NHS
East Midlands

An Independent Investigation into the Care and Treatment of a person using the services of Nottinghamshire Healthcare NHS Trust

Undertaken by Verita

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VERITA

INVESTIGATIONS – REVIEWS – INQUIRIES

An independent investigation into the care and treatment of Mr C and Mr M

A report for
NHS East Midlands

January 2011

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Abbreviations and references

The report refers to NHS staff by their job description.

Acknowledgments

We would like to thank everyone who gave up time to give evidence to the investigation and who spoke so freely to us. We would like to acknowledge the cooperation of the risk manager, Nottinghamshire Healthcare NHS Trust whose assistance has been helpful to us in completing our task.

We would also like to acknowledge the value of the help given by Mr M, and his mother Mrs M and his two sisters who all spoke to us with frankness and provided valuable evidence to the investigation.

1. Introduction

1.1 This investigation is into the care and treatment of Mr C and Mr M. Mr C died as a result of an incident involving Mr M whilst they were both inpatients on an acute admission ward in Nottingham.

1.2 On 13 August 2005 Mr C was found lying on the floor in the corridor with Mr M kneeling over him. Mr C was conscious but had serious injuries to his face. Mr C was taken to the accident and emergency (A&E) department at the Queen's Medical Centre, Nottingham and then admitted to an acute care ward. Mr C died on 19 August 2005.

1.3 Mr M was tried in the Crown Court and found guilty of Mr C's manslaughter. He is currently in Rampton Hospital detained under section 37/41 of the Mental Health Act (1983).

1.4 The Nottinghamshire Healthcare NHS Trust (the trust) established a trust investigation panel to examine the circumstances of the incident and the care given to both Mr M and Mr C. The trust investigation panel undertook interviews between July and October 2006, completed its investigation in October 2007 and made recommendations for improvements to services.

1.5 This independent investigation was commissioned by NHS East Midlands. It follows guidance in the Department of Health (DH) 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. The terms of reference for this investigation are set out on the next page. Our investigation began in June 2009, though interviews were not undertaken until late September 2009 because the trust had difficulty in providing contact details. The final draft report was sent to the commissioners in March 2010 and was then subject to legal review and review by Mr M.

2. Terms of reference

2.1 The following terms of reference were agreed by NHS East Midlands:

2.2 "*Undertake a systematic review of the care and treatment provided to Mr M and Mr C by Nottinghamshire Healthcare NHS Trust and other relevant agencies to identify whether there was any aspect of care and management that could have altered or prevented the events of 13 August 2005.*

The investigation team is asked to pay particular attention to the following:

- *To review the quality of the health and social care provided by the trust and whether this adhered to trust policy and procedure, including:*
    - *To identify whether the care programme approach (CPA) had been followed by the trust with respect to Mr M and Mr C;*
    - *To identify whether the risk assessments of Mr M and Mr C were timely, appropriate and followed by appropriate action;*
    - *To examine the adequacy of care plans, delivery, monitoring and review including standards of documentation and access to comprehensive records;*
    - *The Mental Health Act assessment process (if appropriate);*
    - *To examine the trust procedures in relation to the protection of vulnerable adults and whether these were appropriately followed in respect of Mr C.*
- *To examine the appropriateness of the assessment and outcome of the referral of Mr M to the National Psychosis Unit by West Sussex in May 2004 and the impact this had on his care and treatment.*

- *To examine the adequacy of the referral and transfer process from West Sussex to Nottingham in May 2005 in respect of Mr M and the involvement of his family in informing this process.*

- *To establish whether the recommendations identified in the trust's internal investigation reports were appropriate and to determine the extent of implementation of the action plans produced by the trust in response to these recommendations.*

- *To identify any learning from this investigation through applying root cause analysis (RCA) tools and techniques as applicable.*

- *To report the findings of this investigation to NHS East Midlands Strategic Health Authority."*

3. Executive summary and recommendations

3.1 Mr C died on 19 August 2005 as a result of an incident involving Mr M when they were both inpatients on an acute admission ward in Nottingham.

3.2 On 13 August 2005 Mr C was found lying on the floor in the corridor with Mr M kneeling over him. Mr C was conscious but suffering serious injuries to his face. Mr C was taken by ambulance to A&E at the Queen's Medical Centre, Nottingham and then admitted to an acute care ward. He died on 19 August 2005.

3.3 From 28 July to 12 August 2005 during the beginning of his stay Mr C was allowed to walk continuously around the ward corridor which was built around a square central area. At some point during his stay the door to the female only part of the ward was locked to stop him wandering through it. As a result when Mr C reached the locked door he had to turn around to walk the other way. At times he continued to try and walk through the female only dormitory area of the ward. Consequently on 4 August he was restricted during the day to the day area of the ward, but still at times continued to try and walk through the female only area.

3.4 On 5 August Mr C's observation levels were reduced to low. The rationale for this reduction is not recorded in the notes, but his behaviour is recorded as unchanged.

Comment

The failure to record why Mr C's observation levels were reduced to low when his notes record that his behaviour remained unchanged is of concern as it indicates poor record keeping and possibly an inappropriate level of observation. (See recommendation R2.)

3.5 At 10pm on 13 August 2005 Mr M was found kneeling on the floor, outside the entry to the female dormitory, leaning over Mr C. Mr C was conscious but bleeding profusely from his nose, he had a pen lodged in his right eye.

3.6 Emergency procedures were implemented and Mr C was transferred to the Queen's Medical Centre. He was supported by a nurse from mental health services during this admission.

3.7 Mr C died on the 19 August 2005. His clinical notes record that this was "*following a cardiac arrest.*"

Mr M

3.8 Mr M was 19 when he first had contact with mental health services in 1989. He was admitted to an acute admission ward in Norfolk and was diagnosed with agitated depression.

3.9 In the period between 2001 and 2005 Mr M received inpatient and outpatient care principally in West Sussex, from West Sussex Health and Social Care NHS Trust[1]. A number of his admissions were under sections of the Mental Health Act, 1983 (MHA) including removal to a place of safety under section 136[2].

3.10 Mr M is a qualified operating department practitioner (ODP) (though not now registered as an ODP). In May 2004 concerns about his behaviour led to Mr M being referred to occupational health services by his employer in Brighton. As part of this referral Mr M disclosed his previous mental health problems. He had not previously disclosed these as part of his pre-employment questionnaire. He was signed off as not fit for work. In May 2004 his employer referred him to his regulatory body the Health Professions Council (HPC)[3]. Mr M resigned from his post in August 2004 after a period on sick leave. The HPC hearing was held in May 2005, whilst we have no record of the outcome of that hearing we have checked his current registration status and we have been informed that his name was removed from the HPC register in October 2007.

[1] This trust no longer exists. It was established in April 2002 but merged in April 2006 with Sussex Partnership Foundation NHS Trust

[2] Section 136 gives the police power to remove a person to a place of safety, where they would then be assessed to determine whether they need to be admitted under other sections of the MHA

[3] The Health Professions Council is the regulatory body for 14 health professions including operation department practitioners.

3.11 In January 2005 Mr M was employed as an agency ODP in Wrexham. On 14 February 2005 he interrupted an operation saying the consultant should be arrested.

3.12 He was taken to the A&E department at the same hospital where he was verbally aggressive. He underwent a CAT scan[4] of his brain, which he was told was normal. Mr M viewed the scan and stated that it showed abnormalities. He was adamant that he had a brain haemorrhage. He was assessed by the psychiatric SHO and psychiatric liaison nurse and admitted to a psychiatric ward, under section 2 of the MHA.

3.13 He was transferred back to West Sussex on 18 February 2005. He remained as an inpatient in West Sussex, under section 2 of the MHA, until his move to Nottingham in May 2005.

Diagnosis

3.14 Since Mr M's first contact with mental health services there has been uncertainty over his diagnosis. Diagnoses have included post-traumatic stress disorder, acute psychotic feature, drug induced psychosis, and generalised anxiety symptoms.

3.15 In May 2004 Mr M's consultant in West Sussex referred him to the National Psychosis Unit (NPU) at the Maudsley Hospital for a second opinion. He was seen on three occasions and his last appointment was in April 2005.

3.16 By 2005 the team at the NPU had come to the view that he was paranoid and psychotic but he had none of the typical symptoms. He did not hear voices, did not have cognitive impairment and he did not have negative symptoms characteristic of schizophrenia[5].

