

EXECUTIVE SUMMARY AND RECOMMENDATIONS
FROM
THE REPORT OF THE INQUIRY PANEL (MCCLEERY)
TO THE EASTERN HEALTH AND SOCIAL
SERVICES BOARD



Presented to EHSSB on 11 May 2006

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(v2_Redacted version _no cross references to main report)**

EXECUTIVE SUMMARY

INTRODUCTION

1. On Sunday evening/early Monday morning 9th/10th March 2003, Paul McCleery fatally stabbed his girlfriend, Sharon Moore. Paul was 37 years old at the time, while Sharon was 30. Their relationship had begun in August/September 2002.
2. Paul had gone missing from the Psychiatric Unit at Lagan Valley Hospital, Lisburn, on 6th February 2003, having been admitted just over two weeks earlier following his arrest by the police in relation to an incident in a local shopping centre.
3. On 10 September 2004 Paul pleaded guilty, by reason of diminished responsibility, to the manslaughter of Sharon Moore. On 31 January 2005, at Craigavon Crown Court sitting in Belfast, Mr Justice Girvan imposed a Hospital Order under Article 44 of the Mental Health (NI) Order 1986, subject to the special restrictions set out in Article 47 of that Order, and Paul was ultimately transferred to The State Hospital, Carstairs, in Scotland.

BACKGROUND

4. Paul McCleery had made his first contacts with mental health services between June 1985 and January 1988. However, there was a period of six years before his next contact (May 1994) when he was first admitted to Downshire Hospital as an in-patient. Downshire is one of two hospitals operated by Down Lisburn Health and Social Services Trust ('the Trust') offering mental health in-patient services – the other being Lagan Valley Hospital.
5. In total, Paul had five in-patient psychiatric admissions to Trust hospitals between May 1994 and January 1997. Paul was detained under the Mental Health (Northern Ireland) Order 1986 at some time during three of the five admissions, but was mostly treated as a voluntary patient. He absconded from hospital during two admissions, and attempted to leave during a third. During his third admission (February 1996), a diagnosis was made of "Paranoid Schizophrenia".
6. Paul was admitted, as a voluntary patient, to the Psychiatric Unit of Lagan Valley hospital on 21st January 2003 (the 'index admission') following his arrest at a local shopping mall in Lisburn. Paul had been waving a plastic broomstick and causing a disturbance. When approached by the police, he had pulled out a pocket-knife and made threats against the officers.

7. Paul remained in hospital until 6th February 2003, when he went absent without leave and did not return. Following the involvement of police, it was established that Paul was in Scotland. Sharon joined him in Scotland after approximately one week, and Paul was discharged from the hospital in his absence, with follow-up planned through an out-patient appointment.
8. Paul and Sharon returned to Northern Ireland two to three weeks later. After their return, they visited the Trust's Day Centre (Derriaghy) to which both had previously been referred. Paul and Sharon were apparently happy together and appeared to have got engaged, with Sharon showing a ring to staff at the Day Centre. This took place on Friday 7th March 2003.
9. Paul McCleery was arrested on the morning of Monday 10th March 2003 on suspicion of Sharon's murder.

INDEPENDENT INQUIRY

10. At the conclusion of legal proceedings in February 2005, the Eastern Health and Social Services Board ('the Board'), who had commissioned the mental health services from Down Lisburn Trust, set up an independent Inquiry under the terms of Departmental Guidance issued in May 2004.
11. The Inquiry panel was asked to review and examine the circumstances surrounding Paul McCleery's admission, treatment and discharge to and from the Department of Psychiatry at Lagan Valley hospital.
12. The panel met formally on 16 occasions over a total of 32 days, conducting a series of interviews with key professionals, both clinical and managerial, and seeking written evidence from a number of others. The panel considered this body of evidence, formulated its findings and, following a quality assurance process, agreed the contents of this report. During its first meetings, the panel agreed principles for the conduct of, and a clear methodology for, the Inquiry.
13. The panel's findings and recommendations are made in the context of the current structures within which mental health services are delivered. However, the panel also took account of two important reviews (Review of Public Administration and Review of Mental Health and Learning Disability) that will affect those structures in the future. The panel has concluded that its recommendations are consistent with proposals and principles contained in both of these reviews.
14. Having noted that some previous inquiry reports were severely restricted in their circulation, we concluded that the learning opportunities afforded by our Inquiry outweighed any consideration of the desirability for confidentiality. We have therefore made a recommendation that our report should be published.

FINDINGS

Non-implementation of Departmental Guidance by the Trust

15. Key amongst the Inquiry's Terms of Reference was the requirement for the panel to test whether or not the Trust's processes "complied with statutory obligations, current guidance and local operational policies which were extant at the time". One of the defining elements of this Inquiry is our finding that the Trust failed to implement Guidance issued by the Department of Health and Social Services in 1996 on: "The Discharge from Hospital (or prison) and the Continuing Care in the Community of Mentally Disordered People who are thought could Represent a Future Risk to Themselves or Others".
16. The apparent level of disregard for this Guidance was of concern to the panel, particularly as it was issued following recommendations made by an earlier homicide inquiry. The panel considered the Guidance in detail, and concluded that its proper implementation would, in all likelihood, have resulted in a different set of responses at certain points of Paul's care. The panel believes that that these different responses may have affected the outcome.

