice agencies for over 20 years. He had spent time in Young Offender Institutes and Prison for a range of convictions including Rape, Theft, Robbery, and Unlawful Sexual Intercourse. He had a history of substance misuse, violence and sexual offences.

He had engaged in attempts to change his behaviour through the various programmes on offer within prison, including Sex Offender Treatment Programme and Enhanced Thinking Skills.

He had been involved with psychiatric services for approximately fifteen years. Both his offending history and psychiatric history can be characterised by increasing seriousness.

He had a history of absconding from secure environments, when in lower security settings. He was known to have a medium risk of sexual reoffending and high risk of violent reoffending and high risk of violent and sexual reoffending.

He was known to be confrontational, aggressive, manipulative, and able to split his care teams.

It would have been much better to wait for the transfer of the Tony Hillis Unit to Waddon Ward to be complete before re-admitting Mr R

That he would attempt to abscond again whilst faking symptoms of physical illness had been foreseen and planned for. That he was at high risk of a further violent offence or violent and sexual offence had been foreseen by the prison service.

The plans to prevent this absconsion were inadequate; relying too much on inadequately prepared Agency and Bank nursing staff, and not enough had been learnt or implemented from his previous absconsion. Therefore the dynamic factors affecting the likelihood of a further abscond were missed.

The underlying staffing and management issues within the THU were in large part the root cause of the second absconsion.

The investigation team acknowledge that assessments had classified Mr R as medium or moderate risk of absconding and it was thought the positive factors mitigated the negative factors for absconsion.

But for the absconsion of Mr R from King's College Hospital, the murder of Mr Q would not have taken place.

APPENDIX A: TABLE OF RECOMMENDATIONS

Recommendation 1. Commissioning Roles
We recommend that within 3 months of the publication of this report, NHS Lambeth, London Specialised Commissioning Group, and the national DSPD Programme clarify roles and responsibilities for the funding, performance management, oversight and commissioning of this service.
Recommendation 2. Joint working to manage medical emergencies for high risk patients
We recommend that the South London and Maudsley NHS Foundation Trust and Croydon Health Services NHS Trust meet, immediately, to establish sound and collaborative working relationships at a senior operational level, to develop clear, shared, agreed and understood policies for the management of medical emergencies for medium secure patients. These procedures to be tested and reviewed on an ongoing basis to establish safe working.
Recommendation 3. Use of Restraint
Future planning to manage risk needs to consider the need for ongoing physical restraint whilst patients receive treatment in acute hospital, not just during transit. The investigation team note this has now in fact been incorporated in the Trust Policy for Patient Leave of Absence, Conveyance & Escorting in Medium & Low Secure Services.
Recommendation 4. Communication between Ministry of Justice and Forensic Services
Any future discussions and requirements regarding restrictions placed on prisoners subject to detention under Part III of the Mental Health Act between the Ministry of Justice and Forensic Services should be followed up in writing by the Ministry of Justice.
The Ministry of Justice should correspond in writing with RMOs (RCs) in relation to any aspect of a patient's care, or to follow phone calls with written documentation confirming a conversation, to avoid misunderstandings and discrepancies in care.
Recommendation 5. Assessment of patients and use of previous records
We recommend that efforts are always made to obtain all past medical records on patients receiving in-patient treatment. The importance of obtaining past records to reduce the risk of serious incidents repeating should be reinforced.
Recommendation 6. Timing of future admissions
We recommend that there is multi-disciplinary and management input into the timing of admissions to a service about to undergo a period of significant change. It is better to delay admission than risk a serious incident occurring due to staff pressures to manage the change and increased anxiety caused to patients who are still settling into a new environment and are likely to be unsettled in their mental health.