3.17 In respect of the referral to the NPU the trust investigation report stated that:

[4] Cross sectional x-ray of organs of the body.
[5] These include flattening of emotion, poverty of speech, lack of volition and drive, loss of feeling and social withdrawal.

"…there was no evidence of a consultant opinion and therefore consider that the NPU diagnosis potentially confused the management of Mr M's care and reinforced the patient's view that he did not have schizophrenia and did not require medication. In our opinion this could have been a causal factor in his poor compliance, contributing to his relapse."

3.18 There is no evidence in the trust investigation report to support this finding and no evidence that any attempts were made to discuss directly with the NPU Mr M's care or the process for obtaining second opinions.

Conclusion

C2 Having interviewed the specialist registrar from the NPU who saw Mr M and her supervising consultant we are satisfied that there is a robust process in place for the supervision of specialist registrars by consultant staff. Mr M was seen three times by the NPU specialist registrar and she discussed Mr M with her consultant following the first and last appointment.

Discharge and move to Nottingham

3.19 Following a number of successful spells of home leave during which Mr M stayed with his fiancée, he was discharged from West Sussex on 4 May 2005 and moved to Nottingham to stay with his sister.

3.20 Mr M was seen 14 times at home, in clinic or at CPA meetings during the three months he was living with his sister and before his admission to the acute admission ward on the night of 12/13 August. These appointments were with his community psychiatric nurse, consultant psychiatrist and a clinical psychologist. He was prescribed risperidone 2mg daily, sertraline 150mg daily and diazepam 2mg prn[6].

3.21 During these three months Mr M appeared to be coping with living in the community even though he was experiencing some mental health problems. An example

[6] as required.

of his coping behaviour was that he successfully negotiated the tenancy of a council flat and made arrangements to live in it.

3.22 On 10 August Mr M was involved in an incident in the housing office where he claimed that he knew of a bomb plot. The police were called and he was removed. Mr M contacted his community psychiatric nurse who discussed this with the crisis team. A joint visit was arranged with the crisis team for 11 August and a message was left on Mr M's phone answering system. The community notes describe the visit on 11 August as *"failed at 4pm".*

3.23 There were now growing concerns about Mr M's mental state and on 12 August Mr M was admitted to the acute admission ward as described below. On admission to hospital he was placed on ten minute observations which were appropriate as he was obviously seriously ill and therefore a potential risk to himself and possibly others. Up to 10 August and prior to this sudden relapse Mr M had appeared to be coping quite well and was supported by a range of professionals of whom none had assessed him as a risk to others.

Conclusion

C3 We therefore conclude that up to the point of detention by the police and his subsequent admission to hospital the incident involving Mr C could not have been predicted.

Admission to an Acute Admission Ward

3.24 Around midnight on Friday 12 August 2005 Mr M was admitted to an acute admission ward on section 2 of the MHA. He had been in a pub in Nottingham when he told the barmaid that his drink had been spiked. Because he refused to leave the pub when asked to do so the police were called. He was taken to a police station on section 136 of the MHA. He accused the police surgeon who was called to assess him of killing innocent people in Palestine.

3.25 On admission to the ward the plan was to nurse Mr M on ten minute observations and to undertake physical assessment to include analysis for drugs as Mr M had felt that his drink had been spiked in the pub the previous day. The consultant psychiatrist and approved social worker who had assessed him at the police station and arranged for his admission decided that Mr M should not be given anti-psychotic medication over the weekend. This was to ensure they could conduct a full and proper assessment of his mental state.

3.26 The observation records for Mr M have not been traced by the trust. One of the trust managers we interviewed was a member of the trust investigation panel. She told us that the trust investigation panel had reviewed the observation records for 13 August and found that they had not been completed. The staff on duty at the time of the incident gave evidence in Mr M's trial that they had carried out the observations but not recorded them. In contrast Mr M told us that no one carried out observations on him in the 30 minutes prior to the incident.

3.27 We would have expected the trust investigation panel to have examined the hours leading up to the incident in more detail. This is a serious shortfall.

3.28 The failure to record the observations and the consequent difficulty in evidencing what occurred in the immediate period prior to the homicide highlights the importance of record keeping as a means of demonstrating actions taken by staff.

3.29 At 10pm on 13 August 2005 Mr M was found kneeling on the floor over Mr C outside the entry to the female dormitory. Mr C was conscious and had serious injuries to his face.

Conclusions

C4 Our review of Mr M's mental care history shows that he received substantial care and support in West Sussex, Wales and Nottinghamshire. On transfer to Nottingham he was followed up quickly, seen by a range of different staff and his care was in full compliance with the care programme approach. The staff who cared for him did so with appropriate levels of skill and professionalism. There was one significant area of

weakness which relates to the acute admission ward staff compliance with the trust observation policy. (See recommendation R2.)

C5 Because of the conflict in the evidence between the staff who were on duty and Mr M about whether observations were carried out and the failure of the trust investigation panel to examine in any detail the immediate period prior to the homicide we are unable to determine whether this incident was preventable.

Serious untoward incident process

3.30 We examined the serious untoward incident process, the trust investigation report and progress with the action plan that was drawn up after the trust investigation report was completed.

3.31 The notes of the trust investigation panel interviews indicate that some staff felt the support offered to those who were on duty on the ward at the time of the incident and in the immediate hours and days following the incident, was inadequate. We are unaware of any team debriefing following the incident. (See recommendation R3.)

3.32 The final trust investigation report was not completed until October 2007, two years after the incident. The trust investigation panel interviews took place during July to October 2006. One of the reasons we have been given for the delay was the request by police to delay any investigation until the police had completed their enquiries. Assuming the interviews took place after the police enquiries the completion of the report a year later is an unacceptable delay.

3.33 In our interviews with managers we have been assured that improvements to the process have been made and that investigations are now conducted in a timely fashion. We have included the need to ensure investigations are undertaken within an agreed timescale as part of recommendation R3.

3.34 The trust investigation panel interviewed a large number of witnesses. However the ward manager (at the time of the incident) had retired and the trust did not ask her if she would be interviewed. She willingly met with us for this investigation. Mr M's

community consultant (who assessed Mr M on 23 May) was not interviewed for the trust investigation either but she was phoned by the clinical director on the day she was moving house and had a brief discussion about the case. (See recommendation R3.)

3.35 Only the executive summary of the final report was circulated to those who had been interviewed. Due to legal advice sought by the trust and because Mr M had signed a disclosure that limited what could be shared with his family, Mr M's family were not shown the report and only had the main points shared with them in a meeting.

3.36 At our interview with Mr M's family we were told that no support was offered to them by the trust immediately after the incident. The first time they were seen by a trust member of staff was in relation to the trust investigation in 2006. Mr M explained to us that he had not seen the report only *"…a page"* and would like to do so. The trust sought legal advice on what could be shared with Mr M and were advised that because its report contained third party information (Mr C's care details) only a summary report should be shared with Mr M. We were told that a summary report was sent to Mr M's solicitor. If the one page report seen by Mr M was the summary report sent to his solicitor then this would be an inadequate summary. It would have been possible to send the whole or most of the report with third party information redacted. Sending a copy of the summary report to Mr M's solicitor was appropriate but additionally a member of the trust or the trust investigation panel could have taken the opportunity to discuss the report with Mr M.

3.37 There is a section in the trust's SUI policy on support for families and communication to discuss findings but not specifically about giving a copy of the report. The SUI policy does not make it clear what can be communicated to staff and families following an investigation. There should be clarity in relation to how the final report is shared with staff, perpetrators, victims and family members. (See recommendation R3)

3.38 The trust investigation report makes 12 recommendations. There is no evidence contained in that report to support recommendation 7 which deals with junior doctor access to senior medical staff and recommendation 10 which deals with the quadrangle layout of the ward. (See our recommendation R3.)

3.39 We are pleased to see that progress has been made with many of the recommendations. However there are still some actions that have not been completed. We are concerned that actions agreed in 2007 particularly recommendations 2 and 6 of the trust investigation report, have not been fully actioned. There has been little progress with some of the recommendations even those that are central to the trust delivering high quality care. (See our recommendations R5 and R6.)

3.40 Whilst our report identifies that the trust has improved its processes for learning from serious untoward incidents there is a need to continue this improvement particularly at trust level. (See our recommendation R7.)