Accountability and implementation of further guidance

17. The failure to implement the 1996 Guidance also raised issues about the accountability of Health and Social Services Trusts under the current structures within which services are delivered. The panel has made suggestions to the Department of Health, Social Services and Public Safety ('the Department') regarding the need for appropriate monitoring procedures for mental health services to be developed in partnership with those commissioning and delivering services.
18. Specifically, the panel has concluded that Trusts' implementation of further Departmental Guidance, issued in 2004, would go a long way towards addressing many of the issues identified during the Inquiry. We have therefore suggested that implementation of the 2004 Guidance should be closely monitored, and have highlighted a way in which this might be done.
19. We have acknowledged that implementation of the 2004 Guidance may have some resource implications, and have suggested that the Department should consider provision of resources for the re-training of staff.

Individual and Corporate Level Practice

20. The panel found that there was no negligence on the part of any individual involved in the care of Paul McCleery. We have, however, identified instances of poor practice among individuals before, and during, Paul's index admission to hospital, as well as immediately after Paul was noticed to be missing. During our investigations into Paul's care, the panel also found examples of good practice, and these are highlighted throughout the report.
21. Importantly, and in accordance with the panel's desire to determine the root cause of problems identified, we also found that best practice was not necessarily supported by some of the Trust's policies and procedures that were in place at the time. These included policies on Assessment and Management of Risk, AWOL, Observations and Leave. Indeed, we identified evidence of deficiencies in the way policies were developed, implemented and monitored within the Trust, and in the way the Trust responds to new departmental guidance.
22. The panel has therefore recommended a wide-ranging set of principles for policies and procedures, and made recommendations relating to the development and implementation of policies and procedures in general, as well as to the improvement of individual policies or procedures. We have also addressed the need for the Trust to consider new Departmental guidance in a strategic policy context, and to develop appropriate infrastructure to guide, support and communicate implementation of change.
23. The panel also considered the Trust's management structures, at corporate and operational levels. We made suggestions regarding responsibility, representation and access to information at Director level. We also highlighted the panel's concerns about the Trust's operational structure, in terms of clinical governance, line management and professional accountability, citing two examples (Clinical Supervision and implementation of policies and procedures) where we believed confusion or ambiguity to have been in evidence.

Care Prior to the Index Admission

24. Paul's care following his discharge from hospital in 1997 included a short stay in a Down Lisburn Trust hostel facility, regular out-patient appointments, a referral to an Occupational Therapy group, attendance at the Derriaghy Day Centre, (another mental health facility operated by the Trust) and contacts with a Community Psychiatric Nurse.
25. The panel's view was that these services provided regular reviews and contacts with Paul and that these were entirely reasonable during a period of relative stability in Paul's symptoms.
26. However, in considering Paul's history of hospital admissions and care, the Inquiry panel identified an apparent correlation between instances of Paul's aggressive behaviour and his abuse of alcohol. This included

an occasion (in October 2000) on which Paul presented to Lagan Valley hospital in an intoxicated state, brandishing a knife and making threats to kill someone.

27. The panel recognised that these instances were spread over time, and that there was no 'dual diagnosis' service in place in the Trust at the time. However, given the seriousness of the knife incident, and several other alcohol-related incidents, the panel believes that an attempt should have been made to review Paul's case, and to refer him to services relating to alcohol abuse. This has also led the panel to make recommendations on the wider issue of dual diagnosis service provision.
28. The panel also looked closely at the six to seven month period leading up to Paul's index admission to hospital, not least because Paul's parents expressed a view that a change in Paul's medication, in June 2002, contributed to the tragic events.
29. The panel concluded that the level of monitoring of Paul's condition was appropriate over the four months following his change in medication. We believe that the contacts between Paul, his Consultant Psychiatrist and CPN, backed up by Paul's high level of attendance at the Day Centre, were sufficient to have identified any difficulties.
30. However, we established that there was a loss of contact between Paul and his CPN from October 2002 until the index admission, and we concluded that the CPN should have been more proactive in informing other professionals that contact had been lost. The panel also noted that Paul's attendance at the Day Centre also fell away around this time, with 24th October recorded as his last day of attendance.
31. The panel concluded that the loss of contact and lack of engagement were more likely to have been related to Paul's relationship with Sharon than to the change of medication. That said, Paul's compliance with his medication may have fallen off at this time, and these reduced elements of Paul's care denied professionals the opportunity to monitor efficacy and compliance. We have therefore made recommendations regarding the provision of guidance for community staff in circumstances where contact is lost.
32. The Inquiry also discovered information on two relevant incidents that occurred during the period immediately prior to Paul's index admission. In the first, Sharon Moore was admitted to Lagan Valley Hospital on 18th December 2002, following an overdose of drugs, which included Seroquel (Paul's anti-psychotic medication). There is evidence that Paul's involvement was recognised at the time as Sharon's boyfriend, and that he had become violent towards Sharon. The panel believed that a sharing of information with Paul's multi-disciplinary team would have been appropriate, although members recognised that such cross-referencing can be difficult.