Recommendation 7. Risk Assessment
We recommend that the grab pack highlights the nature and level of risk presented by a patient in simplified terms as a guide to appreciating the risk.
Recommendation 8. Social Work
We recommend that Social Workers play an active role in liaising with external agencies, including family members and criminal justice agencies, to collect and corroborate information which could be extremely important in risk assessment and management. This should be directed by the RMO (RC) and agreed by the multi-disciplinary team.
Recommendation 9. Multi-disciplinary assessment for new patients
We recommend that all admissions, whether they are new or re-admissions, be subject to a multi-disciplinary assessment prior to admission. A medical assessment is key to ascertaining diagnosis and suitability for treatment, but a nursing assessment is necessary to advise and prepare staff for manageability within a ward environment. In the case of a population of patients with a personality disorder, a psychology assessment is also recommended. All assessments should involve the preparation of a written report, and the outcomes of the assessment discussed to agree a final common pathway.
Recommendation 10. Multi-disciplinary assessment, meetings and planning of admissions
Where such multi-disciplinary meetings take place in future, minutes should be produced and should include agreed actions and a formally agreed plan that should be distributed to all members of the clinical team.
We recommend that notes of such meetings recording clinical decisions are entered contemporaneously into ePJS.
Recommendation 11. Multi-disciplinary Review
We recommend that all new admissions which are undergoing assessment for a time-limited period, which we understood to be 3 months, are subject to weekly multi-disciplinary review.
Recommendation 12. Nursing Leadership
Nursing leadership and historically high churn rates within the nursing team is a known risk to the Trust for this service. A contingency plan should be in place for managing the risks incurred when senior positions in the team are vacant to ensure stability on the unit.
The practice of long periods of acting up does not provide real continuity for the team nor the post holder. The Trust should recruit a substantive Ward Manager for Waddon Ward immediately.

Supervision, mentorship opportunities and appropriate training for managers must be resourced that are specific to this client group to prevent staff burnout[56].
The full involvement of the nursing staff in the assessment, treatment planning and provision of therapeutic interventions must be monitored and audited on an ongoing basis to ensure that it is embedded and continues.
Admissions should be carefully monitored and risk assessments completed to ensure the service has capacity and is functioning at safe levels for current patients as well as new individuals without permanent nursing leadership. If necessary, alternative arrangements for admission should be made to ensure service continuity and patient care.
Recommendation 13. Recruitment and Retention
A robust strategy for monitoring the Recruitment and Retention of all staff in the FIPT Service, especially Waddon Ward, should be produced and monitored monthly and include the involvement of the MDT. This strategy should include meaningful feedback from staff who leave the service and must be fed back into the service via Clinical Governance and other performance management meetings.
A threshold should be agreed and set on the maximum vacancy levels of staff to be held by the team on Waddon Ward. If breached, these should ensure extra resources be provided and admissions stopped until the team is stabilised.
Links with other similar services must be forged to develop strategies for staff support.
Staff should be polled annually on their experience of working within the FIPT Service and concerns noted and acted upon by senior staff.
Leaver's questionnaires should be fully utilised by management to examine why high management turnover has occurred and possible solutions to end the cycle.
Recommendation 14. Section 17 leave and Restricted Patients
That RMOs (now Responsible Clinicians, RCs) complete Section 17 leave forms when any detained patient is granted leave for any purpose.
That a copy of the care plan, outlining appropriate measures to protect the public, be placed, for the guidance of the escorting nurses, in the 'grab pack[57]' which is now in place on the unit for the transfer of emergencies. That escorting nurses are made aware of this care plan and conditions.

[56] Ministry of Justice, Department of Health. "*Working with personality disordered offenders – A practioners guide*" (January 2011)

[57] Grab Packs have been developed since the Mr R incident. Grab Packs contain high level information, a photograph and description of the patient, and a summary of their care requirements and their assessed risks, to be used in an emergency situation, literally 'grabbed' to accompany a patient requiring urgent transfer.

That the use of Section 17 for restricted patients be routinely and regularly audited
Recommendation 15. Relational Security
Training in relational security and boundary management be included within the induction package and all staff become familiar with the terminology and behaviours required to maintain a therapeutic and dynamic service environment. This could be evidenced by better retention/reduction in sickness levels and a reduction in ward incidents. This needs to be clearly reinforced by reference to the Mental Health Act to ensure there is a clear understanding of the implications and requirements under Part III of the Act and the meaning of restriction within this.
Recommendation 16. Induction Process
Regular monitoring of the usefulness of the current 2 week induction process should be undertaken and feedback sought on any improvements required to ensure it is an evolving process and meets the needs of all staff that experience it. Supernumerary status must be preserved during induction for all staff.
Agency staff Induction must be reviewed and ensured that it meets relational and procedural needs of the service.
Recommendations 17. Use of Mobile Phones
The Fallon Inquiry highlights concerns over communications usage and sets guidelines which should be adapted by River House to include mobile phone usage. We recommend that it is essential to control and monitor the use of ward-based telephones carefully in order to prevent abuse, control fraud and prevent the introduction of prohibited substances and articles into the Hospital.
We recommend a revised policy on the use and restriction of access to mobile phones whilst in the unit, based on best practice and guidelines arising from the Fallon Inquiry, is developed, implemented, and regularly audited for implementation.
Recommendation 18. Boundaries
Boundary management will remain an ongoing issue for staff working with DSPD patients and constant training in this area must be supplied and monitored for its effectiveness by the Trust. This training should commence in induction and be an ongoing feature in supervision and all clinical meetings so that grooming and coercion can be closely monitored between staff and patients. This must be monitored and resources developed to ensure that the skills being gained are held within the team. If clinical supervision/group supervision is suspended then senior managers must be alerted and act to replace resources in a timely manner.

