REPORT INTO THE CARE OF

MR [redacted]

FOR READING PRIMARY CARE NHS TRUST

20TH AUGUST 2004

GW Management Consultants Ltd

CONTENTS

1. INTRODUCTION

1.1 On the 3rd June 2003, Mr [redacted], whilst on Section 17 leave of the Mental Health Act 1983, fatally strangled his girlfriend, Ms [redacted] in a garage in Theale, Berkshire. Mr [redacted] was 25 years old at the time, a divorced man with one daughter who lives with his ex wife in Manchester. Mr [redacted] was convicted of Manslaughter with Diminished Responsibility and sentenced to nine years in prison. He had been in receipt of mental health services from the Berkshire Healthcare NHS Trust (BHCT) since December 2002. Ms [redacted] was also a patient of the Trust.

1.2 Following the incident, BHCT set up an internal review to examine the care and treatment received by Mr [redacted] prior to the death of Ms [redacted]. The purpose of this was to learn any lessons and act on any identified shortcomings within the service. Staff interviews took place in December 2003 and January 2004. The review panel met for two days, 10th and 11th March 2004 to discuss their findings and plan the report.

1.3 The internal review was conducted by a multi-agency panel consisting of an external Social Services Representative and a Consultant Psychiatrist, and from BHCT a Non-executive Director and Director of Nursing. The panel was chaired by the Buckinghamshire Mental Health NHS Trust Chair. The panel used the problem solving methodology of 'Root Cause Analysis' as its reference and completed their report in June 2004.

1.4 Subsequently Reading Primary Care Trust commissioned an independent scrutiny of the internal review report from GW Management Consultants Ltd, a company that has extensive experience in dealing with serious untoward events and the completion of internal reviews. Lynda Winchcombe and Ann Griffiths, both management consultants undertook the review.

1.5 The purpose of the scrutiny was to ensure that the internal review was conducted in accordance with its Terms of Reference and to consider whether the review met the requirements of the Department of Health Guidance HSG (94) 27, which recommends that an independent mental health inquiry is set up if an individual who has been in receipt of mental health services within the past year, commits a homicide. Terms of Reference for the scrutiny of the internal review is on page 2 of this report.

1.6 An Independent Mental Health Inquiry is set up with an independent team of expert professionals who have access to information from all of the agencies involved in the case including, for example, probation, police, solicitors, special hospital and prison records. This enables a comprehensive overview of the care and treatment provided to the individual concerned to be considered and often has access to information that was not available to the relevant mental health services at the time of delivering care.

1.7 It is anticipated that this scrutiny will replace a full independent inquiry unless there are issues identified which have not been addressed adequately or other areas that warrant further investigation by a panel of external professional experts.

2. TERMS OF REFERENCE

The following Terms of Reference for the scrutiny have been agreed by Reading Primary Care Trust.

Terms of Reference

1 To review the conduct and process of the internal review, the evidence taken and how the examination of the circumstances surrounding the care and treatment of Mr [redacted] was undertaken.

2 To identify any areas where there may have been omissions or weaknesses in the process, outcome and recommendations.

3 To conduct a detailed review of those areas identified at (2), and subsequently to draw additional conclusions and recommendations if appropriate.

4 To establish the extent to which the recommendations of the internal review are already being addressed by the relevant parties taking into account the learning applied from this incident to include whether the review:-

- Was of robust methodology
- Had appropriate panel members
- Considered appropriate evidence
- Interviewed and sought views from relevant people
- Recommendations are robust
- Recommendations would reduce re-occurrence

5 To establish if anything more could be learnt from further review of the care and whether further recommendations or actions to be taken are required.

6 To prepare a report on whether or not to accept the adequacy of the internal review and to make recommendations to Reading Primary Care Trust by the end of August 2004.

2.1 In addition the scrutiny has also taken into consideration the National Patient Safety Agency publication 'Steps, Patient Safety-a guide for NHS staff'. This

guidance sets out seven steps to be taken in relation to patient safety and is as follows:-

1. *Safety culture - create a culture that is safe*
2. *Establish a clear focus for patient safety across the organisation*
3. *Integrate risk management activities, develop processes to manage risk and identify the processes that could have been done better*
4. *Promote reporting, ensure staff report incidents*
5. *Involve and communicate with the patients and the public, develop ways to communicate openly with and listen to patients*
6. *Learn and share safety lessons, encourage staff to use root cause analysis, learn how and why incidents happen*
7. *Implement solutions to prevent harm, imbed lessons to change practices and processes or systems*

3. SCRUTINY METHODOLOGY

3.1 The methodology focused on achieving the Terms of Reference as well as considering the Seven Steps as in section 2.1 in the analysis of the internal review report. No interviews of the individuals involved in the case took place.

3.2 The writers of this report only had access to the internal review report and appendix documentation and based the analysis that follows on these. The report has identified areas that may need further exploration and includes actions to be taken to ensure that processes are put in place to reduce the likelihood of a similar incident reoccurring. However it is impossible to state that incidents like this will never happen again. We can, nevertheless, all learn from incidents to ensure that the services provided to people with a mental illness are safer and as comprehensive as possible; that the lessons learnt are understood and that appropriate actions are taken to inform those commissioning and delivering the services.