33. In the second incident, Sharon made a complaint of assault against Paul on 18th January 2003. Sharon mentioned to the police in Lisburn that Paul was officially diagnosed as a schizophrenic. The panel recognised that current mechanisms did not allow formal alerts from the police to mental health services in such circumstances, but suggested that contacts might be appropriate in the context of a multi-agency approach to issues such as domestic violence. In the context of assessment and management of risk, the panel also made recommendations about the involvement of police.
34. Finally, the panel found no information on the hospital's files as to the exact time of Paul's arrival at hospital on 21st January 2003, how he was brought to the hospital, how he was handed over to nursing staff, and by whom. We have therefore made a recommendation that nursing staff should exchange details with professionals such as the police or ambulance staff.

Paul McCleery's Status as a Voluntary Patient

35. The panel considered the decision not to detain Paul under the Mental Health (Northern Ireland) Order 1986, and to allow him to remain in hospital as a voluntary patient during his index admission. This was certainly an issue of concern to both families, particularly in view of the seriousness of the incident for which Paul was taken into custody.
36. We considered the decisions made by Paul's GP, who assessed him at the police station after his arrest, and who decided that Paul did not require detention under the Mental Health Order because he was willing to be admitted to hospital. We then considered the actions of an SHO who examined Paul after his admission to hospital. This SHO was at first content to allow Paul to remain as a voluntary patient, but subsequently signed a 'Form 5', which allowed Paul to be detained for up to 48 hours in order that an application for assessment might be made. Finally, we considered the decisions of the Consultant Psychiatrist, who allowed this 48-hour holding form to lapse, some three hours after it had been signed by the SHO, but who qualified this with an instruction to "Detain if [*Paul*] wishes to leave".
37. The panel concluded that the GP's judgement was reasonable in the prevailing circumstances. We also concluded that it was reasonable for the SHO to complete a Form 5, given her stated concerns that Paul might leave the hospital. However, evidence was given to the panel regarding Consultants' expectations of SHOs and how Form 5s could be allowed to lapse following discussions between Consultants and nursing staff. The evidence suggested that these forms have on occasions been utilised inappropriately by doctors in Lagan Valley Hospital. The panel has therefore recommended that all Trusts should review their use of Form 5s to ensure they comply with the Code of Practice to the Mental Health (Northern Ireland) Order 1986.

38. We have concluded that the Consultant Psychiatrist did not act illegally in stopping the process normally begun by the Form 5. However, we have recommended that the process should normally be allowed to continue. Because of our concerns about the ways in which the Consultant's instruction regarding detention were, and could be, interpreted, we have also made a recommendation against the use of the phrase "detain if wishes to leave".
39. The panel believed that the Consultant did not have access to all relevant information regarding the risks that Paul McCleery presented, and that his decision regarding the Form 5 may have been different if he had access to information such as the alleged recent assault. Certainly it might have been argued that Paul's knife-wielding in a public place, the previous knife incident and instances of aggression, and Paul's history of absconding from the ward were legitimate grounds for detention despite Paul's willingness to remain as a voluntary patient.
40. However, we also took into account the principle of "least degree of control and segregation" and the requirement to discharge a patient "from any form of restraint or control" immediately it is no longer necessary, as contained in the Code of Practice to the Mental Health Order.
41. Having weighed up the evidence, the panel's conclusion was that the decision not to detain Paul under the Mental Health (Northern Ireland) Order 1986 was not an unreasonable one in the circumstances that pertained.

Care During the Index Admission

42. As our investigation of Paul's index admission continued, we concluded that staff had acted contrary to the Trust's policy on Observations by failing to apply 'Admission Level' observations to Paul. We believe that this level of observations, including a restriction on movement off the ward, would have been suitable for Paul. There was also poor documentation of on-going reviews of the level of nursing observations on which Paul was placed.
43. We also found weaknesses in the formal risk assessment that was carried out on Paul and an inconsistency in practice between the Trust's two hospitals. Other issues led us to conclude that professionals should have access to a full, up-to-date history for certain patients. Such a history would include information on risk and aggressive and violent behaviour, but would be equally concerned with matters of neglect, exploitation and other vulnerabilities. We were also concerned about a lack of documentation of the multi-disciplinary team's on-going assessment and management of the risk relating to Paul.