Recommendations 19. Future Investigations
We recommend that the Trust adopts the NPSA "*Good Practice Guide for Independent Investigations of Serious Patient Safety Incidents in Mental Health*", and provides one single robust investigation and action plan.
That in future, in all such investigations, attempts are made to obtain the contact details and to contact both the victim and the perpetrators family/next of kin to explain the process and purpose of the investigation, and as appropriate the outcome.
That the contact details of staff involved in the incident are kept on file as part of the investigation process for serious incidents (especially homicides and suicides) to aid future independent investigations
That the Trust reviews security arrangements, use of mobile phones and management of visitors within Waddon Ward.
Recommendation 20. Ongoing monitoring of implementation of Action Plans
The investigation team recommends that the successful implementation of these actions and initiatives is monitored, along with the implementation of the investigation recommendations, by NHS London and commissioners of the service

APPENDIX B: TABLE OF STAFF TITLES - INTERVIEWS

Table of Staff Titles - Interviews

Consultant Forensic Psychiatrist

Deputy Ward Manager

Service Director & Joint Leader

Deputy Director

Detective Chief Inspector

Registered Mental Nurse

Acting Team Leader

Occupational Therapist

Senior House Officer

Clinical Psychologist

Registered Mental Nurse

Registered Mental Nurse

Sister (Oliver Ward KCH)

Matron (Oliver Ward KCH)

Staff Nurse (Oliver Ward KCH)

London Specialised Commissioning Divisional Director

Ministry of Justice

London Probation

King's College Hospital

Clinical Psychologist

Clinical Psychologist

Clinical Psychologist (Lead Psychologist)

Lead Clinician for Personality Disorder

Social Worker

Health Care Assistant

Ward Manager

Registered Mental Nurse

Nurse Consultant - Promotion of Safe and Therapeutic Services

Trust Investigations Facilitator

GLOSSARY

A&E	Accident and Emergency	
CQC	Care Quality Commission	
DBT	Dialectical Behavioural Therapy	
DoH	Department of Health	
DSPD	Dangerous and Severe Personality Disorder	A title given to a few people with high levels of risk and serious criminal offending history, combined with a diagnosed personality disorder
ePJS	electronic Patient Journey System	The electronic clinical records for patients within the Trust
ETS	Enhanced Thinking Skills	A cognitively based programme given to people in prison to help reduce reoffending
FIPTS	Forensic Intensive Psychology Therapy Service	
GTN	Glycerol Trinitrate	Medication for the treatment of angina
HCR-20	Historical Clinical Risk Management 20	A clinical risk assessment tool used to predict the degree of a person's risk of future violence
HMP	Her Majesty's Prison	
HMYOI	Her Majesty's Young Offender Institute	
HSG	Health Service Guidelines	
KCH	King's College Hospital	
MHA	Mental Health Act	
LMI	Local Management Investigation	
MoJ	Ministry of Justice	
MSU	Medium Secure Unit	A secure unit for treating people with serious mental health problems who are a significant risk to other people
NPSA	National Patient Safety Agency	
PCL-R	Psychopathy Check List – Revised	Commonly used assessment tool for psychopathy
RC	Responsible Clinician	The clinician responsible for the treatment of a patient detained under the Mental Health Act 1983 (Amended in 2007).
RCA	Root Cause Analysis	The Root Cause is the prime reason(s) why an incident occurred. A root cause is a fundamental contributory factor. Removal of these will either prevent, or reduce the chances of a similar type of incident from happening in similar circumstances in the future
RMO	Responsible Medical Officer	The doctor responsible for the medical treatment of a patient detained under the Mental Health Act 1983 until the Act was amended in 2007
SARN	Structured Assessment of Risk and Need	A risk assessment used in prisons to predict the likelihood of further reoffending
SLAM	South London and Maudsley NHS Foundation Trust	

