

Independent Investigation into SUI 2005/2880

June 2009

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This independent investigation was commissioned by Yorkshire and the Humber Strategic Health Authority in keeping with the statutory requirement detailed in the Department of Health guidance "Independent Investigation of Adverse Events in Mental Health Services" issued in June 2005. Page 2 of this guidance enables Strategic Health Authorities (SHAs) to commission independent investigations where a SHA deems that an independent analysis of a service user's care and treatment is warranted. In this case the victim of an unprovoked attack by an in-patient at Leeds Mental Health Teaching Trust was lucky not to lose her life. It was this near death experience that prompted the SHA to call for an independent investigation in this case.

The Investigation Team members were:

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- Mr Mike Foster, Assistant Director of Nursing, Oxfordshire and Buckinghamshire Mental Health NHS Trust
- Dr Maureen Devlin, Independent Healthcare Consultant and Associate Consequence UK Ltd
- Dr Mary Jackson, Consultant Clinical Psychologist and Associate Consequence UK Ltd
- Dr Mark Potter, Consultant Psychiatrist, South West London and St George's Mental Health Trust

Acknowledgements

The Investigation Team wishes to thank:

- West Yorkshire Police;
 - staff at Leeds Partnerships Foundation NHS Trust;
 - the service user; (the MHSU)
 - the voluntary (third sector) agencies in Leeds who met with the Investigation Team;
 - the independent investigation team appointed by the former Leeds Mental Health Teaching Trust; and
 - staff at the secure hospital currently caring for 2880
- who all assisted in the completion of the investigation conducted.

TABLE OF CONTENTS

Section	Title	Page
	Executive Summary	4
1.0	Background	8
2.0	Terms of Reference	11
3.0	Methodology	13
4.0	Contact with the Family of the Service User and the Family of the Victim	14
5.0	Findings of the Investigation	16
	5.1 The independent Investigation Team's analysis of Leeds Mental Health Teaching Trust's internal investigation into the care and management of the MHSU (June 2006)	17
	5.2 The approach to and quality of client-focused risk assessments undertaken in adult services	20
	5.3 Perspectives of three third sector (voluntary) agencies who interface with specialist mental health services in Leeds.	29
	5.4 Clinical supervision	34
	5.5 CPA	39
	5.6 Nursing observation practice and escorted and unescorted leave	41
6.0	Actions Taken by LMHTT/LPFT to address Issues Raised in its own Investigation Report	42
7.0	Conclusions of the Investigation Team	47
8.0	Recommendations	50
Appendix 1	The full detail of section 5.1. The completeness and quality of the internal investigation commissioned by the then Leeds Mental Health Teaching Trust (LMHTT)	53
Appendix 2	Chronology of the MHSU's Contacts with Mental Health Services	69
Appendix 3	Sources of Information used to inform the Investigation Team's findings	75
Appendix 4	Glossary	77

EXECUTIVE SUMMARY

Intention

On 20 December 2005 a patient (the MHSU) of Leeds Mental Health Trust (LMHTT) was convicted with wounding with intent on 27 July 2005, by stabbing a female who was unknown to him. The MHSU was transferred from HMP Leeds to a high secure hospital facility on 11 January 2006, detained under section 48 of the mental health act for urgent treatment of his mental illness. He remains an inpatient at this hospital.

This report sets out the findings of the independent Investigation Team following its analysis of the independent internal investigation report commissioned by Leeds Mental Health Teaching Trust (LMHTT) into the care and management of MHSU 2880 (the MHSU), meetings with a number of key voluntary agencies working with mental health service users in Leeds, and exploration of key issues relevant to the care and management of the MHSU with staff currently working for Leeds Partnerships NHS Foundation Trust (LPFT).

Purpose

The terms of reference for the work commissioned were to:

- ❑ Undertake an analysis of the MHSU's mental health clinical records and to identify any significant care management concerns that would require investigating as part of independent review.
- ❑ Undertake an assessment of the internal investigation undertaken by Leeds Mental Health Teaching Trust to determine the extent to which it provides reasonable analysis and explanation of the care management concerns identified by the independent Investigation Team.
- ❑ Undertake any further analysis of the care management concerns in the MHSU's case where appropriate and necessary.

Outline of the review process

To deliver the above the following activities occurred:

- ❑ A detailed and critical analysis of the MHSU's clinical records using timelining methodology.
- ❑ A critical appraisal of the Trust's internal investigation report
- ❑ The use of a semi-structured survey instrument.
- ❑ Focus group meetings with three voluntary agencies.

Main conclusions

The independent Investigation Team supports the findings and main conclusions of the LMHTT internal investigation report (June 2006) in

every respect except for its assertion that the attack that occurred was predictable and preventable.

However both this independent Investigation Team, and the original LMHTT investigation team believe that had any one or a combination of factors been present, then it is possible that the unprovoked attack on the victim may have been prevented.

However, the Independent Investigation Team does not believe that one can assert with any certainty that the incident was preventable had the assessment and management of the MHSU been better. Our reasoning for questioning absolute preventability is the variables that could have still enabled the MHSU to have left the ward unnoticed even if his management had been optimal.

These variables were:

- ❑ The open door policy at the time. This means that the ward was unlocked and even if the MHSU had been on more closely timed observations he still could have left the clinical area unnoticed and been back on the ward before he was missed.
- ❑ The period of time for which the MHSU was absent from the ward. It is significant that he was only absent for a period of eight minutes. For staff to have known where the MHSU was at all times would have required 'within eyesight', or 'within arm's length' observation. Even with optimal management this MHSU would not have attracted this level of observation.
- ❑ The MHSU was an informal patient and technically was free to leave the ward.

With regards to the question: "Could the incident occur in LPFT today?" One would be foolish to assert that a service user will not ever leave a ward and harm another again. However, if LPFT:

- ❑ ensures that the standard of 'no ground leave' in the first 72hrs following admission is robustly upheld in all inpatient areas;
- ❑ continues with a more robust approach to risk assessment training;
- ❑ continues to undertake meaningful analysis of absconding incidents; and
- ❑ continues with its commitment to develop effective and healthy working relationships with third sector agencies which includes the respect of their time served experience and knowledge of a service user,

then an incident with similar features should not occur again.

LPFT has made considerable investments in the security of its acute inpatient building, numbers of staff employed and staff skill mix as well as in embedding strong governance arrangements. The models and approaches to care are significantly different to those in place in 2005

across the whole of the Adult Services Directorate. Ward 1 as it was in 2005 no longer exists and the new Ward 1 has effective and dynamic leadership. In spite of the horror of this incident for the victim who continues to live with her injuries today, the Trust does deserve recognition for the commitment it has made to improving its service.

Main Recommendations

For LPFT

Recommendation 1: LPFT is encouraged to explore the potential for named third sector agencies to be awarded direct referral rights to CMHTs without having to go via the GP. If this suggestion is considered at all feasible LPFT is encouraged, with the support of Volition¹, to run a pilot project over a defined period of time for example 6 months, with clear auditable outcomes.

Recommendation 2: For the Adult Services Directorate, LPFT, Volition and Supporting People² to explore the feasibility of having named individuals at a sufficiently senior level to act as the central conduit of information relating to the availability of beds within the voluntary sector.

Recommendation 3: It is recommended that the Director of Service Delivery – Chief Nurse and the Chief Officer of Volition meet to discuss the findings of this investigation and develop a detailed action plan, preferably utilising a multi-pronged approach, to achieve further improvement in the grass roots relationships between LPFT staff and third sector agencies working substantially with mental health service users. It is expected that addressing the reported ineffectiveness of the current shadowing arrangements will form part of the action implementation plan.

Any plan agreed must be shared with the SHA and the commissioners and have measurable objectives so that the impact of the agreed action implementation plan can be monitored in the short, medium and long term.

Recommendation 4: As LPFT develops PARIS³, and its Care Programme Approach (CPA)⁴ and FACE⁵ risk assessment tools the Trust needs to look at how information about third sector agencies providing services to individual service users can be best incorporated so that:

¹ Volition - Leeds is an alliance of voluntary sector organisations that either provide mental health services for or work with people who have mental health needs.

² The Supporting People Programme was launched in 2003 to support vulnerable people to live more independently and maintain their tenancies. It provides housing related support to over 1.2 million people.

³ PARIS is an electronic documentation package.

⁴ CPA - see glossary.

⁵ FACE is a model of risk assessment used to determine the risks a service user poses to him or herself and the risks posed to others (see glossary).