44. The panel found that, apart from some examples of good practice, there was little communication with Paul's parents on any of these issues. There was also a general lack of detail in entries recorded in the nursing notes, particularly in terms of therapeutic interventions. We have made a number of recommendations to address these issues of concern.
45. The management of Paul's leave and other time off the ward also caused us concern, there being no evidence of this being discussed or reviewed at any time. Furthermore, Paul's parents had a very different view of Paul's ability to come and go as he pleased than that outlined to the panel by nursing staff. We were unable to reach conclusions on how often Paul went off the ward during the index admission. This was worrying in itself, and the panel has made recommendations regarding the leave policy and documentation of decisions on leave.
46. Evidence of good practice during Paul's index admission included the hospital's use of multi-disciplinary weekly Team Assessment Meetings (TAMs). The panel commended professionals' preparation for the first of these meetings following Paul's admission, which included one very thorough summary found in the nursing notes. The panel also concluded that it had no difficulty with the management of Paul's medication while he was in hospital.
47. We also commended the hand-over of information on patients from a Consultant Psychiatrist to his colleague, who was to provide cover while the former took a period of leave during Paul's admission. However, the Consultant's leave coincided with the last days of a junior doctor's rotation, and this may have contributed to the fact that the multi-disciplinary TAM did not take place in the Consultant's absence. This may have been significant, given that Paul absconded two days after the TAM was due to take place. There had been instances of bizarre and unsettled behaviour recorded in Paul's nursing notes in the days prior to the scheduled TAM, and a request by Paul to be allowed to go home. These were not discussed in the usual multi-disciplinary forum.
48. Other aspects on which we have commented include the files and recording system in use at Lagan Valley hospital, the apparent lack of guidance to staff on the roles of Primary and Associate Nurse, and how allocations to those roles should be made. We have made further recommendations on these issues.

The response of hospital staff and other agencies when Paul left the hospital

49. The panel's investigation identified a series of missed opportunities to locate Paul and return him to hospital. We believe that, if any of these opportunities had been taken, the course of events, which ended so tragically, may have been changed.

50. We found that staff's initial responses to the situation were influenced by Paul's status as a voluntary patient, rather than the risks he presented to himself or others. The panel's main criticisms relate to the delay in implementing the existing AWOL policy, the decision to put Paul "on leave" overnight pending implementation, and in how the policy was implemented after the delay. We had particular concerns about delays in informing the police and senior staff and providing them with appropriate and timely information.
51. The panel identified problems in the communication of information (after Paul had left the hospital) among hospital staff, community staff, and with Paul's parents. We were also concerned at the absence of a plan to provide direction and through which specific roles could be allocated in a co-ordinated effort to locate Paul. For example, we found that nursing staff considered that their involvement was complete once certain people had been informed, and that this affected their response to the receipt of new and important information. We were also concerned that important matters relating to Paul's absence were not recorded on his file.
52. These concerns led the panel to make a series of recommendations regarding the AWOL policy and the need to retrain staff in its use.
53. We made several references to the part played by the Police Service for Northern Ireland (PSNI) in seeking to locate Paul as a 'missing person'. We commended the carefully timed recording of events evidenced in their files, and in their prompt response and communication with the hospital and Paul's parents. We concluded, however, that it would have been desirable for the police to seek to identify potential risks when Sharon decided to go to Scotland to meet with Paul.
54. Furthermore, there is evidence that the police expected confirmation from Paul's Consultant Psychiatrist that no further police action was necessary after Paul had been found and Sharon had joined him. The panel believed this to be entirely appropriate, given that the Consultant is recorded as having told the police that Paul was "a risk to the public". However, there is no evidence that this confirmation was forthcoming.

Paul's discharge from hospital

55. There is no record of Paul's case being discussed in the TAM held on 18th February. On 25th February, at the TAM, a decision was taken to discharge Paul from hospital, and to send an out-patient appointment to Paul's father's house.
56. The panel concluded that the process surrounding Paul's discharge from hospital, while he remained AWOL, was inadequate and did not

adhere to either the Trust's own discharge policy or the departmental guidance that was available to the Trust.

57. We also found that the attempt to follow-up Paul's discharge through an out-patient appointment was flawed, in that hospital staff had information that Paul's parents were away on holiday at that time. Furthermore, we found that the proposal to review Paul's case, a further 2 months after Paul missed his out-patient appointment, demonstrated a casualness and lack of concern about Paul's disengagement from mental health services and probable non-compliance with medication for a period that by then was more than 4 weeks.

The Trust's response following Paul's arrest on suspicion of Sharon's murder

58. We considered the Trust's response against the requirements and obligations contained in the 1996 Guidance, and in particular the section entitled "If things go wrong".

59. While acknowledging that the Trust had no specific obligations towards the family of the victim, the panel was content that Trust staff had made appropriate enquiries about services available to Sharon's family. However, we have made suggestions regarding what we consider would be best practice in offering support to a victim's family in similar circumstances in the future.

60. The panel concluded that the Trust fully met its obligations in terms of support offered to Paul McCleery, and in the support and services offered to Paul's family, both in the short and longer-term. We also found that appropriate support was made available to Trust staff who wished to avail of it.

61. However, the panel concluded that Paul McCleery's parents were poorly served by the Trust in the content of the Trust's response (issued in March 2005) to a letter of complaint that they forwarded in August 2003. The panel conclusion was that the response concentrated on defending the Trust's actions rather than seeking to identify areas for improvement and addressing Paul's parents' concerns. Nor did the panel find any evidence that a "full investigation" had been carried out as promised to Paul's family in response to their initial letter.