3.41 The trust's policy and procedure on the reporting, management and investigation of serious untoward incidents dated November 2008 does not contain any information on the Memorandum of Understanding (MOU) that has been agreed with the police advising how to deal with NHS investigations that also involve a criminal investigation. The MOU was issued in February 2006. We have seen the November 2009 SUI policy which now includes guidance from the MOU. (See our recommendation R4.)

3.42 Throughout our investigation we made a number of requests to the trust for documents, information and the identification of witnesses. The trust failed to respond to some of these requests and we had to make further requests. This may indicate a resource problem or an insufficient priority given to supporting the process of independent investigations. As these investigations are commissioned to ensure any improvements can be identified and shared they should be given an appropriate level of trust support. (See our recommendation R8.)

3.43 Our report makes recommendations for service improvement which are listed below.

Recommendations

R1 The trust should audit whether health care assistants who undertake HoNOS assessments and other risk assessments have been appropriately trained and approved by the trust to do so.

R2 The trust should continue to audit compliance with its observation policy and provide evidence of the audit outcomes to its lead commissioners Nottingham City PCT.

R3 The trust should audit its SUI policy and practice to ensure the actions listed below are implemented.

- There is a more robust process for the debriefing of staff after a serious untoward incident and include this as an explicit and important part of the trust's policy.
- Staff who have left the trust are followed up if their participation in an investigation is necessary and the trust should develop a more flexible approach to staff seeing notes prior to an interview.
- Serious incident investigations are undertaken within agreed timeframes.
- The trust SUI policy and procedure contains a statement that the final report will be shared with all those who participated in the investigation unless there are clear and justifiable reasons not to do so.
- That before reports are finalised they are robustly peer reviewed to ensure there are clear links between evidence and the recommendations made in the report.

R4 The trust should ensure policies and procedures are updated in a timely way when new guidance is issued.

R5 Nottingham City PCT as lead commissioners should seek a firm commitment from the trust that recommendation 2 of the trust action plan relating to patient record summaries is implemented within an agreed timeframe and no later than the end of 2010.

R6 Nottingham City PCT as lead commissioners should seek a firm commitment from the trust that recommendation 6 of the trust action plan relating to copies of process notes is implemented within an agreed timeframe and no later than the end of September 2010.

R7 The trust board should ensure that its progress in putting in place processes for trust wide learning of systemic, policy or procedural issues arising from serious untoward incidents is continued and this should be included as part of the trust's performance reviews with its lead commissioner.

R8 The trust should ensure that sufficient resources and priority is given to supporting external independent investigations.

4. Methodology

4.1 The independent investigation team comprised Tariq Hussain a senior consultant at Verita and Elizabeth Howes an associate with Verita.

4.2 Dr Tim Amor, consultant psychiatrist, provided expert advice to the investigation team.

4.3 The approach agreed with the commissioners was that "*the investigation will not duplicate earlier internal investigations; the work is being commissioned to build upon the internal investigation."* The trust's investigation report contained comprehensive chronologies for both Mr C and Mr M. The approach we have taken is to verify the chronologies and to include in the main body of this report only a shortened narrative chronology of the care provided to Mr M and Mr C, sufficient to put our conclusions, findings and recommendations into context.

4.4 We reviewed all of Mr C and Mr M's case notes. In respect of Mr M this included his case notes from West Sussex, North Wales and Nottinghamshire. The other documentary evidence we reviewed is listed in appendix B.

4.5 Our terms of reference state that this investigation should cover the *"…care and treatment provided to Mr M and Mr C by Nottinghamshire Healthcare NHS Trust and other relevant agencies…"* We have not interviewed staff from other trusts. The one exception is that we interviewed staff from the NPU. We did this because the trust investigation panel made specific criticism of the service Mr M received from staff there. As the panel had not interviewed the relevant staff from the National Psychosis Unit (NPU) we decided that it was fair and appropriate for us to do so.

4.6 We held interviews in September, October, November and December 2009. All interviews were transcribed and witnesses were offered the opportunity to be accompanied and to review the transcript of their interview.

4.7 We have also reviewed the trust action plan and progress with its implementation.

4.8 Mr M's mother (Mrs M) and sister (Miss M) agreed to be interviewed. They gave us valuable information that helped us to understand more fully the events that led up to the tragic incident. At the end of the investigation we met both Mrs M and this time both of M's sisters to share with them the report's findings.

4.9 We also interviewed Mr M who was able to give us a clear account of his history and his mental state. This has helped us to understand a number of key issues from his perspective.

4.10 The trust offered to interview Mr C's family as part of the trust investigation. The family said they would prefer to wait until after the trial and initiate contact with the trust themselves. No contact was made by them after the trial. Given the time lapse since these events and the previous lack of contact by the family we felt it would be inappropriate to contact them now. We believe that the lack of information from Mr C's family does not materially affect this investigation.

5. Care and treatment of Mr C

Narrative chronology

5.1 On 26 July 2005 Mr C was admitted to an acute admission ward in Nottingham after being taken that day to the A&E department at the Queen's Medical Centre, Nottingham. During the previous two weeks his behaviour had deteriorated at the residential home. He had become increasingly manic and verbally aggressive to staff and residents and had been mumbling and not sleeping. On 26 July 2005 he had hit a member of staff and a member of the ambulance crew when they had been called. The ward staff were not able to gain information directly from Mr C due to difficulty in understanding his speech.

5.2 The key components of his care plan were:

- to review his medication
- to assist Mr C with his personal hygiene
- to nurse him initially on ten minute observation levels which could be reduced to 30 minutes if his presentation changed
- to retest and recheck his lithium level after five days and, if he failed to settle, consider a CAT head scan.

5.3 From 28 July to 12 August at the beginning of his stay Mr C was allowed to walk continuously around the ward corridor which was built around a square central area.

5.4 At some point during his stay the door to the female only part of the ward was locked to stop him wandering through it. As a result when Mr C reached the locked door he had to turn around to walk the other way. He still at times continued to try and walk through the female only dormitory area of the ward. Consequently on 4 August he was restricted during the day to the day area of the ward, but still at times continued to try and walk through the female only area.

5.5 On 2 August Mr C remained unsettled and was being nursed on ten minute observations.

5.6 On 5 August the case notes record that Mr C's observation level was reduced to low, 30 minute observation levels. The case notes record the decision was taken following a *"joint decision amongst nursing staff and ward manager".*

5.7 On 7 August Mr C appeared chaotic and agitated and he hit another patient twice in the stomach. Mr C spent time in his room and staff counselled Mr C that hitting another patient was not acceptable behaviour. No incident form was completed and no review of his observation level was undertaken.

5.8 On 13 August the assault by Mr M on Mr C occurred. The police and ambulance service were called. Mr C was taken by ambulance to the A&E department at the Queen's Medical Centre, Nottingham and was later admitted to an acute care ward. He was supported by a nurse from mental health services during his time at the Queen's Medical Centre.

5.9 Mr C died on 19 August 2005 at the Queen's Medical Centre. His clinical notes record that this was "*following a cardiac arrest."*

Issues arising from Mr C's chronology

Risk management during admission

5.10 A HoNOS assessment and a risk summary were completed on 27 July by a health care assistant (HCA).. This noted that Mr C had a past and current risk of danger to others and current risk of self-neglect.

Conclusion

C1 Mr C had a long history of mental health care and our review of his records and our interviews indicate that he was being appropriately cared for and that his care was regularly reviewed and every effort made to address his needs. His admission to the

ward was well handled and staff were seeking to ensure his physical and mental health needs were met.

6. Care and treatment of Mr M

Short tabular chronology [7]

- 1989 - first contact with mental health services - inpatient admission
- 2001 – 2005 inpatient and outpatient care in West Sussex
- Uncertain date in 2004/5 inpatient admission in Corfu while on holiday
- February 2005 inpatient admission in Wales where he was working as a locum
- February 2005 returned to West Sussex on a Mental Health Act section
- 4 May 2005 discharged from inpatient care in West Sussex and transferred to community care in Nottingham living with his sister
- 12 August 2005 admitted to an acute admission ward in Nottingham on section 2 of the Mental Health Act
- 13 August 2005 assaulted patient Mr C.

Narrative chronology

6.1 Mr M's first contact with mental health services was in 1989 when he was admitted to an acute admission ward in Norfolk. He was diagnosed with agitated depression which was thought to have been associated with relationship stress and anxiety relating to his concerns over his exam results.