- the degree of their involvement is clear;
- the contact details of the key worker are readily available;
- the wishes of the service user with regards to information that can be shared with the voluntary agency are recorded; and
- whether or not they are to be invited to CPA discharge planning and CPA meetings generally is stated.

Recommendation 5: The training provided to LPFT care coordinators needs to highlight the valuable role of the third (voluntary) sector in supporting the provision of an effective mental health service.

For Volition and Commissioners Of Mental Health Services

Recommendation 6: All third sector agencies registered with Volition who work on a regular basis with LPFT should consider using the FACE risk assessment. Ideally where possible these third sector agencies need to fund attendance by their staff attendance at LPFT's risk assessment training workshops.

Recommendation 7: There needs to be a clear pathway to enable workers in the voluntary sector to be able to access relevant specialist mental health services appropriately. It is recommended that LPFT and Volition work jointly with commissioners to achieve this.

Recommendation 8: Commissioners of mental health services in Leeds need to consider the value to the delivery of safe and effective services of supporting financially the development of, and delivery of, a single training programme for risk assessment of mental health service users across the secondary and third sectors. Clearly should such an initiative be considered sensible, then careful consideration will need to be given to which third sector agencies should be included as a matter of course, and those for whom automatic training provision is not considered an appropriate use of the training resource.

Recommendation 9: To assist appropriate information sharing between third sector agencies and the specialist mental health service in Leeds. It is recommended that the Chief Officer for Volition initiate a meeting with those third sector agencies who work most closely with specialist mental health services and assess the feasibility of using a common design, or content specification, of consent form. This form would not only seek the consent of third sector clients to share appropriate information with specialist mental health services where both sectors are engaged in care and management, but also the consent of the client for the third sector agency to receive information from specialist mental health services in relation to:

- the treatment plan
- CPA
- Risk Assessment

In the interests of completeness the validity of the consent should be checked periodically. The Investigation Team suggests that the advice of the legal advisors to NHS Leeds or Yorkshire and the Humber SHA should be sought regarding pragmatic time periods for this.

1.0 BACKGROUND⁶

On 27 July 2005 the victim of a near fatal assault was walking across the car park at Roxby Close Leeds. She saw a man approaching her from the left hand side. Initially he was walking towards her from the side of the flats near to Lindsey Road. He had his hands in his pockets. The victim was not concerned about him. She continued her walk and then suddenly became aware of the man around the back of her to her right shoulder. She then felt a thump to the right side of her neck just below the jaw. The man did not touch her or say anything. He then hit her once and ran off. The woman had been stabbed in the neck and suffered facial injury.

The assailant was an in-patient at the Becklin Centre Leeds Mental Health Teaching Trust at the time of the attack, having been admitted there two days prior to the incident. He is referred to as the MHSU throughout this report.

Although the victim survived the attack, the seriousness of it prompted Yorkshire and Humber Strategic Health Authority to determine that an independent investigation of the MHSU's care and treatment was appropriate.

Outline history of the MHSU's contact with mental health services

1999 and 2001: The MHSU's first contact with psychiatric services was during a three year custodial sentence for car theft and dangerous driving. The MHSU was a passenger in the car and a pedestrian was seriously injured. At this time he was noted to be suffering from anxiety and was prescribed trifluoperazine for a period of three weeks.

March 2002: The MHSU's first psychiatric admission was to High Royds Hospital under Section 2 of the Mental Health Act 1983. He displayed clear signs of psychosis immediately prior to this admission. The precipitating event was his self-presentation at Killingbeck Police Station stating there was a warrant out for his arrest. He also hit the female receptionist in the face. On assessment by the duty psychiatrist he said the television had eyes, and that he had been taken over by the Jews and that a microphone was fitted to his body.

2003: The MHSU had a number of contacts with the specialist mental health service, two of which were via Accident and Emergency. The common theme around these contacts was the MHSU's belief that people were putting leeches on him, a snake was biting him, and that people were poisoning his food. He was placed on an anti-psychotic medication zuclopenthixol, initially 4mg which was then increased to 10mg at night.

2004: The MHSU was detained under Section 3 of the Mental Health Act (1983) in April. He was admitted for a second time in December

⁶ Note a fuller chronology is detailed at Appendix 2 (page 67) of this report

2003. Following this admission he was not discharged until November 2004.

His diagnosis was stated as “paranoid schizophrenia and opioid dependence”. Medication at discharge was:

- ❑ Fluoxetine 20mg once a day.
- ❑ Procyclidine 10 mg twice a day.
- ❑ Pipothiazine 150mg IM four weekly.
- ❑ Flucloxacillin 250mg four times a day to stop on 23 November 2004.

2005: The course of the MHSU’s care and treatment in 2005 was unremarkable until the end of July.

25 July 2005: Consultant Psychiatrist 2 was asked to assess the MHSU at Alexander House⁷. The MHSU’s mental state was unusual for him. He was quite chatty which was not the norm. The history obtained from the Alexander staff was that the MHSU had had a week of restlessness and caginess. The consultant agreed with the staff at Alexander House that the situation appeared to have deteriorated but not to the point of being intolerable. A decision was made for the MHSU to remain at Alexander House with the staff there receiving support, especially as the MHSU was taking his medication.

26 July 2005: Consultant Psychiatrist 2 received another call from Alexander House as two knives had been found in the MHSU’s bed room. Consultant Psychiatrist 2 asked for urgent assessment by the Crisis Resolution and Home Treatment Team (CRHT). Assessment and admission to hospital on an informal basis did subsequently occur.

A FACE risk assessment completed by the third sector agency identified:

- ❑ Significant risk of harm to others.
- ❑ No risk of suicide.
- ❑ Low risk of accidental harm to self.
- ❑ No risk to children.
- ❑ No risk re. physical health.
- ❑ Low risk of severe self neglect.
- ❑ Low risk of vulnerability/ exploitation.

The risk assessment states: “The MHSU is currently displaying relapse signatures that in the past have come before acts of assault and relapse.”

The preadmission CRHT holistic assessment states: “Due to risk history and presentation an informal admission to Ward 1 Becklin Centre for further assessment and treatment. To be considered for early discharge assessment by CRHT to facilitate discharge back to Alexandra House.”

⁷ Alexander House provides supported living accommodation and is run by Community Links.

27 July 2005: The MHSU was admitted to Ward 1 Becklin Centre. The progress notes at 11.50hrs note that the MHSU feels “stressed out” and “sick” but there were no reported ideas of reference⁸ from the TV as on previous admissions. The MHSU is also noted to say that he “has a feeling to hurt himself but no plans nor any ideas to harm others”. It is noted that a staff member from Alexander House reports that the MHSU “has presented as increasingly confused, agitated and bizarre in his behaviour over the last four weeks. Obsessively washing hands, touching the road and kissing staff and peers at Alexander House”. It is also noted that the staff at Alexander House would not be happy to support discharge back to Alexander House “at this moment”.

Following a ward round with Consultant Psychiatrist 4, the nursing records note that this consultant was content to discharge the MHSU back to Alexander House. Alexander House staff were advised of this and it is again noted that they have concerns. The nursing progress notes also record the fact that Alexander House staff advised Ward 1 staff that knives had been found in the MHSU’s room.

The progress notes record that Consultant Psychiatrist 2 attended Ward 1 and “fully informed staff of his concerns about the MHSU and that he has known the MHSU for a period of time as his community psychiatrist”. As a result of the additional information provided a decision was made to keep the MHSU on ward 1 for a fuller assessment, and liaison between the CRHT, Consultant Psychiatrist 2 and Consultant Psychiatrist 3.

27 July 2005 17.31 – 17.39hrs: Between these times a gentleman meeting the description of the MHSU made an unprovoked attack on a female. She suffered a one inch by two inch neck wound that damaged her facial nerves and required a number of bags of blood to compensate for blood loss.

The subsequent progress notes between this date and 20.20hrs on 30 July 2005 show that the staff on Ward 1 Becklin Centre were not aware of the MHSU having left the ward on 27 July. His potential involvement in the assault came to light because a member of staff from Ward 3 contacted Ward 1 to advise that the MHSU had confided in one of their service users that he had stabbed someone in the last few days. Ward 3 staff did inform the police and following interview with the informant the MHSU was taken into custody from Ward 1. On police advice the MHSU’s room was locked pending further police examination.

PLEASE SEE APPENDIX 2 (page 69) FOR A MORE DETAILED CHRONOLOGY OF THE MHSU’S CONTACTS WITH SPECIALIST MENTAL HEALTH and PROBATION SERVICES

⁸ Ideas of reference are incorrect interpretations of casual incidents and external events as having direct reference to oneself, which may be sufficiently intense as to constitute delusions.