62. Within 8 days of the tragedy occurring, the Trust had begun an internal review of the incident, and a Critical Incident Review Report (CIRR) was signed off by the Chair of the review on 17th April 2003. This internal investigation was the subject of considerable scrutiny by the panel. The panel commended the promptness of the review, but suggested that an independent Chair, appointed by the Trust Board, would have been appropriate.

63. The Critical Incident Review Report's main finding was that "*there is no evidence to suggest that this event could have been foreseen or prevented*". In evidence before the Inquiry, Paul McCleery was variously described as "quiet", "solitary", "polite", "pleasant" and "well-mannered". A Social Worker who had known him for some time told the panel that she "would not have anticipated" that Paul "could have been so violent". On the face of it, therefore, the Trust's finding might seem reasonable.
64. The panel does not, however, concur with this finding, for reasons related to the internal review process, the contents of the review report, and the findings of our own investigations, which we have outlined in this summary and which are detailed comprehensively in the main report.
65. In terms of the Critical Incident Review process, the panel found no evidence of the involvement of a number of staff whose evidence we considered to have been crucial. Nor was there any involvement of the families. In terms of the review report, we also found that there were important omissions from the report, and that some facts had been reported inaccurately. The panel also found the report's presentation to be of an unacceptable standard.
66. It is the panel's view that the Trust's immediate investigation lacked sufficient process and critical, in-depth, analysis to identify and rectify possible shortcomings in operational procedures (as it was required to by the Departmental Guidance issued in 1996) and to reach its main conclusion. In this context, the panel has made a recommendation regarding the use of 'Root Cause Analysis' techniques in managing untoward incidents in the future.
67. When asking about the Trust's internal investigation, the panel was told that the Incident Review was standard methodology and was intended as an urgent review of the actions of individuals. The panel believed that an investigation at this level may have been appropriate had a more detailed investigation followed quickly thereafter. Paul's Consultant Psychiatrist told the panel that he had anticipated a more formal review, with external input, but that this had "been aborted" when it was established that [*this*] independent Inquiry would be established. This was consistent with a later report that a Professor (Consultant Psychiatrist) from outside Northern Ireland had been approached by the Trust's Clinical Director. However, no review materialised from this approach.

The role of the Eastern Health and Social Services Board in ensuring that the Trust met its obligations

68. In reviewing copy correspondence provided by the Trust, the panel commended prompt action taken by the Board Chief Executive in

spelling out (in a letter to the Trust Chief Executive) her expectations regarding the Trust's internal investigation. We found these expectations to be in accordance with the 1996 Guidance. However, we also concluded that Board staff could have been more proactive in following up the Chief Executive's letter, given that her expectations were not, in the panel's view, met by the report provided by the Trust to the Board.

69. The panel also commended the Board's Chief Executive for raising (with the Trust) the issue of securing records for a possible Inquiry. We found that not all of the records we required had been secured (or at least that they were not forwarded automatically to the panel) and we have therefore made a recommendation on securing documents in order to maximise confidence in, and to protect the integrity of, future inquiries.

CONCLUSIONS

70. Based on the evidence before the panel, including a report from the Consultant Forensic Psychiatrist who assessed Paul shortly after his arrest, we believe it very likely that, when he killed Sharon, Paul McCleery was extremely psychotic, that he was delusional and paranoid, and that his condition was exacerbated by abuse of alcohol and probable non-compliance with his anti-psychotic medication.
71. The panel has identified matters, some of which we believe may, if Trust policies had supported best practice and if best practice had been applied by staff, have changed the course of events which resulted in Sharon's untimely death.
72. Rather than concentrating on apportioning blame, the panel has made a series of constructive suggestions and recommendations, many of which should be addressed as a matter of urgency. It was, and remains, the desire of panel members that the Inquiry's findings will help those delivering important services to do so within a robust policy and procedural framework, and to avoid a recurrence of past mistakes. We believe that implementation of our recommendations will help towards this outcome.
73. The Inquiry report is made to the Eastern Health and Social Services Board. The panel's suggestions and recommendations are, however, made to the Trust, the Board and the Department. We are confident of the Board's co-operation in disseminating our findings and of the willingness of all the organisations to consider them in the context of the Department's 2004 Guidance. It is on their action following this consideration, measured through formal and robust monitoring processes, that we believe the Trust and others should be judged.

RECOMMENDATIONS

Circulation of the Inquiry Report

1. It is the panel's clear view, and our first recommendation, that the Board should publish this report, and that it should provide copies, in advance, to the two families involved. In support of this recommendation we have not used the names of staff involved. The panel acknowledges that the Board, in considering this recommendation, must look to its obligations to the families involved, and explore issues such as human rights and data protection.