4. THE INTERNAL REVIEW REPORT – GENERAL COMMENTS

4.1 Overall the report was well balanced; well written; showed a good analysis of the issues identified and was extremely detailed. It covered the points raised within both the chronology and causes as identified within the Root Cause Analysis. The recommendations addressed most of the points raised.

4.2 However, generally it would have been helpful to have included the Terms of Reference that should have been set at the beginning of the review. It has to be assumed that the panel did not follow any Terms of Reference as there is no reference to these within the text of the report. Therefore it is difficult to ascertain how successful the panel was in meeting their objectives. It is standard practice to set out Terms of Reference for reviews such as this and these should have been agreed prior to the review commencing.

4.3 The following analysis has been set out in accordance with the sequence of the internal review report and to reflect the headings contained within section 4 of the Terms of Reference, (page 2)

Robust methodology

4.4 A detailed 'Outline of the Investigation Process' was included in the report regarding how the review was undertaken. It was stated that the panel were allocated tasks to undertake during the two days that the panel met. However, it is unclear as to what these tasks were and who undertook them. It might have been helpful to have had a breakdown of these tasks added as an Appendix to the final report. The other area requiring clarity was whether the panel as a whole agreed the areas of questioning when considering the interviews or whether these were just compiled by one member. It appeared that individual panel members interviewed staff. Access to transcripts of those meetings was available to the whole panel, however due to poor recording and difficulties in staff being able to accept the transcripts as accurate records of the interviews this could have restricted the sharing of valuable information between the panel members.

4.5 The panel should be praised on their use of 'Root Cause Analysis' as recommended by the Patient Safety Agency as good practice. However, the report would have benefited from having the 'Systems Analysis' added as an appendix in order for the reader to follow the identification of Root Causes and the issues discussed by the panel. This would have led to a better understanding of the actions that might have been taken at the time. It must be acknowledged that the report does contain details of the issues raised and discussed.

Appropriate Panel Members

4.6 The composition of the panel with three external members, one a medical director, another, (the chair), a chairperson from another Trust and a representative from Social Services is commended and in accordance with good practice. However, it is unclear whether any of the panel members had expertise in substance misuse. The inclusion of such a professional should have been essential given the degree of long standing substance misuse by Mr [redacted]

Appropriate evidence considered

4.7 The report set out a comprehensive list of the information obtained for the report in relation to both Mr [redacted] and MS [redacted] It does however remains unclear whether the panel had access to the appropriate polices and procedures in particular CPA, Risk Assessment and Absence Without Leave.

4.8 The report listed individuals who were interviewed but did not include their professional status and title. This would have helped in understanding the roles and responsibilities of each member of staff. It might also have been helpful to have interviewed the Care Programme Approach (CPA) Manager to have ascertained whether the Trust policy was followed, particularly as one of the final recommendations relates to the use of CPA.

4.9 It was noted that although letters were sent to professionals less involved requesting information, the response was poor and there is no explanation as to what further action would be taken regarding those still employed by the Trust or as to why this was not followed up. Ongoing staff support following incidents such as this needs to be taken into consideration. The recommendation section (49), in the internal review, does identify this as an issue to be resolved.

4.10 According to the chronology of events it does appear that the relevant individuals were interviewed with the exception of those mentioned above. However, the report failed to mention who (in terms of job title) prepared the chronologies for Mr [redacted] and Ms [redacted]. If, as indicated in section 49, the 'Timeline Chronology' was developed on the 10th and 11th of March 2004 it might have been more useful to have set this out earlier at the beginning of the review to aid all panel members in their deliberations and identification of areas for questioning.

Recommendations

4.11 the report identified eight main recommendations which addressed the issues raised within the analysis undertaken by the review panel. Each recommendation has several sub headings that takes in the various findings in the following categories:

- Care Management
- Systems
- Patient Problems

4.12 However these might have more impact if a timetable for completion of each recommendation had been added, although there is the assumption that this will be acted upon by BHCT and agreed with Reading Primary Care NHS Trust taking into account monitoring and clinical governance

5. ISSUES IDENTIFIED

5.1 Detailed examination of the internal review report identified a number of areas where it was considered that additional information, or other consideration of the available information, might have raised different issues. We do however acknowledge that some, if not all, might have been included in the final deliberations of the review panel but not stated in the report.

Assessment of Risk

5.2 The review panel identified three areas where the assessments of Mr [redacted]'s risk were inadequate and dealt with these within their analysis. However it is considered that there should be a recommendation that relates specifically to Risk Assessments. Therefore it is recommended that BHCT reviews their training programme on Risk Assessment and undertakes an evaluation of its application, particularly on the four wards at Prospect Park Hospital mentioned in the report.