2.0 TERMS OF REFERENCE

The Terms of Reference for this Independent Investigation set by Yorkshire and the Humber Strategic Health Authority (the SHA), in consultation with Leeds Partnerships NHS Foundation Trust (LPFT), Leeds Primary Care Trust (now NHS Leeds) and Consequence UK were:

To:

Undertake an analysis of the MHSU's mental health clinical records and to identify any significant care management concerns that would require investigating as part of independent review.

Undertake an assessment of the internal investigation undertaken by Leeds Mental Health Teaching Trust to determine the extent to which it provides reasonable analysis and explanation of the care management concerns identified by the Independent Investigation Team.

Undertake further analysis of the care management concerns in the MHSU's case where appropriate and necessary.

In undertaking the above it is expected that the independent Investigation Team will be mindful of:

- The Care Programme Approach.
- Risk assessment of the MHSU, including risk relapse planning and risk containment plans.
- The clarity of and evidence of appropriate care planning.
- The effectiveness of communications between LMHTT staff and staff from other statutory and voluntary agencies that may have been involved in the MHSU's care.
- Evidence of contact with carers and/or other family members.

In addition, Consequence UK Ltd will undertake:

- An analysis of LPFT's present use of the Care Programme Approach.
- A more systematic assessment of the present approach to and quality of client-focused risk assessments.
- An analysis of ease of access to historical and significant clinical history including risk history.
- An analysis of the approach LPFT takes to the training of its staff in client focused risk assessment and its assessment of practice standards.
- An assessment of LPFT's approach to the clinical and management supervision of its community and ward-based staff, including team and ward leaders.

- ❑ To explore nursing observation practice and how decisions are made around escorted and unescorted leave.
- ❑ To establish the contemporary culture within the Adult Services Directorate of LPFT, particularly in relation to attitudes to external statutory and voluntary agencies.
- ❑ An analysis of the relationship between staff working at hostels such as Alexander House and LPFT adult inpatient services. (It is intended that all hostels managed by the voluntary agency that manages Alexander House will be included in this).
- ❑ To understand how the healthcare governance systems in the Adult Services Directorate assess and monitor the quality of practice delivered by its employees (nursing, social care and medical).
- ❑ Identify significant learning points for improving systems and services within LPFT and its partner organisations.
- ❑ Identify developments in services since the user's engagement with mental health services and action taken since the incident.
- ❑ To make recommendations for action to address the learning points to improve systems and services.

The Investigation Team will submit a report detailing its findings and recommendations to the Board of Yorkshire and the Humber Strategic Health Authority.

3.0 METHODOLOGY

The methodology for this investigation constituted:

- Critical appraisal of the MHSU's clinical records and the identification of areas to explore that would have been 'essential' and 'desirable' were the investigation to be undertaken from scratch.
- Benchmarking the LMHTT investigation report and its content against the issues identified during the appraisal of the MHSU's clinical records. During this process the Investigation Team came to a decision regarding the merits of undertaking any re-investigation of the MHSU's care and management in 2005.
- Conducting a contemporary analysis of discrete aspects of the specialist mental health service and the working relationship between third sector agencies and the specialist mental health service. The following techniques were employed in this:
 - Round-the-table, focus group style meetings with inpatient staff.
 - A semi-structured questionnaire exploring key aspects of contemporary practice and support systems in adult mental health services.
 - Focus group meetings with three third sector agencies who work substantively with specialist mental health services.
 - Document analysis.
 - Non-participant observer analysis.
 - One-to-one discussions with key staff.

The primary documentary sources of information used to underpin this review were:

- the MHSU's mental health records held by Leeds Partnerships NHS Foundation Trust;
- the *Report into the Care and Management of the MHSU* by Leeds Mental Health Teaching Trust (June 2006); and
- Trust policy documents such as the:
 - CPA policy;
 - risk assessment policy document;
 - Operational policy for CMHTs; and the
 - risk assessment policy.

4.0 CONTACT WITH THE FAMILY OF THE MHSU AND THE FAMILY OF THE VICTIM

At the commencement of the investigation the Investigation Team wrote to the MHSU advising him of the investigation, offering him the opportunity to meet with the Investigation Team and seeking his permission to have access to his medical and police records.

The MHSU expressed no wish to meet with the Investigation team but did give his consent for the Investigation Team to access relevant records where they believed it necessary to deliver the terms of reference of the investigation.

A letter was sent to the MHSU's mother by 'signed for' delivery. This letter was returned to the offices of Consequence UK Ltd when a) no one was available to take receipt of the letter when it was first delivered, and b) the letter was not collected from the post office near to where the MHSU's mother lives.

The MHSU's current consultant psychiatrist advised Consequence UK that the MHSU's mother could be elusive and they had experienced difficulties in contacting her. She did not feel that it was in the best interests of the MHSU's well being to press the matter.

A letter by signed for delivery was also sent to the victim of the assault. The address was provided by West Yorkshire Police who Consequence believes had made contact with her and advised that we would be in contact. This letter too was returned after a period of seven days. A second letter was therefore sent. No response was received to this at the time this report was published. Yorkshire and Humber SHA also contacted the victim's place of employment to ensure that she was aware of the investigation.

Both the MHSU and his mother were sent letters advising them of the imminent completion of the investigation report in March 2009. Both were offered the opportunity of a supervised reading of the report. The letter to the MHSU's mother was again returned unopened with a note "moved away".

On 17 April 2009 the investigation team leader (ITL) met with the MHSU to take him through the report. The MHSU asked for the following recollections of his to be noted within this report.

- ❑ He did not set out to hurt anyone on the 27 July. He left the ward to buy a can of lager that was all. He regrets what happened and is very sorry that it happened.
- ❑ He took the knife into the Becklin Centre with him, wrapped in a towel in his bag. He recalls the staff checking his bag but they did not undo the towel, or unfold any of his things.

- He was surprised that he was not asked to stay on the ward when admitted. On previous admissions he remembers being asked not to leave the ward and if he did so he would be sectioned. He likes being outside, there was nothing to stop him leaving the ward so he did.

The MHSU also advised that it was unlikely that his mother would go to the door to collect post. He kindly provided the ITL with her telephone number. A message was left for her but no further contact was achieved.

5.0 FINDINGS OF THE INVESTIGATION

This section of the report sets out the main findings of the Independent Investigation Team in relation to its assessment of the MHSU's clinical records and:

- 5.1 The completeness and quality of the internal investigation commissioned by the then Leeds Mental Health Teaching Trust (LMHTT).
- 5.2 The approach to and quality of clinically focused risk assessments undertaken in adult services.
- 5.3 Contemporary experiences of three third sector (voluntary) agencies who interface with LPFT.
- 5.4 Clinical supervision.
- 5.5 CPA.
- 5.6 Nursing observation practice and escorted and unescorted leave.

It is quite clear from our analysis of the MHSU's clinical records, and the analysis conducted by the investigation team appointed by LMHTT, that the critical period of care that needed to be understood in relation to the unprovoked attack on a member of the public on 27 July 2005 was his care and management on Ward 1 of the Becklin Centre following his admission there from Alexander House on 27 July 2005.

The MHSU's care and management up until this point was perfectly reasonable and there were no significant care management concerns. Indeed the records reveal that the MHSU received a high standard of care and that staff made continual efforts to try and maintain engagement with him. Furthermore the records also evidence good liaison and cooperation between the specialist mental health service and the third sector agencies involved with the MHSU.

The Investigation Team did have a range of questions and areas that it would have explored had it been conducting the investigation in a time period closer to the incident and if the LMHTT report had not evidenced a reasonable investigation had already taken place. Because of the time period (three years post incident), and because the LMHTT report addressed all key points pertaining to the antecedents to the incident, the Investigation Team concluded that there was no advantage to clinical learning and clinical quality to repeat the investigation process. The Investigation Team's concentration therefore was on points 5.1 – 5.6 listed above.

Before proceeding to report on the above issues, the Investigation Team wishes to state that it fully supports the decision of the LMHTT investigation team to focus its investigation on the period of time immediately preceding the incident. There is nothing to suggest that there is anything in the MHSU's care and management pre-dating 27

July 2005 that would have had any impact of the events of 27 July 2005.