6.2 In the period between 2001 and 2005 Mr M received inpatient and outpatient care principally in West Sussex from West Sussex Health and Social Care NHS Trust. A number of his admissions were under sections of the Mental Health Act including a section 136 police transfer to a place of safety. He was also admitted for a psychotic episode while on holiday in Corfu.

6.3 Mr M is a qualified ODP (though not now registered). In May 2004 Mr M was referred to the occupational health service by his employer in Brighton because of concerns about his behaviour. As part of this referral Mr M disclosed his previous mental health problems. He had not previously disclosed these as part of his pre-employment

[7] This short tabular chronology is provided to give an overview of the key dates related to Mr M's care.

questionnaire. He was signed off as not fit for work. In May 2004 his employer referred him to his regulatory body the Health Professions Council.

6.4 Mr M resigned from his post in Brighton in August 2004 and in January 2005 he secured work through an agency as an ODP at a district general hospital in Wrexham.

6.5 On 14 February 2005 Mr M interrupted an operation saying the consultant should be arrested. He was taken to the A&E department at the same hospital where he was verbally aggressive. As no psychiatric history was available he underwent a CAT scan of his brain which he was told was normal. Mr M viewed the scan and stated that it showed abnormalities and was adamant that he had a brain haemorrhage. He remained anxious and stressed and threatening to staff and was assessed by the psychiatric SHO and psychiatric liaison nurse. He was found to be suffering from acute psychosis with extremely threatening and aggressive behaviour and admitted, under section 2 of the Mental Health Act, to a psychiatric ward at the Wrexham Maelor Hospital on the same site.

6.6 On the same day he left the psychiatric ward and returned to the A&E department where he assaulted the doctor and sister who had treated him. He was returned to the psychiatric ward after being given intravenous sedation.

6.7 He was transferred on 18 February 2005 to a psychiatric ward at West Sussex Health and Social Care NHS Trust and remained on section 2 of the Mental Health Act.

Transfer from West Sussex to Nottingham

6.8 Mr M had split up with his fiancée in Sussex and his family were in Nottingham. After a number of successful overnight leaves he was discharged from the ward on 4 May 2005 to his sister's address in Nottingham.

Comment

The transfer arrangements from West Sussex were well planned and executed. Except for confusion over who was going to be his primary carer, his mother or his

sister, and what support they would receive. This is dealt with in more detail later in the report.

Community care in Nottingham

6.9 The West Sussex staff ensured that a planned transfer was put in place and Mr M was first seen by his Nottingham care coordinator on 9 May 2005. He was then seen by the consultant psychiatrist on 23 May for review and CPA. Mr M was prescribed risperidone 2mg daily, sertraline 150mg daily and diazepam 2mg prn.

6.10 We summarise below the community contacts made between his transfer from Sussex to Nottingham and his admission to an acute admission ward a period of approximately three months.

Contact	**Frequency**	**Date**
Home visits by CPN	Six times	First visit 9 May 2005 last visit on 9 August 2005 when it was reported *"Mr M was settled in mood. No psychotic features."*
Mr M attended CMHT base to collect medication	Twice	Last visit on 2 August 2005
Attended clinic	Once	30 June 2005
Referred to clinical psychologist on 16 June 2005	Seen twice	7 July and 20 July 2005
CPA meetings	Twice	23 May 2005 and reviewed on 11 July 2005
Risk assessment	Once	Completed 28 June 2005

6.11 In May 2005 the Health Professions Council held a Fitness to Practise hearing to deal with the referral from Mr M's Brighton employer and determine whether he was fit to remain registered with the council. Mr M did not attend the hearing and whilst we have no record of the outcome of that hearing we have checked his current registration

status and we have been informed that his name was removed from the HPC register in October 2007.

6.12 His consultant from West Sussex who knew him for the longest period prior to the homicide provided a clinical summary report for the HPC hearing. We deal with this letter in more detail below but at the end of the letter the consultant says:

> *"However I think it is far more likely that [Mr M] has a brief limited intermittent psychosis which is particularly sensitive to stress. In terms of clarifying at which end of this possible diagnostic spectrum [Mr M] sits, I think only time will tell but with the right treatment I think he has a realistic chance of remaining well into the future."*

6.13 During May Mr M was spending time preparing his case for submission to the Health Professions Council.

6.14 Mr M's community psychiatric nurse (CPN) in Nottingham referred him to the clinical psychology service in June 2005. Mr M was keen to undertake some work on addressing his anxieties, particularly his fear of attack by persons unknown.

6.15 On 28 June 2005 Mr M's CPN completed a risk assessment which stated that:

- he can be threatening and hostile if unwell.
- he does not accept a model of psychotic thoughts to explain his irrationality.
- he does not accept that his previous behaviour has presented a risk to other people.

6.16 The risk assessment plan was to:

- avoid over stimulating environments.
- make joint visits.
- encourage use of anxiety management skills.

6.17 On 20 July 2005 Mr M was seen by a clinical psychologist. At the time Mr M felt his main difficulty was the anxiety he felt about being attacked. The fear increased the more people there were around him and this affected everyday activities such as using public transport and going to the pub. He also mentioned to the psychologist that occasionally when watching the news he would worry that he was to blame for the incident that was being reported.

6.18 He was seen again by the psychologist on 2 August and a further appointment was made for 16 August which Mr M was unable to keep due to his admission to hospital.

6.19 On 9 August Mr M was offered and accepted the tenancy of a council flat.

Events prior to admission

6.20 Mr M was making arrangements to move into his own accommodation, organising for furniture to be delivered and applying for increased housing and council tax benefits.

6.21 His care coordinator summed up his assessment of Mr M just prior to the incident as:

> *"At the last point when I saw him, I did not feel that he presented a risk to other people. He came across as very rational, there had been no evidence of the intensity of the previous discussions we had. He seemed to me to be looking ahead in the sense that he was building his future, setting his new flat up and that was specific to that particular meeting."*

Comment

It is clear that outwardly Mr M gave the impression of a young man who was coping even though still experiencing some mental health issues.

6.22 Mr M told us that while outwardly he was giving the impression of coping he was increasingly becoming paranoid, believing that he was under threat from paramilitaries and other terrorist organisations.

6.23 On 10 August Mr M went to the housing office to report that he had lost his keys. On being shown into the interview room Mr M locked himself in saying that he knew of a bomb plot. The police were called and he vacated the room when asked to do so by police officers.

6.24 Later that day, at 1pm, Mr M called the CPN and asked him to visit. Mr M explained to the CPN that he had visited his new flat and saw grey powder that he thought was explosives. Mr M told the CPN that he had earlier gone to the housing office requesting that the police investigate. The police visited his flat and told him it was dust. He was unhappy that no forensic tests were undertaken.

6.25 The CPN discussed this with the crisis team and a joint visit was arranged with the team for the next day 11 August and a message was left on Mr M's phone. The community notes describe the visit on 11 August as *"failed at 4pm".*

6.26 On 11 August, whilst drinking in a pub during the afternoon and early evening, Mr M was detained under section 136 of the MHA. He was taken to a police station. It became clear that he had not been taking his medication and he was concerned about the dust in his flat being radioactive. He also believed he had been charged with terrorist activity. He had been unwilling to talk to the police surgeon and accused him of killing innocent people in Palestine. At the police station he claimed he could hear whipping and cries of pain from women. A Mental Health Act assessment was undertaken. The notes of the assessment record a risk of aggression when unwell. He was visited by his mother whilst at the police station.

Admission to ward - midnight Friday 12 August 2005

6.27 Mr M was subsequently taken to an acute psychiatric admission ward at about midnight on Friday 12 August 2005. He was admitted under section 2 of the MHA.

6.28 Up to 10 August and prior to this sudden relapse Mr M had appeared to be coping quite well and was supported by a range of professionals of whom none had assessed him as a risk to others.

Conclusion

C3[8] We conclude that up to the point of detention by the police and his subsequent admission to hospital the incident involving Mr C could not have been predicted.

6.29 Mr M was assessed on the ward on 12 August by the SHO, having been previously assessed by a consultant in the police station as part of the MHA assessment. Mr M told the admitting doctor that he had gone to the pub where he had told the barmaid that his drink was poisoned and that everyone should check their drinks. She called the police because he refused to leave.