Detention under the Mental Health (Northern Ireland) Order 1986

2. Evidence heard by the panel could be interpreted as suggesting that the Form 5 is used in Lagan Valley Hospital as a 'stop-gap' pending the arrival of the Consultant, and that it is subject to veto by other hospital staff. This would clearly not be the purpose intended for the Form 5 and we recommend that all Trusts should review their use of Form 5s to ensure that they comply with the Code of Practice to the Mental Health Order.
3. We believe the Consultant did not act illegally in stopping the process begun by the completion of a Form 5. However, we would recommend that once the process has begun it should normally be allowed to continue, with appropriate contact made among hospital staff, the GP, Approved Social Worker and nearest relative.
4. The panel agreed that the term "Detain if wishes to leave" is not a satisfactory one. It is clearly open to interpretation. It is not in keeping with the processes required under the Mental Health (Northern Ireland) Order 1986 and could appear to mean detention by default. It could also contravene the patient's human rights. The panel recommends that this phrase should no longer be used.

Implementation of 2004 Departmental Guidance

5. We recommend that the Department put in place a robust audit of each service provider's implementation of the May 2004 Guidance on 'Discharge from Hospital and the Continuing Care in the Community of People with a Mental Disorder who could Represent a Risk of Serious Physical Harm to Themselves or Others'.
6. While we believe that much of the 2004 Guidance could be implemented without significant additional resources, we recommend that the Department should consider providing whatever resources prove necessary for the re-training of staff in new responsibilities outlined in the Guidance, such as those of the Care Co-ordinator.

7. We recommend that the Trust should ensure that there are formal guidelines in place for its community staff to follow in 'loss of contact' cases and that these are brought to the attention of all community staff.
8. We further recommend that all care plans (for those who meet the criteria under the 2004 Guidance) should include relapse indicators and crisis and contingency planning, particularly in relation to loss of contact with services.

Principles for Policies and Procedures

9. The panel recommends that all policies and procedures should:
 - be developed with multi-disciplinary input and include user/carer consultation where appropriate;
 - be signed off at Trust Board level;
 - clearly state the purpose of the policy;
 - include reference to relevant statutory provisions and/or Guidance that have dictated or influenced the policy;
 - provide definitions;
 - be disseminated to those who have been identified as being affected by the policy (including new staff such as junior doctors and locums), with this process supported by targeted training or awareness-raising;
 - clearly state actions that are required of staff, and clearly identify the staff responsible for carrying these out;
 - provide for a robust system of monitoring and evaluation and demonstrate how this will relate to clinical governance arrangements;
 - provide for a review within one or two years (as appropriate); and
 - provide a clear linkage to other policies and procedures relevant to the subject matter and list any policies that are superseded by them.

Policies and procedures on the Management of Untoward Incidents

10. We recommend that the Trust (and others delivering similar services) should seek the assistance of the National Patient Safety Agency (NPSA) to train staff in the techniques of Root Cause Analysis (RCA), and that they should then develop policies and guidance on how untoward incidents are to be managed. We understand that the Department of Health, Social Services and Public Safety is in discussion with the NPSA about the development of a service level agreement. We would hope, therefore, that health and social care professionals will learn from those who are already using the RCA techniques, and implement them in Northern Ireland as soon as possible.

11. Other policies that we have considered differentiate between, and provide definitions of, untoward incidents and serious untoward incidents. They provide categories of incidents, with each category requiring a different response for which clear instructions are given. There is also a clear indication of staff responsibilities, including the reporting of each incident. The panel found this to be a very thorough approach, and one which we endorse and recommend for use by this and other Trusts.
12. We recommend that the Trust's response to homicides should be included in revised policies and procedures on Serious Untoward Incidents, rather than forming a stand-alone policy.

Admission and Discharge Policy and Procedures

13. We recommend that nursing staff who receive a patient into their care from the police or ambulance staff should exchange contact information with those staff. Nurses should record this information, together with the time of transfer, on the patient's file. We believe this to be important in terms of the safety of both patients and staff.
14. In the panel's view, admission to and discharge from adult mental health in-patient facilities should be considered a single process that provides staff with a framework for providing structured and continuous care. Our recommendation is that the Trust's Procedures for admission and discharge should not be separate.
15. The panel recommends that risk assessment should be included, or cross-referenced, in an Admission and Discharge policy. The panel has noted the section of the 2004 Guidance on 'Identification of those at-risk prior to discharge' and would endorse its contents as suitable for inclusion in the Trust's Admission and Discharge policy.
16. We recommend that relevant policies, particularly those pertaining to the delivery of care from the point of admission to the point of discharge, explicitly detail the Primary Nurse role. The duties and responsibilities of the role should be defined, as should the process as to how staff are allocated to that role. Similarly, clarity is required for the role of Associate Nurse, and how this role backs up and complements the work of the Primary Nurse. Equally important is the need to inform patients and their family and carers of the name and responsibilities of the Primary Nurse, as soon as possible after admission.

Assessment and Management of Risk Policy and Procedures

17. We recommend that the Trust must ensure that there is an adequate Assessment and Management of Risk Policy. The policy must be clear on responsibilities, how and when risk is to be assessed, managed and reviewed, and how records should be kept. The policy should be

consistent with, and draw from, the 2004 Guidance on Discharge (etc.). It must also be supported by an appropriate risk assessment tool, which should facilitate collation of information on historical, current and future risk.