5.1 The independent Investigation Team's analysis of Leeds Mental Health Teaching Trust's internal investigation into the care and management of the MHSU (June 2006)

Following the assault in July 2005, the Trust's then chief executive commissioned a team of individuals, external to the organisation, to undertake the internal investigation on the Trust's behalf. That LMHTT took such a step is to be commended. It is recognised that it can be challenging for staff employed by an organisation to deliver the objectivity required when analysing local serious untoward incidents. It is much easier for outsiders to achieve this.

These individuals were:

- A former chief executive of the Northern Centre for Mental Health.
- A consultant psychiatrist.
- A director of nursing from another mental health trust.

Even though the investigation was undertaken on an 'external' basis it was assessed against the key questions Consequence UK would normally use to benchmark an internally conducted investigation. Consequence has used this benchmarking criterion since 2006, and initially devised its outline when critiquing root cause analysis investigations undertaken by the National Patient Safety Agency pilot sites in 2002 and 2003⁹. The standards applied pre-date the Trust's investigation report and reflect the standards expected of serious untoward investigations in the NHS since 2003/2004, including the application of root cause analysis.

The questions were also agreed with Yorkshire and Humber SHA.

The questions were:

- 5.1.1 Were the terms of reference of the investigation reasonable and does the LMHTT investigation report evidence that these have been addressed?
- 5.1.2 Have all key facts been identified in the LMHTT report based on independent analysis of the clinical records?
- 5.1.3 Have the diagnosis and adequacy of care of the MHSU, including key issues of concern, been appropriately explored?
- 5.1.4 Have issues such as

⁹ Consequence led the delivery of the NPSA's RCA pilot learning set programme and contributed to the development of the NPSA's e-learning tool kit. The evaluation of the quality of investigations undertaken by pilot participants was a key component of how participants' understanding of the RCA investigation was assessed. The NPSA began its roll out of RCA investigation training to the NHS in 2004.

- risk assessment (including risk management and relapse planning);
 - care planning;
 - Care Programme Approach;
 - clinical supervision;
 - interagency communications;
 - inter-team communications;
 - housing;
 - Support for carers/families including Carers Assessment;
 - team performance and leadership; and
 - service culture
- been adequately explored?
- ❑ 5.1.5 Are the conclusions of the Trust's investigation report congruent with the facts and are they reasonable for the case investigated?
 - ❑ 5.1.6 Did the recommendations made appear to be appropriate based on the findings of the Trust's own investigation? Furthermore, will they, if implemented, reduce the risk of a) the incident occurring in the future and b) the occurrence of similar care management concerns to those identified in this case?
 - ❑ 5.1.7 Was there evidence of a systems based approach to the investigation?
 - ❑ 5.1.8 Where the LMHTT investigation identified care concerns, how satisfied was the independent Investigation Team with the quality of the analysis of these, based on the information documented within the report ?

In addition to presenting our perspective on the completeness and quality of the Trust's investigation report where appropriate, this Investigation Team has provided its reflections on some aspects of the MHSU's care and management.

The overall conclusion of the Investigation Team's critique of the LMHTT Investigation Team is that the key issues relating to:

- ❑ the lack of appropriate assessment of the MHSU on admission to ward 1 in July 2005;
- ❑ the lack of credence given to the risk assessment undertaken by Alexander House staff; and
- ❑ the open door policy in place at the Becklin Centre at the time

were highlighted by the LMHTT independent investigation team. Although the reasons for these lapses in service and care delivery were not explored as fully as one would have expected, the LMHTT independent investigation team was robust in recommending a full review of the management and leadership of Ward 1, as well as the systems and processes in place to support the delivery of effective care and management.

In spite of the lack of systems analysis undertaken during the original investigation it is the opinion of the independent Investigation Team that the LMHTT report was sufficiently robust to render the need for further re-examination of the care unnecessary.

The full detail of the Investigation Team's critique of the original LMHTT Investigation Report is presented at Appendix 1 (page 53).

5.2 The approach to and quality of client-focused risk assessments undertaken in the Adult Services Directorate.

The LMHTT report highlights a serious omission in the care and treatment of the MHSU while he was a patient of Ward 1 of the Becklin Centre in that no risk assessment was undertaken, or risk management plan devised.

There was also the seeming disregard of the risk assessment undertaken by Alexander House staff which identified the MHSU of medium risk of harm to others and in possession of knives.

In light of the fact that inadequate assessment and risk assessment have been highlighted in another investigation of a serious incident involving a service user of the then LMHTT in 2005, it was agreed with LPFT and Yorkshire and Humber SHA that the Investigation Team would seek to gain insight into present practice in client-focused risk assessment.

Four key activities were undertaken to gain an insight to this:

- A meeting with the professional identified as the lead for risk assessment in the trust (2008).
- The physical review of a randomised sample of completed risk assessments across three wards, the Crisis Resolution and Home Treatment Team (CRHT) and three CMHTs.
- Information gathered via a semi-structured survey of staff working in the Adult Services Directorate (inpatient and community).
- Round table discussion with a selection of inpatient staff.

5.2.1 Information provided by the Trust risk assessment lead.

The lead for client-focused risk assessments in the Adult Services Directorate advised that:

- The formal training provided to date focused mainly on how to use the FACE risk tool rather than how to do a good risk assessment. However, there have been some practice based elements included in the workshops. These are:
 - The use of vignettes. These are provided by FACE and workshop attendees use these to work through a FACE risk assessment.
 - Contextual information is included from the findings of independent investigations following homicides and data from the suicide and homicide confidential inquiry report.
 - An emphasis that it is not OK to just identify risk and then not to identify how it is to be managed.
 - Highlighting that past history is an important indicator of potential future risk behaviour.

- ❑ The training provided to date has not been as in-depth as the current risk lead would have wished. It is only a one-day programme and therefore has time limitations.
- ❑ There is a separate training programme for safeguarding children and vulnerable adults.
- ❑ The training department holds records of all staff who have attended the FACE training since its inception.
- ❑ In addition to the formal training the risk lead has provided informal training to staff on request. The content of this has always been responsive to the team's needs, but would often include working with the FACE vignettes.
- ❑ Staff, in the opinion of the risk lead, do need clearer guidance on how to complete a risk assessment and a better understanding of how to use FACE.

In addition to the above the risk lead advised that LPFT has embarked on a complete overhaul of how it delivers risk assessment training and the content of the programme. This is in recognition of the need for more in-depth practice focused training.

A number of trainers for each directorate have been identified and they have been trained by the consultant nurse for forensic services and the risk lead. Once trained, the consultant nurse will shadow the trainers until both he and they are satisfied that the trainer is delivering the new programme to the desired standard.

It is expected that each trainer whilst delivering the core programme content will be responsive to the needs and experience of the persons attending a workshop. It is also expected that the trainer will be responsive to the needs of the directorate in terms of getting key risk assessment messages across, for example following an incident review.

The new programme is based on the DH document "Best Practice on the management of risk", and also recent Royal College of Psychiatrists reports.

The initial aim of the Trust is to get all qualified staff through the core training programme and then to review and expand the programme as necessary. Ideally, the Trust's risk lead revealed, they would like a two-day programme to be developed. **Note:** If the training is delivered on a team basis all team members can attend – qualified or unqualified. However, qualified members cannot opt out.

Finally, and reassuringly, a full audit of FACE is also planned.

5.2.2 Information elicited from staff via the semi-structured survey

The number of respondents to the survey was disappointing (29 out of 80 questionnaires circulated – 36%). This was particularly so as the questionnaires were sent to each care location by recorded delivery.

The recipients were the:

- clinical team leaders on Wards 1,3, 4 and 5.
- Clinical service manager for inpatient services.
- Clinical team leaders for the North-East, South, East, North-West, and Central Community Mental Health Teams.
- The clinical team leader and clinical services manager for the CRHT.
- The medical director of LPFT for circulation to a random group of consultant psychiatrists and other appropriate members of the medical staff.

Each bundle of questionnaires (5-7 in a bundle) to the clinical team leaders was accompanied by a letter of instruction and explanation about the importance of the survey. Pre-addressed envelopes were also provided to facilitate the return of the completed questionnaires.

Although the response rate is not statistically significant from a 'research paper' perspective there were sufficient responses to make the data meaningful and of relevance to this investigation.

A number of questions were posed to staff in the survey instrument. These were:

- When did you last attend the Trust's training work shop on client focused risk assessment?
- How valuable was the training in relation to your practice in the risk assessment of service users?
- How confident are you in your knowledge and skill base in undertaking a full risk assessment with someone presenting with apparent complex needs?