6.30 On admission he was placed on ten minute observations which were appropriate as he was obviously seriously ill and therefore a potential risk to himself and possibly others. He was written up for "*lorazepam prn only and should he need haloperidol duty doctor needs to assess*." Mr M was to be transferred to the locality ward on Monday.

6.31 Mr M went to bed after accepting 2mg lorazepam.

Saturday 13 August

6.32 At 1.30pm on Saturday 13 August Mr M demanded his medication. The duty doctor was called. Mr M was offered prn medication which he refused stating that he preferred to take sertraline 150mg which he was on before. The duty doctor was to attend the ward to assess.

6.33 The notes record that he had been agitated and was demanding his regular medication which he said was sertraline. He was offered lorazepam prn but he declined. He then appeared to settle.

6.34 His mother contacted the ward to say she was coming from Staffordshire where she worked. Mr M's rights regarding section 2 of the Mental Health Act were explained to him. He appeared to understand but felt the reason for his detention was terrorism.

[8] The numbering of conclusions in the main section of the report match those in the executive summary and therefore conclusions 2 & 3 are not in sequence.

6.35 His mother and sister visited between 6pm and 7.30pm. They spent time with Mr M and spoke to ward staff about Mr M's care.

6.36 There are no entries in Mr M's case notes covering the period between 7.30pm and the incident at 10pm.

6.37 At 10pm Mr M assaulted Mr C outside the entry to the female dormitory. Mr C was found lying on the floor in the corridor with Mr M kneeling over him. Mr C was conscious but had serious injuries to his face.

6.38 The police and ambulance service were called.

Post incident

6.39 Initially the plan was to transfer Mr M to a community forensic ward but he was taken to the custody suite by police. The police surgeon report states that Mr M was not fit to be charged as he was unable to understand the charges. The police surgeon felt that Mr M needed to be treated in a mental health facility under section 2 of the MHA.

6.40 He was transferred to the community forensic ward at approximately 11pm and placed in seclusion where he spent 20 minutes singing and at 11.30pm he was arrested for grievous bodily harm and taken into custody and back to the police station.

6.41 On Sunday 14 August Mr M was assessed by a CPN at the police custody suite. A psychiatric opinion was arranged for later that day with a view to inpatient care being provided in a medium secure facility.

6.42 At 9.15pm the consultant psychiatrist from the secure unit made contact, the police had not charged Mr M due to lack of evidence. The plan was for him to go to the community forensic ward and be placed in seclusion and be reviewed in the morning. Mr M remained in seclusion until his transfer to the medium secure unit on 17 August. There are several entries highlighting the need for this transfer due to clear risk to others and that he could not be managed safely if he was not in seclusion.

Issues arising from Mr M's chronology

Diagnosis

6.43 Since Mr M's first contact with mental health services there has been uncertainty over his diagnosis, these have included post-traumatic stress disorder, acute psychotic feature, drug induced psychosis, and generalised anxiety symptoms. Mr M was a difficult man to diagnose. He was very capable, he was holding down a responsible job as an operating department practitioner and he did not fulfil the negative symptoms of schizophrenia. In 2004 he was diagnosed as suffering from paranoid schizophrenia a diagnosis Mr M did not accept. Mr M became very angry when the consultant psychiatrist tried to explain this to him.

6.44 Mr M was referred to the NPU at the Maudsley in May 2004 by the consultant in West Sussex for a second opinion. The Maudsley is a teaching hospital and has been offering a second opinion service since 1978. Patients are either seen by a junior doctor or a specialist registrar. The medical staff that see the patients are under close supervision from a consultant. We interviewed the specialist registrar and supervising consultant who were involved in assessing Mr M.

6.45 A report was prepared for the Health Professions Council's fitness to practise hearing in May 2005 by the consultant psychiatrist who cared for Mr M in West Sussex and who knew him well. It stated:

> "*…with the right support and the right treatment Mr M functions at an extremely high level and can be symptom free for long periods."*

6.46 The report went on to say that:

> *"…if he remains compliant with medication and relevant work is done around relapse indicators and insight then it is likely that he will be well and capable of doing his job at the same level as before."*

6.47 This episode of Mr M's paranoia came on very quickly when he was in Wales and again a few days prior to his admission on 12 August in Nottingham. This is unusual and may have been due to the effect of the cannabis that he used to take earlier in his life. At interview the consultant psychiatrist at the NPU explained that:

> "*I see a lot of people with drug-related psychosis and this is one thing that we have been learning more about recently, that if you have abused drugs, you may sensitise your receptors, so that a stress which would not normally affect an individual can have a much greater effect, even five years later. There are now studies – mostly animal studies but also some human studies which show that just because you have stopped taking a drug does not mean your receptors go back to normal.*"

Referral to the National Psychosis Unit

6.48 At the NPU Mr M was seen by an honorary specialist registrar who had completed the MRCPsych[9]. His case was discussed with the supervising consultant after the first appointment. No discussion was held after the second appointment but a meeting to discuss his case was held with the supervising consultant after the third appointment. By this time Mr M was more ill.

6.49 The specialist registrar told us that at the first appointment on 9 July 2004 Mr M was accompanied by his girlfriend. He presented as having anxiety and he believed that people had been tampering with his locker at work and with his motorbike and that somebody had been moving some furniture around his flat. His girlfriend said she had witnessed what had happened to the motorbike. The specialist registrar told us:

> *"He did not describe any auditory hallucinations or visual hallucinations; he was not talking about a big plot against him. So there was nothing that was overtly paranoid, in that sense. In his mental state, he presented really well, very*

[9] MRCPsych (Member of the Royal College of Psychiatrists) is a qualification awarded to doctors who have completed three years of training and passed the relevant qualifications.

coherent, one was able to have quite a good interaction with him. I had quite a good rapport with him, as I have said here, he was not distractible or anything like that. His mood appeared to be good. I did not detect any other abnormal thoughts at the time. He talked about having had an acute psychotic episode in the past and we talked a little bit about his anxiety as well, which he acknowledged".

6.50 At Mr M's second appointment on 22 October 2004 his girlfriend was not in attendance. He had no delusional beliefs, and was functioning well. The plan was for him to start an antidepressant and to gradually reduce his antipsychotic drugs. In an interview with us the doctor from the NPU did not recall having any detailed information about the incident that happened in Corfu which led to his admission to a psychiatric ward.

6.51 At the third appointment on 20 April 2005 Mr M's presentation was completely different to the previous two appointments. He was very paranoid. He was certain that he had had a brain haemorrhage and that in Wales he had seen an abnormal scan. The doctor at the Maudsley was clear that Mr M was suffering some kind of psychotic episode. A letter written to the consultant psychiatrist in West Sussex makes this clear.

6.52 There was doubt about Mr M's diagnosis prior to him being referred to the NPU and he was indeed referred for a second opinion because the diagnosis was being queried. There had been uncertainty about his diagnosis throughout his care and at the third appointment with the NPU it was explained to Mr M that he would need long term treatment with an antipsychotic. The recollection of the specialist registrar who saw Mr M at the NPU was that he responded to this in a more positive way than before and accepted, albeit reluctantly, that he would need to be medicated.

6.53 By 2005 the team at the NPU had come to the view that he was paranoid and psychotic but he had none of the typical symptoms. He did not hear voices, he did not have cognitive impairment and he did not have negative symptoms characteristic of schizophrenia.

6.54 Following Mr M's appointment at the NPU on 20 April 2005 a discharge letter was sent to West Sussex dated 27 April 2005. The quote below from the letter indicates that the NPU staff knew about Mr M's forthcoming transfer to Nottingham and had taken that into account in the advice they offered.

> *"It does seem that he has been making a good recovery over the last 6-8 weeks that he has been on the ward and my understanding is that he has engaged very well with the team."*

Also

> *"Since he is particularly worried about sedation we briefly discussed the possibility of an anti psychotic called aripaprazole. However I would certainly not recommend any changes in the coming weeks particularly given his upcoming move to Nottingham."*

6.55 In respect of the referral to the NPU the trust investigation report stated that:

> "*…there was no evidence of a consultant opinion and therefore consider that the NPU diagnosis potentially confused the management of Mr M's care and reinforced the patient's view that he did not have schizophrenia and did not require medication. In our opinion this could have been a causal factor in his poor compliance, contributing to his relapse."*

6.56 There is no evidence in the trust investigation report to support this finding and no evidence that any attempts were made to discuss directly with the NPU Mr M's care or the process for obtaining second opinions.