SOTP	Sex Offender Treatment Programme	A psychological therapeutic programme used to reduce sexual offending
THU	Tony Hillis Unit, Medium Secure Unit for the treatment of patient with severe personality disorder	
UDS	Urine Drug Screen	Urine test to test for the presence of drugs
USI	Unlawful Sexual Intercourse	
VRP	Violence Reduction Programme	A psychological therapeutic programme used to reduce the use of violence in participants

BIBLIOGRAPHY

Trust Policies

Arrangements for Medium Secure Patients outside MSU Boundaries, 2008

Clinical, Academic Group, Patient Tracking Using the Buddi Device, Escalations Protocols Pack

Cane Hill Forensic Mental Health Unit. Search Policy 2005

Working Draft Policy on the Use of Mobile Phones by Patients 20/01/2005

Engagement and Formal Observation Policy 2008

Engagement and Formal Observation Policy 2010

Incident Policy Appendix A - Incident Reporting Guidelines 2006

Incident Policy Appendix B - Open and Honest Incident Reporting

Incident Policy Appendix C - Fact Finding Report Pt1

Incident Policy Appendix D - Risk Analysis Tool Pt 1

Incident Policy Appendix E - Using the Adverse Incident/SUI and Near Miss Grading Tool

Incident Policy Appendix F - Supporting Staff after Injury or Assault at Work

Incident Policy Appendix G - Guidance on Integrated Reporting (children)

Incident Policy Appendix H - Adult Protection Investigations

Incident Policy Appendix I - Commissioning Form

Incident Policy Appendix J - Structured Investigation Process

Incident Policy Appendix K - Recommended Terms of Ref Directorate SUI Panels

Incident Policy Appendix L - Clinical Governance Recommendation Monitoring Form

Incident Policy Appendix M - Investigation Report Template

Incident Policy Appendix N - Procedures for Responding to Serious Clinical Incidents

Lambeth Social Services. Policy and Procedures for Protecting Vulnerable Adults in Lambeth from Abuse, 2001

Management of Medical Emergencies (Forensic Services) Checklist; Visiting Policy and Procedure

Patient Tracking Using the Buddi Device Policy 2011

'What is Buddi?'

Trust Safeguarding Adults Policy, 2008

Absconding Guidelines 2008

SLAM and Metropolitan Police Absent Without Official Leave (AWOL) Policy, 2008

Buddi Patient Tracker Patient Information Leaflet

Care Programme Approach Policy-"Towards Integrated CPA and Care Management", 2000

CPA Policy - Refocusing the Care Programme Approach, 2008

Draft Protocol for Using the Buddi

Education and Training Policy, 2008

Framework for Clinical Risk Assessment and Management of Harm 2001 (Version 3, amended December 2003 and July 2005).

Framework for Clinical Risk Assessment and Management of Harm, 2008

Guidance - Protecting Children and the Public.

Incident Policy 2006

Incident Policy 2008

Leave for Informal and Formal Patients Policy, 2004

Physical Health Care Guidance, 2006

Physical Healthcare Policy (Version 2), 2010

Physical Healthcare Policy, 2008

Policy for Patient Leave of Absence, Conveyance and Escorting in Medium and Low Secure Services, 2009

Policy for the Investigation of Incidents, Complaints and Claims, 2008

Policy on Being Open, 2008

Policy on Being Open, 2009

Policy on Learning and Embedding Lessons Arising from Incidents, Complaints and Claims, 2008

Policy on Learning and Embedding Lessons Arising from Incidents, Complaints and Claims, 2009

Preventing and Managing Violence Policy, 2007

Promoting Safe and Therapeutic Services Preventing and Managing Violence Policy, 2008

Risk Assessment and Management of Harm, 2001 (Amended June 2003)

Risk Management and Assurance Strategy (Version 2), 2007

Risk Management and Assurance Strategy (Version 3), 2008

Staff Induction Package.