The responses to these questions revealed that:

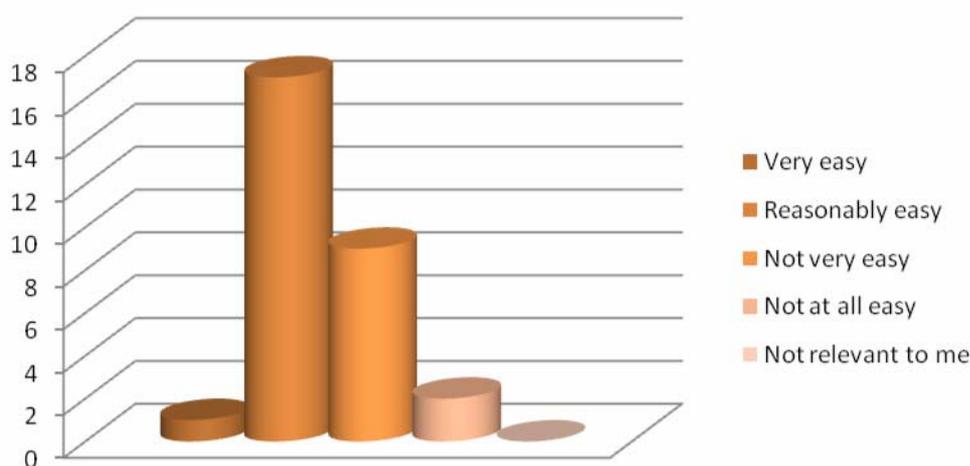
- 50% of respondents had attended risk assessment training within the last three years, in keeping with the recommendation of the 1999 Confidential Inquiry into Homicides and Suicides in England.
- 30% of respondents had not attended any Trust risk assessment training at all. Although a small number of these professionals may have attended training elsewhere the Trust needs to ensure that all staff attend appropriate update training at least every three years.

- Of the 15 staff who said they had attended the Trust’s risk assessment training programme, 90% reported that they found it to be helpful.
- 90% of respondents reported being confident in their knowledge and skill base in undertaking client-focused risk assessments.
- With regards to the question: “How easy is it in Leeds to gain a comprehensive understanding of the risk history of a service user who is known to the mental health service but is a new client for you?” The following graph (graph 1) depicts the responses:

Graph 1

Number of respondents: 29

Very easy	1
Reasonably easy	17
Not very easy	9
Not at all easy	2
Not relevant to me	0



With regards to the quality of documentation only 30% of respondents rated the current quality as “good”. No respondent rated it as “excellent”. 40% said the quality of documentation was “reasonable/OK” and 20% said it was “poor”.

Other questions asked of Trust staff were:

- “Based on your personal experience how would you rate the quality of crisis and relapse prevention plans?”
- “What have been the most significant changes in the Trust’s approach to risk assessment over the past five years?”

Only four respondents rated the quality of crisis and relapse prevention plans as “good”, with 14 rating them as “reasonable/OK”. However 12 respondents also rated these plans as “patchy” or “poor”. Given that

the trust now puts an emphasis on relapse signature planning, one would have hoped for a higher level of perceived quality of these documents from staff. This is something that the Trust needs to consider including in any audit of the success of its revised approach to risk assessment training.

With regards to the changes staff have experienced in the last five years the list below represents what staff collectively said. Individual comments are presented as well as those where more than one person reported a similar view point (x2, x3 etc). The rationale for presenting singular comments as well as grouped comments is that collectively they create a profile of staff perspectives. Clearly one can see that the overriding response from the respondents is positive and that there are few 'less positive' comments and no strong theme within these. Nevertheless the less positive comments should be noted and reflected on by the lead for client focused clinical risk assessments and the governance council for adult services.

Positive comments

- All mental health professionals complete the risk assessment compared with only CPN, ward nurses and other nurses previously.
- Everyone assessed will have an up to date face risk assessment.
- Crisis resolution involvement, central point for information (x5).
- Big focus on 'suicide prevention'.
- Networkable (i.e. now electronic).
- New and revised observation policy (x2).
- This has been done regularly (i.e. risk assessment).
- The importance placed on FACE and RA(x3).
- Appointment of a risk trainer (x2).
- Requirement that every Service User has an up to date FACE risk assessment, and more stringent controls to ensure that this happens (x4).
- Acknowledge that it should be used as a live document.
- Audits (ward level) to ensure up to date RA's are in place.
- Change of culture - at times was a degree of belief no matter what that things sometimes went wrong - now there is a more analytical approach.
- Requirement for there to be a management plan.
- Compulsory provision of Risk Assessment between tiers of CPA.
- FACE risk assessments are reviewed following SUIs.
- Staff are having training (x3).
- The implementation of CPA.

- ❑ FACE Format for adult services has been updated - minor changes only.
- ❑ Risk profiles disseminated to other teams. E.g. Crisis team.
- ❑ Relapse prevention.
- ❑ Care co-ordination has improved- all patients now have a CC within 72 hours of admission has involvement with in-patients (x3).
- ❑ The style of document (FACE).
- ❑ 7 day follow up of all service users following discharge from a mental health in-patient facility (National requirement).
- ❑ Ward managers regularly audit risk assessments.
- ❑ Increased emphasis on the service user and the carers views of Risk - Excellent!
- ❑ Use of word (i.e. I.T.) to complete RA and update.
- ❑ Regular CPA reviews.
- ❑ FACE risk assessments - focus people to confront risk issues.
- ❑ I.T. has made information more easily available.
- ❑ Review and monitoring of mental health.
- ❑ Discharge CPA.
- ❑ Reviewing and updating risk profile.

Less positive comments

- ❑ The Trust has become fixated with the quality of the paperwork rather the quality of the assessment.
- ❑ Not aware of changes (x2).
- ❑ Risk assessments for new admissions should be on the ward prior to the service user being admitted – i.e. available from the Crisis and Home Treatment Team who are the gate keepers of admissions.
- ❑ Various methods taken to complete historical/ current indicators of risk. Not always useful for clarity of accessibility.
- ❑ Not enough support/ encouragement given to therapeutic risk taking.
- ❑ More risk averse.

5.2.3 The assessment of risk assessment documentation by the Investigation Team

It is the experience of Consequence UK that staff tend to be honest, if not a little harsh, in their questionnaire responses. However, because the issue of risk assessment, and the quality of risk assessments, had arisen in three separate serious incidents between 2005 and 2006 that LMHTT reviewed, the Investigation team was asked to independently assess the quality of risk assessment documentation across in-patient and community services.

The Investigation Team visited three in-patient wards, the CRHT and three community mental health teams in the Adult Services Directorate at Leeds Partnerships NHS Foundation Trust. A randomised selection of three or four patient records were selected in each area and the risk documentation and CPA documentation was reviewed. The Investigation Team members also spoke with a range of staff during the site visits.

The key findings from the site visits are that:

- Overall the Investigation Team found the standard of risk documentation to be of a good standard with reasonable qualitative information provided where risk indicators were identified.
- The Investigation team is satisfied that FACE risk profiling is embedded within the Trust, although the quality of record-keeping varies.
- Training and updating of staff in risk assessment has until now been neglected. The training provided on FACE has focused more on the completion of the FACE documentation tool rather than the practice of risk assessment. However, this is to be remedied by the newly appointed risk assessment lead. A key objective for the post holder is to delivery risk assessment training on a team by team basis across the Adult Services Directorate.
- There appears to be no standardised approach to updating of individual service user FACE profiles. This needs to be rectified in the current revision of the Trust's risk assessment guidelines. One suggestion would be to score through any previous document and to mark it as 'Updated', along with the date and the name of the 'assessor'. One would anticipate that the tracking of 'updated'/'revised' profiles will be immeasurably easier once electronic record keeping is the norm.
- There is currently no process in place to validate individual staff competence in client-focused risk assessment. The independent Investigation team appreciates that designing a standalone validation tool may not be easy, but it should be possible for an assessment package to be agreed. Key elements of such a package might include assessment via peer supervision, management supervision, randomised audits of the documented risk profiles, and the use of role play or scenario analysis. Randomised assessment of the quality of risk assessment will also be undertaken by the newly-appointed clinical risk assessment lead.
- CPA documentation was generally good, but there was little evidence of carer involvement. In the community teams visited, in only two out of nine sets of records was evidence of

carer involvement in the CPA process apparent. Furthermore in some instances, the Investigation Team observed that service user agreement was not obtained for their CPA plan, but the plan was circulated to those on the distribution list anyway.