Conclusion

C2 Having interviewed the specialist registrar from the NPU who saw Mr M and her supervising consultant we are satisfied that there is a robust process in place for the supervision of specialist registrars by consultant staff. Mr M was seen three times by the NPU specialist registrar and she discussed Mr M with her consultant following the first and last appointment.

Transfer from West Sussex

6.57 Prior to his move to Nottingham in May 2005, staff in West Sussex faxed comprehensive discharge information to Nottingham which included enhanced CPA, care plan and risk assessment documentation and documentation from the psychologist. It is unclear whether the letters from the NPU were sent to Nottingham at this point.

6.58 The West Sussex documentation indicates some confusion about who was going to be the principal family contact involved in his care. In some care plan records both Mrs M and Miss M are referred to in relation to discharge planning.

6.59 Though copies of his actual notes were not received by Nottingham until 11 July 2005 there is no evidence that the lack of the full set of notes caused any difficulties.

Community care and CPA in Nottingham

6.60 We interviewed Mr M's mother (Mrs M) and his sister (Miss M) who said that they had found it very confusing as to who Mr M was to be staying with. Mrs M had collected him from West Sussex but at interview Miss M said she thought that there had been a phone call previously to say that he would be staying with her.

Comment

From our interview with Mrs M and Miss M it was unclear whether the confusion was caused by the trust or was between Mrs M and Miss M.

6.61 Mr M told us that he was clear that he was staying with his sister. Miss M told us that as part of the discharge planning she had been promised support in caring for Mr M but did not receive any. In discussion with Mr M's CPN/care coordinator he told us that whenever he visited Mr M his sister was at work and his contact was therefore with Mr M's mother.

6.62 The enhanced CPA health and social care assessment document completed on 23 May 2005 records that no carers' assessment was offered to Mrs M who is recorded as the

carer. It also records Mr M's stay with his sister as being temporary as her house was for sale.

6.63 The enhanced care plan developed by West Sussex dated 22 April 2005 includes the statement "(*Mr M) and his sister will monitor his mental health using agreed relapse signature indicator Red, Amber, Green".* A copy of the relapse signature[10] is filed in the case notes.

6.64 At our interview with Mr M's family Miss M complained that she had not been included in any discussions with the community team despite Mr M living with her at the time. The family told us that no one had explained the relapse indicators to them.

6.65 Mr M had a copy of the relapse indicators and was familiar with their use but he told us that he did not share these with his mother and sister. They told us that:

> "…*when (Mr M) arrived we had nothing. He did say these are my traffic lights, that if I go from green to amber, what can cause it."*

6.66 Mr M told us that he did not want his family to treat him differently as a result of his illness and therefore did not share information with them and told the CPN he did not want information to be shared. In an attempt to develop a rapport with Mr M and to keep him engaged with services this had been respected.

Comment

Whilst most of the planning arrangements for Mr M's transfer from West Sussex to Nottingham were of a good standard the failure to ensure that his mother and sister were given copies of the relapse indicators was a serious omission. It left his sister in particular without any information on relapse and left her with an unnecessary level of anxiety. Nevertheless even if this information had been shared it is unlikely that it would have identified Mr M's changing mental health as he was

[10] A relapse signature is a form of early warning signs that a person's mental health is deteriorating

trying to conceal his deterioration. Also there was a sudden and more serious deterioration in the two days prior to his admission.

Mr M's CPN/care coordinator told us that he was seeking to develop a rapport and relationship with Mr M and as a result chose to respect his request for confidentiality. In hindsight this could be considered a failure as the family were obviously best placed to identify a relapse. The decision has to be weighed up against the fact that Mr M had only just been transferred to Nottingham and to breach his confidentiality may have made it more difficult to build a working relationship with him. Mr M's community care contacts were frequent and consequently there was effective monitoring of his mental state. At the time there was no guidance in place within the trust to deal with issues of confidentiality and Mr M's presentation did not give cause for concern. On balance we think that the decision made by the CPN/care coordinator was within the bounds of a reasonable judgement to be made by a professional.

6.67 Mr M was seen by an acting consultant psychiatrist and his CPN on 23 May when he was placed on enhanced CPA. The care plan was to continue with his medication, risperidone 2mg daily, sertraline 150mg daily and diazepam 2mg prn. His CPN was to refer him to psychology and assist him with his disabled living allowance and housing issues. It was arranged for him to have open outpatient appointments which could be requested by his CPN/care coordinator.

Comment

During the three months from 9 May to 9 August Mr M was seen 14 times by a variety of clinicians. He was seen regularly, reviewed at home, at clinic and in CPA meetings. He was referred for clinical psychology services and received and attended two appointments. Mr M continued to be cared for on enhanced CPA and we concur that this was appropriate. Mr M was reviewed in line with the trust CPA policy in force at that time and CPA documentation was effectively completed.

Risk assessment and management - community

6.68 The clinical risk management/risk indicators form completed on 28 June by Mr M's community psychiatric nurse records past incidents of violence, intent to harm others, dangerous impulsive acts and paranoid delusions about others together with signs of anger and frustration. It is also recorded that Mr M did not accept that his previous behaviour had presented a risk to others.

6.69 The care plan objectives recorded on 11 July 2005 were:

- to manage resettlement with minimal disruption.
- to manage anxieties and distress.
- to avoid deterioration of mental health.

6.70 Mr M told us that he now recognises that he was unwell while he was in Nottingham and that he was not compliant with medication.

Comment

Even though Mr M is now able with hindsight to recognise that he was unwell while in the community in Nottingham he managed to cope with his illness and was engaged in a number of practical negotiations. These practical activities and his reviews by clinicians gave the community team no warnings that he was at that time a risk to others.

Risk assessment and management – Acute Admission Ward Nottingham

6.71 On admission to the ward the plan was to nurse Mr M on ten minute observations, undertake physical assessment to include analysis for drugs as he felt that his drink had been spiked in the pub the previous day. It was also decided to avoid anti-psychotic medication over the weekend to enable a full assessment of his mental state.

6.72 The adult mental health directorate observation procedure of patients at risk describes the need to complete an observation sheet to record each time a patient is

observed. The policy also includes a section on the use of an observation rota. The rota should be retained in an identified folder for the financial year and stored in an appropriate place for two years and then filed in medical records.

6.73 We have been unable to find any record of the observations taking place. We requested copies of the observation records that were seen by the trust investigation panel but the trust has been unable to locate them.

6.74 One of the trust managers we interviewed was also part of the trust investigation panel. She told us that the observation records for 13 August had not been completed. The staff on duty at the time of the incident gave evidence in Mr M's trial that they had carried out the observations but not recorded them.

6.75 The trust investigation report says:

> *"Mr M was convinced that Mr C posed a threat to female patients and was being nursed on 'medium' observations at ten minute intervals. It is most unfortunate that the attack on Mr C seemed to have taken place during an intervening period, prior to the next check on Mr M being performed."*

6.76 Mr M described to us the events in the 30 minutes prior to the incident. He told us that he had gone to the ward office and told a member of staff that Mr C was attempting to enter the female-only area, but got no response. He therefore returned to the corridor area to prevent Mr C entering that area. In evidence to us Mr M stated that he was not told he had been placed on observation and he said that in the 30 minutes prior to the incident no one came to observe him.

6.77 The notes of the meetings held by the trust investigation panel with the three nurses on duty at the time of the incident do not deal in any detailed way with the period immediately prior to the incident or when observations were carried out and by whom.

Comment

At Mr M's trial staff on duty stated that they had carried out observations. We accept that the assumption by the trust, as included in the quote in paragraph 6.75 above, that the incident could have occurred between observations is valid.

We would have expected the trust investigation panel to have examined the hours leading up to the incident in more detail. This is a serious shortfall.

The failure to record the observations and the consequent difficulty in evidencing what occurred in the immediate period prior to the homicide highlights the importance of record keeping as a means of demonstrating actions taken by staff.

Recommendation

R2 The trust should continue to audit compliance with its observation policy and provide evidence of the audit outcomes to its lead commissioners Nottingham City PCT.

Conclusions

C4 Our review of Mr M's mental care history shows that he received substantial care and support in West Sussex, Wales and Nottinghamshire. On transfer to Nottingham he was followed up quickly, seen by a range of different staff and his care was in full compliance with the care programme approach. The staff that cared for him did so with appropriate levels of skill and professionalism. There was one significant area of weakness which relates to ward staff compliance with the trust observation policy.