Security Review, Procedure for Escorting Patients to King's College Accident and Emergency

Policy on Disclosure and Working within Multi Agency Public Protection Arrangements, 2008

Additional Trust documents

Action notes from meeting with SLAM at River House on 30th June 2008

Clinical Forum Business Meeting, Minutes from 23rd January, Ramada Grantham.

Contract between London wide programmes team on behalf of London PCTs and SLAM for Specialist Personality Disorder Pilot Services.

DSPD Project Management Group, draft agenda from 9 January 2008, Canonbury Place.

FIPTS (Waddon Ward) Service Level Agreement meeting, 28th July 2008

FIPTS Disclosure Form

Forensic Intensive Psychological Treatment Service (FIPTS) - Discharge summary - no date

London Forensic Personality Disorder Pilot Services.2008/2009 Development Targets.

Missing Persons Risk Assessment Form

Patient Consent Form - Buddi Patient Tracking Scheme

Project Management Group (MSU/Community), Minutes from 24th April 2007, Canonbury Academy

Project Management Group, Minutes from 7 May 2008, Canonbury Academy.

Appendix 4: Mr R Review Timeline

Appendix 7: Review of LMI (Local Management Investigation) into the Absconsion of Mr R on 27th Oct 200, March 2008

Appendix 9: Metropolitan Police. Minutes of meeting between police SLAM re Mr R. 17/01/2008

Appendix 10: Review of the Decision Making Process to Re-admit Mr R back into the Tony Hills Unit on 6th Dec 2007, March 2008

Appendix 11: Leave of Absence - Medium Secure Patients, March 2008.

Appendix 12: Policy Development for the Conveyance and Escorting of Patients off Trust Premises, March 2008

Briefing Note for Trust Board Members

Management of Medical Emergencies (Forensic Services) Checklist; Visiting Policy and Procedure

Summary of post implementation report, February 2008.

SUI Reporting form

Confidential Report, the Investigation into the Absconsion of Mr R from King's College Hospital on 15th Feb 2008, March 2008

Agreement to Share Information with MAPPA Agencies

Appendix 3: Options Paper on Security Arrangements for Medium Secure Patients Outside MSU Boundaries; 21st February 2008

Appendix 5: Briefing note re absconsion of Mr R. Deputy Director SLAM 2008

Appendix 8: Notes of meeting between South London and Maudsley NHS Trust and KCH on 27/02/2008

Appendix E. Local Management Inquiry - Part 1. Mr R. Date of incident 27/10/2005

FIPTS for Severe Personality Disorder.

FIPTS SLA Meeting, 16 January 2008.

Forensic Services PPU/MAPPA Disclosure Checklist

Procedure for the Management of Medical Emergencies in Medium and Low Secure Services, 2008

Procedure for the Management of Medical Emergencies in Medium and Low Secure Services, 2007

Secretary of State briefing re Mr R, 20TH February 2008

Review of Incident Involving Mr R. March 2008

Specification for Medium Secure Unit –The Tony Hills Unit, March 2007

Board Level Inquiry: Mr R, 26 June 2008.

FIPTS SLA Meeting, April 2009 to March 2010

Investigation Report into the Absconding of a Schedule 1 Offender on 15 February 2008, Whilst on Emergency Admission into King's College Hospital from a Trust Medium Secure Unit

South East London Forensic Psychiatry Group, Minutes from 3rd December 2007, Mary Sheridan House, London Bridge

Tony Hills Unit. Security Report Update.31st October 2007.

Security and Custody of Patients April 2008 – March 2009 Report to the Board of Directors: Part II 23rd March 2009

Other local documentation

London Borough of Bromley: Public Protection and Safety Policy, Scrutiny and Development Committee Minutes 17th March 2010.

Behavioural and Developmental Psychiatry Clinical Academic Group (CAG), SlaM "*Learning from Absconding*" report for Bromley Public Protection Scrutiny Committee 4 April 2011

<u>Correspondence</u>

Letter re: SLA Contract 08/09 for Specialist PD Pilot Services-FIPTS.

Letter re: Mental Health Act Commission-Annual report 2006/07 on 23rd March 2007

Letter from Consultant Forensic Psychiatrist to Director Lambeth Adults and Medium Secure Services on 5th March 2008.

Letter to Mr R on 19th June 2006.

Letter to Mr R on 22nd August 2006

Email to re Mr R on 26th September 2006

Email to Dr on 8th January 2007

Email from Dr on 19th March 2007

Email on 3rd August 2007

Email re: Placement at Tony Hills Unit for Mr R on 8th October 2007

Email re: Mr R on 7th December 2007.

