The Niche PATIENT SAFETY

Briefing Paper Series

What Safety Lessons Can we Learn?

Thematic Review of Independent Investigations

Edition One

What safety lessons can we learn?

Thematic Review of independent homicide investigations

1) CONTEXT

We are one of the organisations on the NHS England's independent homicide investigations framework which has been running now for 2 years in its current format. In this paper we have looked back and analysed nine homicide investigations we conducted and completed[1] in 2014 and 2015.

This analysis is timely because of the recently published CQC review of their inspections detailing their key concern around safety and the need for organisations to conduct more though investigations, learn and embed lessons & develop an all embracing safety culture.

The homicide investigations analysed here are clearly at the extreme end of the safety spectrum but they do offer all of us opportunities to learn and share good practice. All were all commissioned by NHS England under Health Service Guidance HSG 94(27) and the NHS Serious Incident Framework (SiF, 2015) [2] to investigate the care and treatment provided where there has been a homicide by a mental health service user. Eight of the service users were cared for by Community Mental Health services whilst one was an in-patient in a rehabilitation setting. All the perpetrators were male. Eight of the perpetrators knew their victims by association, one killed a parent.

Of the seven cases where childhood abuse/neglect has been experienced, in adult life these individuals engaged in self-harm and substance misuse and were considered to be a risk of harm to others.

2) FINDINGS

A total of 78 recommendations were documented in the 9 homicide investigations & these recommendations have been grouped into 8 common areas that are discussed below.

[1] *Completed and published by NHS England http://www.england.nhs.uk/publications/invest-reports/*
[2] *https://www.england.nhs.uk/patientsafety/serious-incident/*

i) Communication

The overriding recommendation in this section was the sharing of information between professionals. There is evidence that many people with mental illness will also have professionals caring for their physical health, substance misuse, pain relief or housing. Some will also be involved with the criminal justice services, including police, prison and probation. In all of the cases reviewed there were examples of breakdowns in communication that may have been detrimental to the mental health of the service user. A number of the service users had input from secondary and inpatient mental health services.

Breakdowns in communication were identified between:

- Multi-disciplinary inpatient and nursing teams
- GP's and mental health teams
- Mental health and prison/probation teams
- GP practices where one manages the methadone programme and the other manages the service user's general health
- Inpatient teams and placement teams when care management has been changed following absconding.

Other recommendations to address the breakdowns in communication included:

- Discharge summaries being sent to all agencies involved
- Full mental and physical health summarises to be provided by primary care when referring a service user to a community mental health or inpatient team
- Feedback to referrers on the same day as assessment
- Comprehensive histories should be documented so as to inform risk assessments
- Changes in diagnosis should be communicated face to face with service users and carers to ensure understanding
- On discharge, information shared should include risk assessments.

ii) Policy management

There are two distinct areas here with recommendations made separatly for local policies and the development of Trust wide assurances.

Local policy development included:

- Drug Detection Policy to include the use of Drug Detection dogs
- Serious Incident Policy to identify that interviews are transcribed and the scripts stored securely
- Safeguarding Policy to include up to date national information.
- Practice guidance to provide framework to support risk assessment
- Review policy that informs service users about changes with regards to their care
- Review policy for management of risk items allowed on unit
- Review Section 17 leave policy in conjunction with AWOL policy

More generalised Trust recommendations included:

- Development of systems that provide assurance of implementation of Risk Policy
- Ensure that mechanisms are in place to provide assurance that changes in structure and policy are aligned and that documentation is accordingly updated
- Consistency in the implementation of policies
- Risk Management Policy to show clear links between risk assessment, care planning and CPA
- Risk Register is maintained and updated

iii) Practice / Documentation of risk

The majority of recommendations relating to practice and risk concerns documentation. These include the following that have been identified in the reports:

- Violent behaviour must be documented and reported to the Police
- Full and comprehensive multi-disciplinary mental health assessment must be undertaken to inform a detailed care plan (including gathering information from family and carers)
- There must be documented multi-disciplinary agreement on the clear link between risk assessment and risk management
- Discharge plans to include trial leave that has been embedded in care prior to leave
- Documentation of historical and current risks to be updated at every assessment
- Detailed history should be updated of actual and potential violence and the documented use of the appropriate risk assessment tool
- A record must be made in the notes when a decision has been made to refer a service user to MAPPA for all service users with a forensic history
- Detailed history of risk behaviours and antecedents should be updated
- Risk plans for service users with mental health issues should identify the housing situations and support patient to be house as appropriate
- Mental Health discharge summaries must contain a narrative description and the context of risk, protective factors and triggers

Two other areas were identified:

- The risk of patient dependency on prescribed analgesics, identified by over requesting of prescriptions
- Rigorous testing of the validity of relapse tools and prevention strategies

A combination of Practice / Risk and Communication made up 32 out of 78 recommendations, 41% of the recommendations concerned the sharing of service user information between professionals.

iv) Training

The recommendations relating to training divide into two very clear areas. Additional training was identified in the following subjects:

- Domestic violence
- Role of the Care co-ordinator
- Therapeutic relationships between inpatient and community teams and service users
- Serious Incident training
- Safeguarding training

Training specifically to address concerns about how SI's have been reported and investigated:

- Primary care and GP notes should be accessed in the cases of homicide
- NICE guidelines should be referenced as part of investigation reports
- Interview must be transcribed and scripts stored securely for future reference
- GP's should be interviewed as part of the investigation
- Executive summaries must include the whole process including the lessons learnt

v) Organisational learning

Learning for organisations considered the development of qualitative and quantitative evidence to support quality:

- Development of systems that provide assurance regarding implementation of key policies
- Development of systems to sign off action plans and an assurance process to evidence that changes are embedded in practice
- Feedback mechanisms to inform staff of outcomes when involved in SI investigations
- Quantitative and qualitative analysis to provide robust evidence regarding patient outcomes
- Qualitative audits of assessments and care plans to include all providers
- Assurance that serious incident investigations are of a requisite quality and sufficiently rigorous and robust to enable organisational learning

vi) Contact with families

Following the Francis Report 2014, Duty of Candour is a key part of the investigation process, involving patients and relatives as appropriate:

- Trusts to contact victim and perpetrator's families following serious incidents
- Development of a resource pack for families who are involved in independent investigations
- When violence to a carer / family member has been reported, the Trust must try to contact the victim and family giving consideration to an assessment of the carer's needs
- Following assessment the lead clinician must be responsible for checking that service user and family understand the outcome. This interaction must be documented

vii) Miscellaneous

These recommendations refer to the review of provisions of care when gaps have been identified:

- Review of services available for assessment and treatment for service users with personality difficulties alongside other mental health issues
- Development of a robust and routine performance management system and Board reports for secondary commissioning of placements
- To demonstrate that quality drives the requirements to review placements
- Evaluate the impact of the changes that are introduced as a direct result of the Serious Incident recommendations
- Review rehabilitation services within an agreed timeframe and develop a clear plan for providing increased local capacity based on current needs assessment

viii) Pathway development

- Integration of specific risk assessments with generic risk assessment and discharge plan
- Development of care pathways for young people in custody at risk and co-ordination across primary and secondary mental health services and the Youth Justice teams
- Application of Personalised Budget to be standard consideration in the support of service users with mental health concerns

3) PREDICTABILITY AND PREVENTABILITY

This is always a fundamental issue: was the homicide either predictable or preventable?

Predictability is 'the quality of being regarded as likely to happen, as behaviour or an event'.[3]

Prevention means to 'stop or hinder something from happening, especially by advance planning or action' and implies 'anticipatory counteraction'; therefore for a homicide to have been preventable there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.[4]

A review of the evidence in 7 applicable cases used to ascertain predictability shows that 4 of the perpetrators were known to have risks of violence against property or person but none had previously identified their victim. 1 of perpetrators had identified another person during treatment sessions but this was not the victim.

3 of the individuals were reluctant to engage with professional services and in one of the cases the independent investigation team identified more information that would have enhanced risk assessments than the Trust internal investigation team was able to find.

Investigations identified that in 2 of cases professionals had omitted to listen to the concerns of the family. Parents and carers had identified changes in mental state, increased alcohol intake or changes in behaviours that gave them cause for concern and were know triggers for increase in risk.

In all of the cases reviewed none of them were considered to be preventable. Whilst investigations identified lack of assessment, care planning, engagement of family and that perpetrators were known to be violent or at risk of reoffending, there was no evidence to suggest that any of the victims were subjects of a pre-planned attack.

4) DISCUSSION AND CONCLUSIONS

- There are consistent recommendations relating to often limited and incomplete serious incident process, management and assurance thereof. This is reflected in the recommendations for training around the SI process.
- Training is also often an issue not just on specific subject but also its quality and timeliness.
- The lack of family inclusion in serious incident investigations would seem to be a common denominator alongside the fact that all subjects were male.
- One final area which causes us concern is the nature of risk assessments. Many service users will be at low risk whilst in in-patient care, as admission is the mitigation to reduce the risk. What is most important is the consideration of the risk posed by the individual, in the community without protective factors. Far too often this seems to have been missed.

From the small sample of cases used for this thematic review it is clear that each individual has received a complex package of care involving a number of multi-disciplinary professionals. This increases the risk of potential breakdown in communication between teams, service user and family.

The service user is often part of a complex family structure within which domestic violence and mental health are major concerns. This background also increases the risk of communication breakdown and understanding. It is therefore extremely important that channels of communication, professional escalation and sharing of risk are fundamental parts of the jigsaw that builds the whole

[3] http://dictionary.reference.com/browse/predictability

[4] *Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry (2000)176: 116-120*

picture of the individual. The recommendations from the homicide reviews conducted by Niche support this.

Recommendations also suggest that the training about the SI process and report writing would greatly enhance the validity and robustness of internal investigations so that services could properly learn from incidents and put changes in place that were more likely to reduce the recurrence of some these incidents.

As we go forward with new mental health service structures and the challenge of limited resources and increased demand it is important that team and organisational memory becomes the glue holding services together to prevent recurrence. It is at those times of the greatest challenge and change that eyes can be taken off the ball, and a tragedy occur.

5) RECOMMENDATIONS

We recommend the following areas of action to enhance the safety of mental health provision in line with our findings from the most serious safety breaches in mental health:

Provider Trusts:

- Should develop a 'Patient Safety Strategy' that sets out the focus of effort , incorporates the process for ensuring learning lessons and the steps needed to embed a safety culture
- Need to focus on improving the quality of investigations and action plans
- Develop, regularly review and refresh risk management systems and structures that identify and mitigate risks
- Develop and deliver a set of metrics that provide quality information to inform the Board of progress on safety in line with its strategy.

CCG's:

- Should work collaboratively to support providers with SI management
- Have transparent structures for quality assurance of reports
- Maintain a rigorous approach to Oversight of action plans
- Use good safety knowledge and awareness when Commissioning

NHS England:

- Analyse and publish an annual review of themes from investigations
- Develop useful information for families about SI and SiF processes
- Hold regular learning events to share new knowledge
- Combine investigations with other statutory bodies where possible

Much work is needed to further develop and embed patient safety cultures in the NHS. We hope this paper adds to the emerging body of evidence. We are passionate about the safety journey and its ultimate destination.

We would be delighted to work with organisations who share this drive. Please feel free to call us to discuss how we might best work with you.

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