C5 Because of the conflict in the evidence between the staff who were on duty and Mr M about whether observations were carried out and the failure of the trust investigation panel to examine in any detail the immediate period prior to the homicide we are unable to determine whether this incident was preventable.

7. Serious untoward incident process

Incident reporting

7.1 An incident on 2 August 2005 involving Mr C and a fellow patient and the incident involving Mr M and Mr C on 13 August were reported in accordance with the trust's incident policy. However, on 7 August (see paragraph 5.19) Mr C punched another patient in the stomach. Whilst this is recorded in the case notes no incident form was completed after the incident.

Debrief after the incident

7.2 The trust's policy on the reporting, management and investigation of serious untoward incidents at that time acknowledges the profound effect serious incidents can have on staff. The policy describes that the investigating officer and the manager of the area should assess whether action is required to support staff.

7.3 The notes of the trust investigation panel interviews indicate that some staff felt the support offered to those who were on duty on the ward at the time of the incident and in the immediate hours and days following the incident, was inadequate. One of the staff on duty stated she left the ward because of the lack of support. One of the other staff on duty did not recall any of the night coordinators coming to the ward after the incident. We were told in interview that offers of support were made to staff. We have seen notes of panel meetings that show the issue of staff support was being discussed by the panel. We are unaware of any team debriefing following the incident.

The trust investigation report

7.4 We have reviewed the trust investigation report and have assessed whether it adhered to the terms of reference, was comprehensive, identified the key practice or policy issues and whether the evidence supports its findings and recommendations.

7.5 The trust investigation report was of a good standard, contains a detailed root cause analysis, good chronologies and identifies areas of good practice. We make the following observations:

Terms of reference

7.6 The trust investigation terms of reference include the following "*review the availability of local and specialist services to meet the assessed mental health and social care needs".* There are no findings or evidence of this in the report.

Investigation process

7.7 The serious incident took place on 13 August 2005. Interviews with staff took place between July and October 2006 (a year later). The panel interviewed a large number of witnesses including the relatives of Mr M and Mr M himself during the period July to October 2006. Mr C's family were offered an interview by the trust and they asked to wait until after the trial. They said they wished to initiate contact themselves. No contact was made by Mr C's family after the trial.

7.8 Notes were taken of the interviews and we were told that staff were offered the opportunity to make amendments if they wished to do so. Though we have not been able to confirm this.

7.9 The ward manager who had left the trust by the time the interviews were conducted was not interviewed. She was contacted by us and freely came for interview. Mr M's community consultant (who assessed Mr M on 23 May) and who was not working in 2006 was invited to interview. She was advised by her representative organisation that she should review the notes prior to interview. She told us that the trust would not copy the notes and because of childcare difficulties she was not able to attend to view the notes. She was phoned by the clinical director and had a brief discussion about the case as she was moving house on that day.

Comment

It is important for the trust to be flexible when arranging interviews. It is also unclear why the notes could not have been copied. Even though the consultant was not working for the trust she could have been asked to sign a confidentiality agreement. She was also under a duty of confidentiality as a result of her registration with the GMC.

7.10 The final report was not completed until October 2007. We were told that there were a variety of reasons for the delay:

- Managerial changes
- Staff were unavailable due to annual leave or sickness
- The panel was keen to include Mr M and family members
- This report was one of the first undertaken using root cause analysis (RCA) and this delayed the process
- In addition the police asked that no action be taken until a clear process had been agreed in relation to their investigation.

Comment

While the reasons stated above provide a part explanation of the delay in undertaking the interviews it does not explain why it took so long to write the report. Such a delay in completing an investigation of a homicide occurring in a ward does seem to indicate that at the time the priority allocated to such investigations was quite low. These investigations are important as part of the trust learning process and if not undertaken swiftly may undermine the ability of the trust to do so.

In our conversation with managers we have been assured that improvements to the process have been made which will ensure that investigations are now conducted in a timely fashion.

7.11 In terms of the RCA process the fishbone diagram used in the root cause analysis does not contain any details of Mr M's previous risks although they were known on admission.

7.12 The membership of the trust investigation panel was appropriate and we were told that all panels now have at least one member who is trained in RCA.

7.13 We support the recent introduction of a secondment of a trust investigation staff member to coordinate the RCA panels and support the process.

7.14 Only the executive summary of the final report was circulated to those who had been interviewed. This decision was made by senior managers within the trust as they determined that the full report contained sensitive information. Our review of the trust report does not identify any information that would be more sensitive than staff would be dealing with in their normal day to day work. Also all staff are bound by a duty of confidentiality and some are also registered professionals and are bound by codes of ethics from their registering bodies. Therefore we cannot see why staff could not be shown full copies of the final report as part of an approach of learning lessons from the incident. As part of our meetings with staff we made provision for them to read the full report prior to our interviews.

7.15 Mr M's family were not shown the report and only had the main points shared with them in a meeting.

Comment

There should be clarity in relation to how the final report is shared with staff perpetrators, victims and family members. There is a section in the trust's SUI policy on support for families and communication to discuss findings but not specifically about giving a copy of the report. The SUI policy does not make it clear what can be communicated to staff and families following an investigation.

Report layout

7.16 The report may have benefited from a different layout for the ease of the reader in the following ways:

- Much of the introduction to the report is describing the methodology used.
- It would have been helpful if the introduction clearly described the incident being investigated.

Evidence

7.17 There is no evidence in the trust investigation report to support the statement that there was a lack of consensus regarding Mr C's care and treatment and risk assessment.

7.18 The trust investigation report makes 12 recommendations. There is no evidence contained in the report to support recommendation 7 which deals with junior doctor access to senior medical staff or recommendation 10 which deals with the quadrangle layout of the ward.

Recommendation

R3 The trust should audit its SUI policy and practice to ensure the actions listed below are implemented.

- There is a more robust process for the debriefing of staff after a serious untoward incident and include this as an explicit and important part of its policy.
- Staff who have left the trust are followed up if their participation in an investigation is necessary and the trust should develop a more flexible approach to staff seeing notes prior to an interview.
- Serious incident investigations are undertaken within agreed timeframes.

- The trust SUI policy and procedure contains a statement that the final report will be shared with all those who participated in the investigation unless there are clear and justifiable reasons for not doing so.
- That before reports are finalised they are robustly peer reviewed to ensure there are clear links between evidence and the recommendations made in the report.

Policy updating

7.19 The trust's policy and procedure on the reporting, management and investigation of serious untoward incidents dated November 2008 does not contain any information on the Memorandum of Understanding (MOU) that has been agreed with the police advising how to deal with NHS investigations that also involve a criminal investigation. The MOU was issued in February 2006. We have seen the November 2009 SUI policy which now includes guidance from the MOU.

Comment

We are concerned that national guidance issued in February 2006 has only just found its way into trust policy in November 2009.

Recommendation

R4 The trust should ensure policies and procedures are updated in a timely way when new guidance is issued.

Family involvement and support

7.20 Mr M's family told us that no support was offered to them by the trust immediately after the incident. The first time they were seen by a member of the trust was in relation to the trust investigation in 2006. They were seen again after the investigation had concluded but were only given verbal feedback not a written copy of the report.

7.21 Mr M explained to us that he had not seen the report and would like to do so.

Comment

We would suggest that the family should have been seen by a senior manager from the trust as soon as possible after the incident to explain what had happened, to answer any questions they had and to offer advice and support to the family.

7.22 We were told at interview with managers that when a serious incident occurs there is now an appointed advocate for victims, perpetrators and friends.

Comment

We support this provision as families of perpetrators' and victims should all be offered support.

Action plan

7.23 We have reviewed the trust action plan and the progress with its implementation. We note that progress has been made with many of the recommendations. We have been told there is now a process in place to sign off and monitor action plans on a six monthly basis via the serious critical incident review group. The action plan was originally signed off on 21 July 2008 and reviewed on 20 January and 22 September 2009.

7.24 We were told that since this incident work has taken place to ensure recommendations are clear and relevant to the incident and more focussed on outcomes rather than process.

7.25 There are however still some actions that have not been completed. These are:

Trust recommendation 2

> *"Where individuals have long term mental health problems patient records would benefit from an extensive up to date summary of mental health care. Significant*

issues should be identified to assist other services such as crisis resolution and home treatment team, or acute psychiatric services at times of admission."