Email re: Leave and escort policy 5.1.06. 10/03/2008

Email re: Mr R 10/03/2008

Email re: Mr R 11/03/2008

Email Briefing re: Mr R 16/09/2008

Email re: Parole board at Albany Prison 18/09/2006

Letter from RMN Escort Nurse to Assistant Director Patient Safety, 1st October 2008

Department of Health and Ministry of Justice

Department of Health. *"A First Class Service: Quality in the New NHS"* (1998)

Home Office & Department of Health. *"Managing Dangerous People with Severe Personality Disorder: Proposals For Policy Development"* (July 1999)

Department of Health. *"Report of the Expert Committee: Review of the Mental Health Act 1983"* (1999)

National Institute for Mental Health. "*No Longer a Diagnosis of Exclusion: Policy implementation guidance for the development of services for people with personality disorder"* (2003)

National Institute for Mental Health. *"Breaking the Cycle of Rejection: The Personality Disorder Capabilities Framework"* (2003)

Department of Health. *"Independent Investigation of Adverse Events in Mental Health Services"* (2005)

Department of Health. *"Offender Mental Health Care Pathway"* (2005)

Department of Health and Health Offender Partnerships. *"Best Practice Guidance Specification for adult medium-secure services"* (2007)

Department of Health & Ministry of Justice. *"Forensic Personality Disorder Medium Secure And Community Pilot Services: Planning & Delivery Guide"* (April 2008)

National Patient Safety Agency. "*Good Practice Guide for Independent Investigations of Serious Patient Safety Incidents in Mental Health*" (2008)

National Patient Safety Agency. "*RCA investigation: evaluation, checklist, tracking and learning log*" (2008)

National Patient Safety Agency, National Reporting and Learning Service. *"Root Cause Analysis Investigation Tools: Investigation Interview guidance"* (2008)

Ministry of Justice. "*Mental Health Casework Section Newsletter"* (29th April 2010)

Department of Health. "*Your Guide to Relational Security: See, Think, Act"* (2010)

Ministry of Justice, Department of Health. "*Working with personality disordered offenders – A practioners guide*" (January 2011)

Department of Health & Ministry of Justice. *"Consultation on the Offender Personality Disorder Pathway Implementation Plan"* (February 2011)

Published Research

Brook, R; Dolan, M; Coorey, P. "*Absconding of Patients Detained in an English Special Hospital*", the Journal of Forensic Psychiatry, 10:1, 46-5 (2008).

Coid, Yang et al "*Predicting and understanding risk of re-offending: the Prisoner Cohort Study"* (2007)

Moore, E; Hammond, S. "*When statistical models fail: problems in the prediction of escape and absconding behaviour from high-security hospitals*", The Journal of Forensic Psychiatry, 11:2,359-37 (2000).

Bowers, L; Jarrett, M; Clark, N; Kimbaya, F; MacFarlane L. "*Runaway Patients: Report to the GNC Trust*". City University London, (1998).

Bowers, L; Alexander, J; Simpson, A. "*Anti-absconding Workbook*". City University London, (2003).

Bowers, L; Alexander, J; Simpson, A. "*Anti-absconding Intervention: A handbook for Ward Managers*". City University London, (2003).

Singleton, N., Meltzer, H. and Gatward, R. "*Psychiatric morbidity among prisoners in England and Wales*", The Stationery Office, London, (1998),

Stewart, D; Bowers, L. "*Absconding from Psychiatric Hospitals: A literature review*" (2010)

Stewart, D. "*The problems and needs of newly sentenced prisoners: results from a national survey"*, Ministry of Justice Research. Series 16/08. London: Ministry of Justice (2008)

Warren, McAuley, et al "*A review of treatments for severe personality disorders*". Home Office Online Report (March 2003)

Other Inquiries

His Honour Peter Fallon QC, Professor Robert Bluglass CBE, Professor Brian Edwards CBE, Mr Granville Daniels (January 1999) "*Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital"* VOLUME 1. The Stationery Office. <http://www.archive.official-documents.co.uk/document/cm41/4194/4194.htm>

Books

Jones, R (2003) "*Mental Health Act Manual*" 8th Edition; London, Sweet & Maxwell