5.3 It was made clear by Mr [redacted] over many weeks that he had thoughts of harming his girlfriend, Ms [redacted] and how this was dealt with is well documented in the internal review report. However it is considered that the services did not take these threats seriously enough, particularly on the first occasion when staff relied upon Mr [redacted] to inform Ms [redacted] that he had thoughts of killing her.

5.4 Notwithstanding a patient's right to confidentiality, this information should have been acted upon and certainly shared with the staff team caring for Ms [redacted]. It is recommended that BHCT review the process taken when others are identified as being at risk and ensure that guidance for staff is developed that sets out a format to be taken regarding informing others who have been identified as at risk.

Hospital Care for People with Borderline Personality Disorder

5.5 The review panel identified the difficulties that mental health services have in managing people with borderline personality disorders and the appropriateness of admitting them to busy acute admission wards.

5.6 Their recommendation requiring that BHCT develops a Strategy to cover all aspects of managing people with personality disorder is endorsed. We acknowledge that this is an extremely difficult area to cover and would not wish to minimise the degree of work that the Trust will need to undertake to fulfil this recommendation.

Section 17 Leave

5.7 The review panel rightly identified that there were flaws in the decision to grant Mr [redacted]'s section 17 leave. They have raised the issue of inconsistencies in the application of this section of the Mental Health Act 1983 and also considered that there were clinical indicators suggesting that Mr [redacted] was a risk to others. The recommendation regarding section 17 leave is endorsed.

Care Management

5.8 The review panel found that there were inconsistencies within the care management of Mr [redacted]; that some staff disagreed with his treatment plan and whether he was receiving the most appropriate services. There was a lack of structure in relation to referrals and access to specialist drug and alcohol services and psychological therapy.

5.9 The recommendations made by the review panel are endorsed.

Care Coordination

5.10 The current system set out by BHCT is that a care coordinator is appointed from the local community mental health team for each patient in receipt of mental health services. In theory this is good practice as the majority of patients/service users receive services in the community. However in Mr [redacted]'s case he was treated almost entirely in hospital and the review panel found that his care coordination was not adequately carried out.

5.11 The recommendations to develop clear policies and agreements for care coordination are endorsed.

Past Forensic History

5.12 Throughout Mr [redacted]'s inpatient admissions there were indicators that he was involved in criminal activities. It was suggested at the CPA meeting on 21st May 2003 that a referral was made for a forensic assessment and that Mr [redacted] was to remain on the ward (Sorrell) until this had been completed.

5.13 In the event, this did not happen. The review panel found that there was an unclear forensic history and no understanding of how available information could have helped to assess risks or provide insight into treatment. It is recommended that establishing links with the forensic service should be included within the proposed development of a Personality Disorder Strategy.

Co- morbid Substance Misuse

5.14 Mr [redacted] was found to be frequently abusing both drugs and alcohol on and off of the ward. The review panel picked up some issues relating to drug screening and drug use on the ward. They included their recommendations within the proposed Personality Disorder Strategy section which are endorsed.

5.15 However, it is further recommended that BHCT reviews its policy on drug and alcohol misuse on the wards and provides guidance to all staff on how this should be dealt with and when police involvement should be sought.

Clinical Leadership

5.16 It is considered that the review panel failed to give adequate direction on the issue of disagreement between clinical staff regarding the treatment and care of patients – as there was in the case of Mr [redacted]. Nor did it thoroughly investigate how clinical decisions are monitored by the Trust and whether clinicians and clinical directors undergo robust supervision. It is recommended that the Trust review Dr S's clinical practice to ensure its quality in relation to assessment, treatment and granting Section 17 leave.

6 CONCLUSIONS

6.1 As already indicated this scrutiny of the internal review found that the majority of issues concerning Mr [redacted]s care and treatment had been raised and dealt with. In our view a robust and comprehensive review was undertaken.

6.2 The Terms of Reference for this scrutiny include a section on whether 'anything more can be learnt from further review of the care and whether further recommendations or actions to be taken are required'. The recommendations contained in the internal review are endorsed and it is recommended that Reading Primary Care Trust and Berkshire Healthcare NHS Trust set out an action plan which includes both the recommendations from the internal review and the following recommendations from the scrutiny. These should include timescales for completion of the actions; regular updates and monitoring that also forms part of the regular Clinical Governance evaluation of service performance.

Additional Recommendations

It is recommended that:-

- Terms of Reference for reviews such as this are agreed prior to the review commencing.

- that BHCT reviews their training programme on Risk Assessment and undertakes an evaluation of its application, particularly on the four wards at Prospect Park Hospital mentioned in the report.

- that BHCT review the process taken when others are identified as being at risk and ensure that guidance for staff is developed that sets out a format to be taken regarding informing others who have been identified as at risk.

- that establishing links with the forensic service should be included within the proposed development of a Personality Disorder Strategy.

- that BHCT reviews its policy on drug and alcohol misuse on the wards and provides guidance to all staff on how this should be dealt with and when police involvement should be sought.

- that BHCT reviews Dr S's clinical practice to ensure its quality in relation to assessment, treatment and granting Section 17 leave.