7.26 Managers told us that a short pilot funded in 2009/10 has been undertaken by a member of medical staff on the assessment ward but this has now ceased and no other progress has been made or planned. We also learned that it is likely to be two years before electronic records are fully available across the trust.

Comment

This action is a key component in ensuring that decisions taken about the care of an individual are informed by a summary of the patient's history, particularly if there is long contact with the service.

Recommendation

R5 Nottingham City PCT as lead commissioners should seek a firm commitment from the trust that this recommendation is implemented within an agreed timeframe and no later than the end of 2010.

Trust recommendation 6

"Copies of process notes should be amalgamated within the body of main body of MDT records."

7.27 Managers told us that no progress has been made with this. The associate medical director is currently chairing a group to develop a record keeping strategy.

Comment

Again this recommendation is a key component in ensuring coordinated care.

Recommendation

R6 Nottingham City PCT as lead commissioners should seek a firm commitment from the trust that recommendation 6 of the trust action plan relating to copies of process notes is implemented within an agreed timeframe and no later than the end of September 2010.

7.28 The action arising from the following recommendation is a positive development:

Trust recommendation 8

> *"Ward based staff should be reminded it is imperative that MDT records contain information provided by relatives/carers, including details of any concerns that are expressed."*

7.29 We were told that the assessment ward now has a carer specialist, and there is a carers' team. This team also checks that a carers' assessment has been offered. This has led to greater awareness of staff to the importance of this issue. Carers' issues are also part of the supervision checklist.

Trust recommendation 10

> *"The quadrangle layout of the acute psychiatric ward makes it difficult to observe patients in the communal areas. The trust is asked to consider precautionary measures for the future."*

7.30 The action for this recommendation is for the ward to decant as part of the adult mental health strategy. This has not happened and is now planned for 2010. We asked whether the trust had undertaken a risk assessment of the ward and if necessary to have put in place relevant interim procedures to reduce risk until longer term plans could be implemented. We were told that no risk assessment had been undertaken. Consequently the trust has left a possible risk unassessed for almost three years. Managers should have undertaken a risk assessment. Despite this we were advised that there have been no incidents due to ward design since this incident.

Comment

We are concerned that actions agreed in 2007 still remain incomplete with significant progress still to be made, some of which are central to the quality and safety of care.

Learning lessons

Trust board

7.31 In terms of learning lessons from SUIs the trust's reporting, management and investigation of serious untoward incidents policy and procedure dated November 2009 includes a section on how the trust board is briefed about serious incidents. Serious incidents are included in the monthly performance report received by the trust board which includes performance against agreed timescales and targets. An executive director has responsibility for reporting the most serious incidents to the board and for providing copies of completed reports.

Serious critical incident review group

7.32 The policy also includes the statement that all investigation reports are reviewed by the trust-wide serious critical incident review group. This group is chaired by the executive director for clinical governance and medical affairs. Key learning points are agreed and collated and forwarded to the executive directors for operational services. Learning points are also circulated to the general managers and governance leads who are responsible for implementing the necessary action.

7.33 Managers told us that a monthly "Learning the Lessons" newsletter is circulated to teams highlighting the learning points from serious incidents. We were provided with examples of these.

7.34 We were also advised that a recently developed checklist to be used in supervision with staff which covers CPA, risk plans, care plans and carers' issues has been implemented. The use of this tool appears to have had a positive impact on the

yearly audits undertaken by the trust. Currently this checklist is used by managers and no data is collected centrally although in March 2010 this data will be collected in adult mental health as part of the audit process.

7.35 The SUI policy indicates that the board now takes a more comprehensive view of the performance around serious incidents. The use of the supervision checklist in adult mental health is a positive development. We asked managers if learning from SUIs was shared across the trust. The general manager, adult mental health services replied:

> *"…Not that I am aware of at a trust level. The trust risk manager sends a learning the lessons briefing out, so she will pick up key themes and that will go out as a briefing to staff, but in terms of a forum that looks at recommendations and issues more generally at trust level, I don't think that happens."*

7.36 The clinical governance lead for mental health services told us about trust wide learning from serious incidents:

> *"Certainly that has been an ongoing discussion in the organisation about how can we reflect on and consider appropriate learning and there has been some thinking that we perhaps would…have biannual events where we would scrutinise in more detail some of the analysis and that would also include our commissioners, who in that process would come and look at the learning that we need to consider. That is an ongoing development."*

7.37 The associate director social care told us:

> *"So we have mechanisms. I don't think all of our systems – I think they are good – but they are not as good as they could be because I don't think they are showing up particularly well and what lots of organisations do is stop at the point of action plan tick off, whereas to my mind that's the beginning. Once you have ticked off your action plan where is your assurance that that has had an impact?"*

Recommendation

R7 The trust board should ensure that its progress in putting in place processes for trust wide learning of systemic, policy or procedural issues arising from serious untoward incidents is continued and this should be included as part of the trust's performance reviews with its commissioners.

7.38 Throughout our investigation we made a number of requests to the trust for documents, information and the identification of witnesses. The trust failed to respond to some of these requests and we had to make further requests. This may indicate a resource problem or an insufficient priority given to supporting the process of independent investigations. As these investigations are commissioned to ensure any improvements can be identified and shared they should be given an appropriate level of trust support.

Recommendation

R8 The trust should ensure that sufficient resources and priority is given to supporting independent investigations.

Appendix A

List of interviewees

Mr M

Mrs M mother of Mr M

Miss M sister of Mr M

Trust consultant psychiatrist (Mr C)

Retired ward manager

Trust community psychiatric nurse

Trust locum consultant psychiatrist (Mr M)

Consultant psychiatrist (National Psychosis Unit)

Specialist registrar (National Psychosis Unit)

Trust service manager

Trust associate director for social care

Trust clinical governance lead

Appendix B

Documents reviewed

- Case notes from Nottinghamshire Healthcare NHS Trust for Mr C
- Case notes from Nottinghamshire Healthcare NHS Trust for Mr M
- Case notes from South London and Maudsley NHS Foundation Trust for Mr M
- Case notes from West Sussex Health and Social Care NHS Trust for Mr M
- Case notes from North Wales NHS Trust for Mr M
- Nottinghamshire Healthcare NHS Trust observation policy June 2004
- Nottinghamshire Healthcare NHS Trust observation procedure of patients at risk-adult mental health directorate. Reviewed August 2005
- Nottinghamshire Healthcare NHS Trust CPA policy dated June 2004
- Nottinghamshire Healthcare NHS Trust policy and procedure for the reporting and management of serious untoward clinical incidents May 2003
- Nottinghamshire Healthcare NHS Trust policy and procedure for the reporting and management of serious untoward clinical incidents May 2009
- Nottinghamshire Healthcare NHS Trust investigation report dated October 2007
- Nottinghamshire Healthcare NHS Trust action plan dated 18 July 2008 (reviewed 20 January 2009)
- Nottinghamshire Healthcare NHS Trust investigation report summary interviews
- Nottinghamshire Healthcare NHS Trust lessons learned newsletters for June, July and August 2009
- Audit of health records checklist dated October 2009
- Meeting notes 24 August and 9 September 2005
- Transcript of Nottingham Crown Court summing up and verdict

Appendix C

Team biographies

Tariq Hussain

Senior consultant Tariq is a former nurse director who brings to Verita his considerable experience of leading change management in the fields of learning disability and mental health services. Tariq has undertaken a wide range of projects for Verita which have included mental health homicide investigations and an investigation into sexual abuse by an eating disorder clinic manager. He also served as a member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain.

Prior to Tariq's appointment with Verita he served for eight years as a non-executive director of a mental health trust with board level responsibility for complaints and serious untoward incident investigations. Tariq also gained extensive experience of investigations and tribunals as director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting.

Liz Howes

Liz Howes has 20 years' experience of senior management in the NHS, specialising in mental health and learning disabilities. Liz led on a service improvement project in mental health services as part of a national pilot with the National Institute for Mental Health in England, and was responsible for leading a multi-agency project plan for the reprovision of homes for people with learning disabilities. This involved providing alternative accommodation and ensuring mainstream services for residents promoted social inclusion and personalised care.

Liz's previous posts have included interim director of learning disabilities and specialist services and head of services redesign and information services at Leicestershire Partnership Trust, and director of mental health services at Leicestershire and Rutland Healthcare NHS Trust.

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