- ❑ Of the CMHT records assessed all were where they should have been and all of good quality.
- ❑ The CRHT only employs staff with post qualification experience and therefore assumes that staff are competent in risk assessment. There is currently no validation process for this.
- ❑ Historical client assessment information, held electronically by the CRHT, is not automatically accessed by staff when a known service user is referred to them. However the CRHT team leader asserts that his staff do seem more alert to the need to access historical information, as a result of previous incidents involving service users.
- ❑ Overall the CRHT notes are of better quality than ward notes.
- ❑ There were CPA plans in all CMHT files. This gave confidence that the CPA process is working.
- ❑ The CMHT CPA documentation consistently showed who had been invited to planning meetings, who attended and who had copies of plans circulated to them.
- ❑ At this time Trust electronic record systems are not synchronised - this means that if there are records held on the outpatients system the CRHT cannot access this. This is problematic when this is the only place where there are records about the service user. LPFT is already working towards improvements in its electronic records systems.

5.2.4 Information elicited from the round-the-table-discussion with inpatient staff

The information shared by inpatient staff employed by the Adult Services Directorate broadly reflects that which the Investigation Team has presented under sections 5.2.3 and 5.2.2. For completeness key elements of the staff feedback is presented here.

Staff told the investigation team that there is now more emphasis on updating risk assessments, for example on a weekly basis or more frequently if the service user presents with a changing risk profile.

One staff member present advised that as a supervisor they review the documentation of risk by staff during supervision, and that they pay particular attention to documentation quality especially the content of contextual information. There was a general assent in the room that

reviewing individual practice around risk assessment was much more commonplace during supervision than in previous years.

All staff advised that whereas in 2004 it was not uncommon to admit a service user and for there to be no contemporary risk assessment available at the time of admission, now all service users are admitted with a contemporary risk assessment.

With regards to the culture of risk assessment, and multi-disciplinary working, the impression given was that the FACE risk assessment document tended to be completed by nursing staff. The actual assessment of a service user's risk presentation was however much more multi-disciplinary now. However, staff did report that there remained scope for improving this.

5.3 Perspectives of three third sector (voluntary) agencies who interface with specialist mental health services in Leeds

The LMHTT investigation report highlighted that there may have been a lack of credence given to the perceptions of staff at Alexander House regarding the potential level of risk the MHSU presented to others.

At an early stage in the independent investigation process the Trust's medical director highlighted that effective working with the third sector in Leeds was an important component of care coordination and the delivery of a good mental health service. Therefore it was agreed that the Independent Investigation Team would facilitate a small number of focus group meetings with some of the third sector agencies (the sample agencies) who had significant input with mental health service users or who had been involved in the care and management of a service user who had been involved in a homicide event.

The aggregated findings of these focus group meetings are presented below:

Working Relationships

Overall all sample agencies and Volition reported that there had been an improvement in these over the last seven years. However, all were consistent in their assertion that the working relationship between LPFT and the third sector remained far from ideal. There were pockets of good practice reported, in particular in relation to the Newsam Centre and in relation to a small number of named staff, two consultant psychiatrists (in sectors two and five) and the current director of service delivery.

The personality disorder service and ASPIRE (the early intervention service) were also cited as examples of positive development with regards to partnership working with the voluntary sector.

One of the sample agencies did highlight a worthwhile initiative between Volition and the Crisis Team, i.e. meeting with voluntary agencies looking at what kinds of cases to refer. These were noted to be very helpful but no longer take place regularly.

The issues that seem to remain problematic in enabling the achievement of optimal working relationships are as follows:

- The sample agencies do not feel that their knowledge and time served experience in working with clients with complex mental health needs is respected by mental health professionals working in specialist mental health services. The Investigation Team gained a sense that the specialist mental health service does not always appreciate the in-depth knowledge third sector workers have of a named client due to

the intensive and long term contact they may have had with him or her.

One agency said “When trying to communicate their assessments of service users to the Crisis Team they are sometimes asked what their qualifications are”. The same agency felt that “they are simply not on the mental health service’s radar”.

- One of the sample agencies told the Investigation Team that they have asked in-patient managers if they can be more involved and offered to provide a link worker to facilitate this. Their request however “came to nothing”.
- Some of the sample agencies organise advisory groups to which LPFT staff are invited, but there has been a poor response to this. This seemingly lack of grass roots engagement is encapsulated by the following:

“A workshop session was organized in the summer looking at partnership working. Forty experienced people attended from the third sector and only two people from LFPT; a healthcare assistant and a newly qualified nurse.” (both notably junior).
- One sample agency suggested that some of the problems between the statutory and third sectors may stem from the use of the word “voluntary”. This may unwittingly infer that the agencies are staffed by “unpaid do-gooders” rather than well trained, professional people carrying out valuable paid work in a flexible and responsive way.

Information sharing

From the information obtained from Volition and the sample agencies with whom the Investigation Team met, the following themes emerged:

- That the quality of information shared with them is variable.
- That whether or not important information around risk assessments and CPA care plans is shared can be ‘person dependent’.
- The sample agencies suggested that when substantially engaged with a service user they are not routinely invited to discharge planning meetings following episodes of in-patient care. In fact the inference was that invitations to discharge planning meetings were ad hoc and attendance, if achieved at all, was often achieved ‘by chance’.
- When a service user is transferred from mental health inpatient services the voluntary agencies advised that sometimes no up-to-date risk or CPA information is provided, and on some occasions at least one of the agencies found an unwillingness to provide this information when asked.

- The sample agencies shared that the CRHT is inconsistent in engaging with them for informant history when undertaking a crisis assessment. One of the more prominent sample agencies suggested that at times it had to insist on providing information to the CRHT.
- All sample agencies expressed that there was a lack of clarity about the care pathways available to them to achieve an appropriate assessment for their client.

The following vignette is an example of the impact of poor communication between statutory and voluntary services:

“There was one example where they (the sample agency) was not involved and the service user was discharged to a flat which had been trashed while he was on the ward. Housing had not had the chance to sort this out but the ward did not know that.”

The following quotation from Volition encapsulates the concerns shared by the sample agencies.

“Communication between LPFT and other organisations is a major concern for Volition members. Examples are frequently given of day centre or housing support workers not being given any information by ward staff; of people being discharged without these workers being informed, with consequent readmission due to necessary support not being in place and of inadequate/inaccurate information being given. There has also been felt to be a lack of commitment from ward staff to provide link workers for housing providers to contact when they have vacancies or general issues.”

One agency has been trying to lead on the link worker issues from the third sector’s end but Volition advised that ideally the funding should come from Supporting People, as the initiative requires proper resourcing and problems could arise if the third sector link worker was provided by one agency.

The Investigation Team also identified that the sample agencies do not appear to have a standardised format for providing the specialist mental health services with information about their client when admitted to hospital, where the third sector agency has been involved in achieving admission. Neither does information appear to be routinely sent in with the service user at the point of admission.

Not all sample agencies have in place a process for seeking the prior consent of their client with regards to information sharing with, and from, primary care or the specialist mental health services should the client become unwell. The absence of formalised consent would make it more problematic for the specialist mental health services to share relevant information, especially if it is the service user’s first episode of

contact with mental health services, or the third sector agency is not already identified on the service user's CPA care plan.

Note: Although there is frustration amongst the sample agencies with regards to achieving effective communications with LPFT especially in relation to discharge planning and housing issues Volition advised that there is an accommodation pathways review project in progress whose aim is to reduce the number of delayed discharges. The project is funded by Supporting People for a period of six months to enable *“a whole system review of the accommodation referral and assessment processes for people in secondary mental health inpatient services; in order to make recommendations for service improvement.”*

The project team have made significant progress in mapping the current issues, and drafting the framework for a new protocol. As part of the final stage they met in March 2009 with Supporting People funded mental health providers to give a brief overview of their findings and share the elements of the proposed protocol.

CPA

It was encouraging to hear that the sample agencies have all engaged with LPFT's CPA training programme. However, there has been no CPA training since previous trainer left post in September 2008.

The information shared with the independent Investigation Team suggests that although all sample agencies have experience of being invited to, and attending, CPA meetings they all reported that there was no consistency in this. Furthermore the sample agencies advised they did not always receive a formal invitation via the CPA coordinator or care coordinator of the date and time of the meeting but found out about it from the service user him or herself.