18. We recommend that the initial risk assessment should be completed through joint assessment by the doctor and nursing staff. If a joint interview with the patient is not immediately possible or desirable, then medical and nursing staff should come together, as soon as possible after their initial assessments, to produce a joint risk assessment and to jointly agree the patient's care. The risk assessment form would then be signed by both medical and nursing staff.
19. We recommend that when police are involved in an admission because of a patient's aggression or violence, all relevant details should be obtained from the police, by the hospital, including previous instances of aggression or violence. Such action should also form part of the risk assessment process when a patient self-reports to mental health staff about incidents of his or her violent or aggressive behaviour that have involved the police.
20. Assessment and Management of Risk is applicable to all service users. However, we recommend that a full risk history (including neglect, exploitation and other vulnerabilities as well as violent and aggressive behaviour) should be undertaken on those patients considered to fall under the 2004 Guidance. It is important that someone is given responsibility for creating and updating each individual patient's history and ensuring it is available to all those involved in a patient's continuous care. We believe that this is a role that might be undertaken by a Key Worker, as referred to in the 2004 Guidance, but we recommend that adequate training must be provided to whoever is allocated this role.

Observations and Leave Policies and Procedures

21. We recommend that the Observations policy should explicitly refer to the 'Assessment and Management of Risk' policy as one that is linked to it. There is also an obvious link to the Admissions and Discharge policy and this should be recorded too. In all cases, we believe that the initial decision on observations (after the time for 'Admission Level' observations has 'expired') should be based on a joint medical and nursing assessment. The policy should clarify responsibilities, showing clearly who can apply and who can amend levels of observations, and under what circumstances they can do so.
22. We recommend that the Trust should consider the introduction of a "Level of Observations Record" which would provide a co-signed record of decisions taken on the levels of observations to be applied.

This would be retained prominently in the file and would help communication between nursing shifts.

23. We recommend that all patients' observations levels should be formally reviewed at least once a week (at the multi-disciplinary Team Assessment Meeting (TAM)), discussed with the patient and carers and decisions (including "no change") documented in the file.
24. We recommend that decisions on patients being allowed to leave the Unit (e.g. ground pass, hourly pass, day pass etc.) should be covered by the Leave Policy. In this context, clear responsibilities should be established regarding decision-making for these 'passes' and the policy should stipulate that decisions are recorded on the patient's file. In addition, we recommend that the policy should be clear on the responsibilities of families/carers regarding accompanying patients off the ward.
25. We would endorse the existing Leave policy's requirement that the decision to agree to a patient going on planned leave should normally be taken by the multi-disciplinary team at the TAM. We further recommend that this decision should be documented on the patient's file, and discussed with the patient, relevant community resources (e.g. CPN, Day Centre) and with carers (where appropriate). This will help ensure that the period of leave, and the team's expectations of the patient and others, are clearly understood.
26. We recommend that the Leave Policy should contain provisions requiring staff to inform the patient and carer/family about crisis and contingency planning in the event that something goes wrong during the period of leave. Staff should also provide a point of contact where the carer/family members can avail of advice.
27. We recommend that the policies (and procedures) on Observations and Leave should be explicitly cross-referenced.

Report Writing and Record Keeping Policies and Procedures

28. We acknowledge that it may be difficult for one file to cover both care in the community and periods of in-patient admission. However, we believe it is entirely practical for all multi-disciplinary records to be kept in one section of the in-patient file in continuous, chronological order and we recommend this to the Trust. We also believe that the inpatient care team should receive a report from the community team as part of the admissions process.
29. We recommend that nursing staff should be encouraged to follow the recommended practice found in Guidelines produced by the Nursing & Midwifery Council (NMC): 'Guidelines for records and record keeping'.

30. We recommend that all information available at the time of a multi-disciplinary team meeting (e.g. reports of aggressive behaviour) should be evaluated by the team, particularly in terms of re-assessment of risk, observations level and leave status, and that decisions flowing from this evaluation should be documented on the patient's file. The details recorded should be agreed by those present at the TAM.
31. We recommend that all notes documented in patients' files should record the actual, or approximate, time of events.
32. We recommend that the Trust's Report Writing and Record Keeping Policy should have a clear section on record-keeping. The Trust may even wish to consider separating the two into two different policies. Either way, the revised policy should incorporate our recommendations and information taken from the NMC Guidelines. The policy should highlight the importance of record-keeping and set appropriate standards for it.

Absent Without Leave (AWOL) Policy and Procedures

33. We recommend that the Trust's AWOL policy should provide greater clarity about staff's responsibilities when voluntary patients are AWOL, including the need to alert the Consultant and senior management at an earlier stage than was done in this case. This is particularly important where risk factors have been identified regarding a patient.
34. We recommend that the AWOL policy should be put into effect immediately when a patient is noticed to be missing. The policy, however, needs to cater for the circumstances where a patient, either voluntary or detained under the Mental Health Order, has been located and is known to be safe. The policy should also give clear instructions that decisions related to such circumstances must be recorded on the patient's file and that an alternative plan of action for the patient's return to hospital should also be recorded.
35. We recommend that the AWOL policy should be clear that the Nurse-in-charge at the time of an AWOL 'event' is responsible for arranging the immediate actions under the policy (organising a search, informing the senior nurse, (whether on-site or on-call) SHO, next of kin/carers, assessing risk and informing the PSNI. It should also be clear that the SHO must inform the Consultant.
36. We recommend that the AWOL policy should establish clear categories of risk under which the patient should be assessed when his absence is noted. The Nurse-in-charge should be identified as having responsibility for considering the most recent risk assessment, (including a full risk history if available) the care plan and the most recent clinical entries in order to establish the appropriate category. The decision as to whether or not to contact the police should be a joint one, following detailed discussion with the SHO (or duty SHO) and the

on-call senior nurse (outside routine hours). The discussions and decision should be recorded on the patient's file. When a decision is made to inform the police, they must be given information from the assessment of risk that has just been made.

37. We recommend that the AWOL policy should require that next of kin/carers be given advice about what to do if they locate the patient, and given a specific contact point or communication channel for use in such circumstances, and for more general contact regarding the AWOL situation.
38. We recommend that the Trust consider the development of a standard 'AWOL form' which could be used to prompt specific actions and to capture information likely to be of use if the police are involved. This may include information on the patient's appearance, clothing, possible whereabouts, level of risk presented and current mental state.
39. We recommend that the AWOL policy should include both immediate and longer-term actions, which should be proportionate to the assessed level of risk. Action might, for example, include a multi-disciplinary review, from which a clear plan of action should emerge. Where the police have been informed they should be invited to participate in the multi-disciplinary review, and clear roles and responsibilities should be identified between Trust and police personnel.
40. We recommend that an action plan emerging from a multi-disciplinary review should include identification of a person responsible for informing all others involved in a patient's care in the community (e.g. GP, CPN, Social Worker, Day Centre, Hostel management, carers, voluntary sector providers, as appropriate). This is likely to be one of the roles of the 'Key Worker' (as defined by the 2004 Guidance) and this role must be incorporated into the new AWOL policy. When they are being alerted, these people should also be advised regarding their response should they locate the patient.
41. We recommend that the action plan should include provision to make hospital staff aware of what they should do if the patient should appear at the hospital, and how they are expected to co-operate with family, carers and the police. There must be clear responsibility given to individuals to ensure that this information is transmitted to the various nursing shifts.
42. We recommend that the Trust should consider retraining for all staff who may be faced with responding to an AWOL situation. In addition, the AWOL policy should be quite clear that the nurse in charge should take the lead when such circumstances arise.

Provision of a Dual diagnosis Service

43. The panel endorses the following recommendations from the 'Safety First Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental illness - 2001':

- "services should make provision for patients with severe mental illness and alcohol or drug misuse as part of mainstream mental health services";
- "Local services should have a strategy for the comprehensive care of patients with dual diagnosis, to include liaison between mental health and substance misuse services, statutory and voluntary agencies, staff training and the appointment of key staff who will lead clinical developments"; and
- "training for staff in general psychiatry services should include the management of alcohol and drug misuse."

44. While it is our hope that the Trust will ensure that its current service provision lives up to these recommendations, we would also recommend that the Department should ensure that the services recommended above are among those that are commissioned by the various Boards.

Integration of Hospital and Community Services

45. We recommend that the Trust should develop a procedure by which community mental health staff remain actively involved after their patients' admission to hospital, and that they are also involved in discharge planning for individual patients back into the community. This is consistent with the 2004 Guidance and, together with our recommendations of community staff involvement in Leave and AWOL policies, should ensure maximum integration between hospital and community services and continuity of care.

Clinical Supervision and Staff Training

46. We recommend that the development of supervision arrangements, proposed in the Trust's Learning and Development Strategy and Action Plan 2005-2008 (Draft 2), must address Clinical Supervision. This should include clear identification of responsibility for putting in place a written policy to introduce and maintain Clinical Supervision for Nursing staff. The policy's contents should be in accordance with the Nursing and Midwifery Council's principles on Clinical Supervision as contained in: 'Supporting nurses and midwives through lifelong learning' (revised edition April 2002).

47. We recommend that the Trust undertakes appropriate assessment of training needs to ensure that training provision is focused on individuals' continued professional development and organisational

needs, and that a multi-disciplinary approach to training should be facilitated where appropriate.

Securing Papers for Future Inquiries

48. In order to maximise confidence in, and to protect the integrity of, any investigation (whether internal or external) the panel recommends that the Trust should make it standard practice for all papers relevant to a patient's care (from whatever source and from first contact with services) to be secured immediately after such a serious incident and stored at one site. We recognise that papers may be required for a number of purposes, including internal reports, but this can be managed from the central site, and copies, rather than original documents, can be used. We further recommend that the responsible Board should satisfy itself that papers have indeed been secured in a timely fashion.

INQUIRY PANEL (McCLEERY) – JANUARY 2006