The Investigation Team reviewed the content of LPFT's current CPA policy. We could not find anything in this document that highlights the importance of inviting substantially engaged third sector agencies or, in section 5.2 entitled “User Involvement in the Care Coordination Process”, anything that promotes gaining input from the service user as regards whom should be invited to CPA meetings. Furthermore the CPA documentation tools in the appendix of the CPA policy do not give the same prominence to those third sector agencies significantly involved with a service user as they do agencies such as social services. The Investigation Team has discussed these issues with the CPA lead for the Trust and he has agreed to be mindful of them in his imminent redrafting of the Trust's revised CPA policy document.

Risk assessment

It appears that all of the sample agencies do utilise a risk assessment process with their clients. Two of the sample agencies use the same

risk assessment process as LPFT and one uses the Sainsbury's model. Those using FACE have attended the FACE training provided by LPFT.

Volition advised that it believes that the ideal situation would be for all third sector agencies to be working with the same model of risk assessment, for example FACE.

One of the sample agencies said that the quality of documentation at LPFT in relation to risk assessment was poor with the FACE form only being partially completed. This however was not supported by the independent Investigation Team's own assessment of the quality of documentation which it found to be good.

The overriding message received from the sample agencies and Volition was that the risk assessment undertaken by specialist mental health services is a key piece of information that is required by voluntary agencies if they are to become engaged with a mental health service user at the point of discharge from psychiatric in-patient services, or at any stage during the service user's contacts with mental health services. All third sector agencies take risk assessment very seriously and all third sector employees acting as key workers will have had training in this.

Observation by the independent Investigation Team

It seems that although the voluntary sector asserts strongly its need to have access to the risk assessment profile completed by specialist mental health services when becoming engaged with a mental health service user, they are not so rigorous in ensuring that when a client is transferred from their care into specialist mental health services that core information including their risk assessment is provided at the point of admission. In the case of the MHSU, who is the subject of this report, risk assessment information was provided to the CRHT at the time of their assessment by Alexander House staff.

5.4 Clinical supervision

The serious lapse in clinical care afforded the MHSU, whose care is the focus of this report, did raise questions about clinical leadership and clinical supervision. This Investigation Team has met the current clinical team manager of Ward 1 of the Becklin Centre and were impressed by her engagement with the investigation process and her diligence in ensuring that we had a realistic picture of the contemporary situation in LPFT. Indeed we have been impressed with all of the CTMs we have met on our various site visits.

With regards to clinical supervision LPFT staff accept that historically this was problematic, predominantly due to a lack of senior staff (minimum nursing Band 6) to carry this out. However in recent times the working shifts have been altered and this has enabled a two hour protected period to be allocated to undertaking one-to-one supervision sessions with staff. Furthermore staff advised that not only is there increased opportunity for supervision but that culturally there has been a shift of emphasis from management to clinical supervision.

The staff who attended the round-the-table meeting also advised the investigation team that the Becklin Centre is also looking to achieve accreditation with the Practice Development Unit (a two year programme accredited by Leeds University).

The in-patient staff also advised that all wards now have reflective practice groups in addition to individual supervision and these were not in place in 2005.

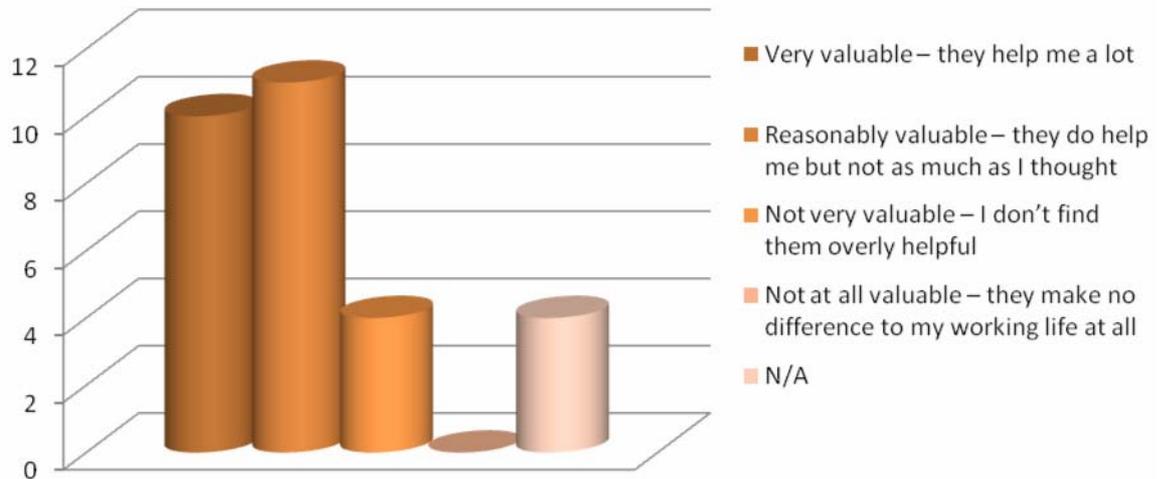
To test out what the in-patient staff told the investigation team a range of questions about management and clinical supervision were included in the questionnaire issued to a wider cohort of staff. The information gathered revealed that:

- 16 out of 28 (57%) respondents had attended for management supervision within a four week period.
- 4 out of 28 (14%) respondents had received management supervision in a time period of between four and eight weeks.
- 4 out of 28 (14%) respondents had received management supervision in a time period of between eight and twelve weeks.
- 4 out of 28 (14%) respondents had received no management supervision at all.

With regards to the usefulness of management supervision sessions, staff said:

- ❑ Very valuable – they help me a lot (10 out of 29 respondents).
- ❑ Reasonably valuable – they do help me but not as much as I thought (11 out of 29 respondents).
- ❑ Not very valuable – I don't find them overly helpful (4 out of 29 respondents).
- ❑ Not at all valuable – they make no difference to my working life at all (No respondents).
- ❑ N/A (4 respondents).

Graph 2



With regards to clinical supervision:

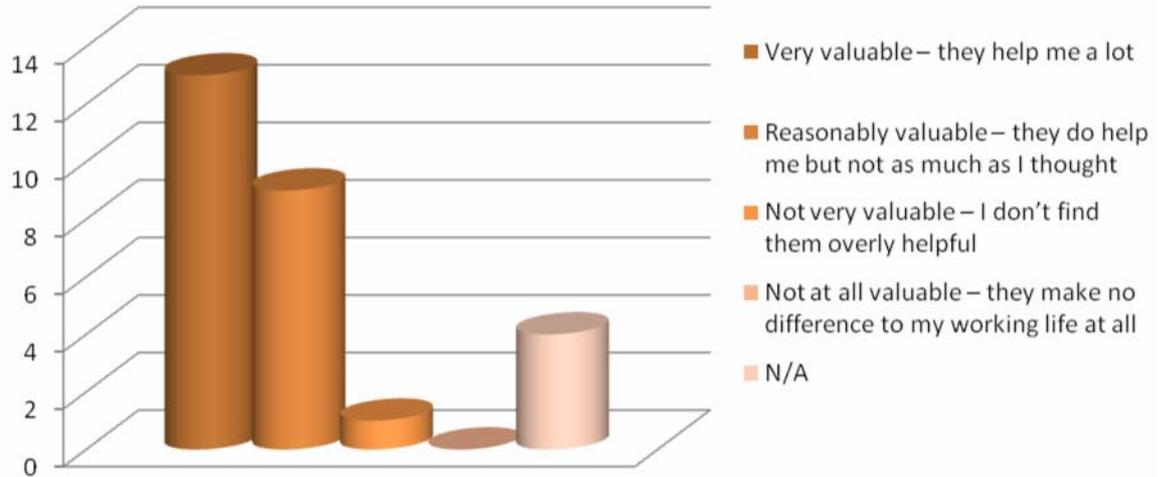
- ❑ 14 out of 28 respondents (50%) had received clinical supervision within the last four weeks.
- ❑ 5 out of 28 (14%) respondents had received clinical supervision in a time period of between four and eight weeks.
- ❑ 5 out of 28 (14%) respondents had received clinical supervision in a time period of between eight and twelve weeks.
- ❑ 4 out of 28 (14%) respondents had never received clinical supervision.

With regards to usefulness staff said:

- ❑ Very valuable – they help me a lot (13 out of 29 respondents).

- ❑ Reasonably valuable – they do help me but not as much as I thought (9 out of 29 respondents).
- ❑ Not very valuable – I don't find them overly helpful (1 respondent).
- ❑ Not at all valuable – they make no difference to my working life at all (no respondents).
- ❑ N/A (4 respondents)

Graph 3



Staff were also asked to identify from a list of subjects which were included in their management or clinical supervision meetings. The responses to this question revealed:

Clinical supervision

- ❑ Case load management 12
- ❑ Case load weighting 9
- ❑ Clinical concerns about specific clients 22
- ❑ Review of the quality of my documentation 8
- ❑ An assessment of the quality of my risk assessments 8
- ❑ An assessment of the quality of my care plans 8
- ❑ An assessment of the quality of my risk management and/or relapse prevention plans 5
- ❑ The appropriateness of the level of CPA for my client 2
- ❑ Work based issues that I want to talk about 16
- ❑ Personal issues that I want to talk about 14

Management supervision

- ❑ Case load management 15
- ❑ Case load weighting 12
- ❑ Clinical concerns about specific clients 12
- ❑ Review of the quality of my documentation 10
- ❑ An assessment of the quality of my risk assessments 4

- ❑ An assessment of the quality of my care plans 4
- ❑ An assessment of the quality of my risk management and/or relapse prevention plans 4
- ❑ The appropriateness of the level of CPA for my client 4
- ❑ Work based issues that I want to talk about 19
- ❑ Personal issues that I want to talk about 14

In addition to the above the following were cited as topics that would regularly feature within management and/or clinical supervision meetings:

Clinical supervision

- ❑ Team issues.
- ❑ Developing clinical knowledge needs specific to role.
- ❑ How to work in teams under pressure.
- ❑ Social service updates etc.
- ❑ Own agenda so content varies.
- ❑ Personal development.
- ❑ Transference/counter transference.
- ❑ Managing stress.
- ❑ Interpersonal conflict.
- ❑ Professional development.

Management supervision

- ❑ Team updates.
- ❑ Ongoing development needs.
- ❑ Budget management.
- ❑ PDP.
- ❑ Dealings/management issues with staff.
- ❑ Pressure of workload.
- ❑ Sickness monitoring.
- ❑ Team deficiencies.
- ❑ Future education/training needs.
- ❑ Staffing issues/capabilities recruitment.
- ❑ Training needs.
- ❑ Annual leave/sickness.
- ❑ Training.
- ❑ Feedback overall practice and leadership qualities.

Finally staff were asked what would make their supervision sessions more valuable. Very little was suggested in relation to clinical supervision. It seems as though staff are reasonably satisfied with how this is currently provided.

With regards to management supervision the following suggestions emerged:

- ❑ More time to focus on each service user's needs and my perception.
- ❑ More time to discuss specific issues in detail.
- ❑ How to develop myself/access to training.

- CTMs to supervise less staff.
- More frequent.
- If areas of concern within a wider sphere it allows opportunity to discuss such issues.
- My strengths/ weaknesses feedback.
- Proper training - never had any for management supervision. Not sure if anyone is really qualified in this trust to carry out this role.
- More planning as to when and where the meetings will be held.
- To feel relaxed with supervisee.

5.5 CPA

Following the initial analysis of clinical records associated with the MHSU referred to in this report, the LMHTT investigation team was concerned that he had not been placed on enhanced CPA. However we are satisfied that he was on an enhanced care package and that he received appropriate clinical review and input from relevant professionals and services. It was agreed however that the investigation team would undertake a “litmus test” of CPA practice.

As previously mentioned in this report during the review of contemporary clinical records the investigation saw nothing that suggested that CPA was not being adhered to. Furthermore the 2007 Patient Survey conducted on behalf of the Healthcare Commission (HCC) revealed that LPFT received a score of 70/100 in relation to the CPA review question: “Have you had a care review in the last 12 months?”

This score placed LPFT in the top 20% of trusts, based on the aggregated responses from the 15,900 service users who responded to the survey.

The HCC survey also revealed that LPFT also scored more than 85 out of 100 in response to the CPA review question: “Were you given a chance to talk to your care coordinator about what would happen?”. This put LPFT at the top end of the top 20% of trusts.

LPFT also scored highly¹⁰ in relation to the following questions:

- Were you told you could bring a friend or a relative to the meetings?
- Have you been given a copy of your care plan?
- Can you contact your care coordinator if you have a problem?
- Has your family/carer been given sufficient information, and have they received enough support?

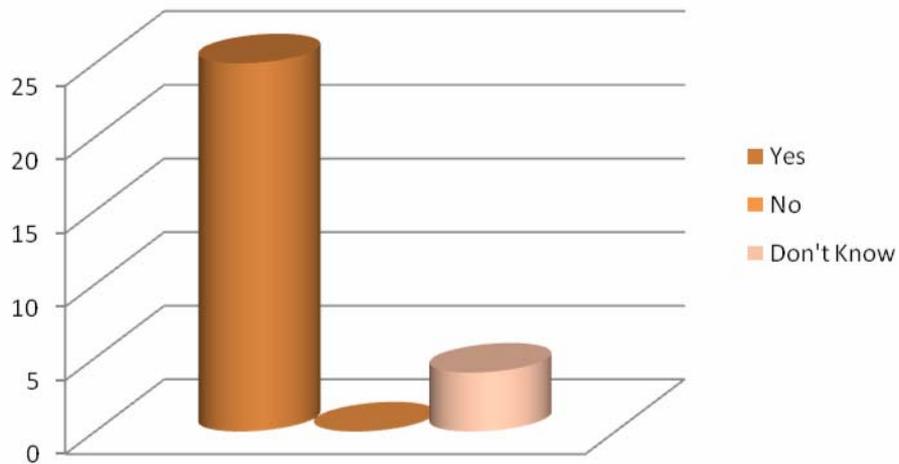
Inpatient staff at LPFT told the investigation team that CPA was more formalised now than it was a few years ago and that a CPA coordinator is now allocated to a service user within 48 hours of admission if they do not already have one. It is the role of the appointed care coordinator to maintain contact with the inpatient team and to attend the discharge planning meeting(s).

¹⁰ That is, in the top 20% of mental health trusts who participated in the HCC survey.

In response to the question “Under normal circumstances do CPA reviews usually take place in the time period they are planned for?” posed to staff in the questionnaire, staff said:

- Yes -25 out of 29 respondents (86%).
- No -zero respondents.
- Don't know - 4 out of 29 respondents.

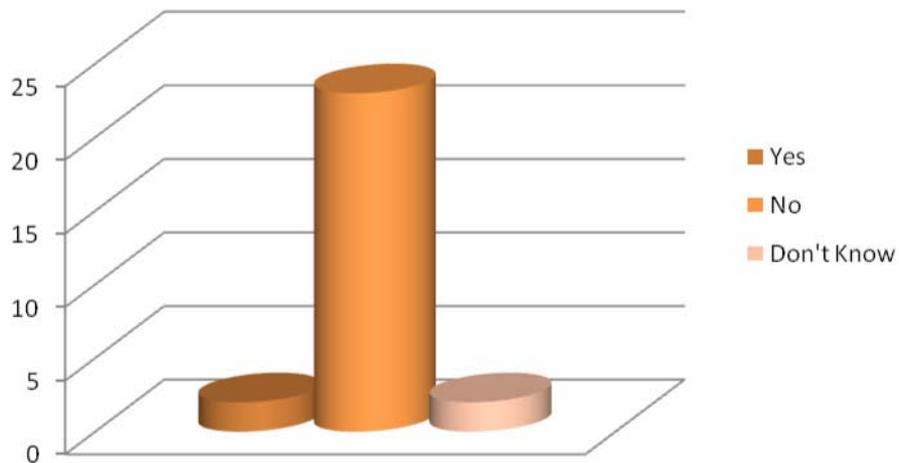
Graph 4



In response to the question: “Do you have any service users with severe and enduring mental illness such as schizophrenia on your caseload that has not received a review in the last 18 months?”, the 29 questionnaire responses revealed:

- Yes - 2 responses.
- No -23 responses.
- Don't know -2 responses.

Graph 5



5.6 Nursing observation practice and escorted and unescorted leave

A key concern identified in the LMHTT investigation report was the fact that the MHSU was able to come and go from Ward 1 freely immediately after admission even though he had been admitted for assessment, and with a medium risk rating for harm to others, including staff, other patients and the public.

During the round-the-table meeting with inpatient staff the Investigation Team therefore sought to understand the present situation in the Becklin Centre. The inpatient staff informed the investigation team that all new admissions are asked to stay on the ward without leave for the first 72 hours following admission, regardless of their admission status. This enables a reasonable assessment of risk to be made.

Furthermore the Trust now has an electronically controlled access/exit card that is supplied to informal service users. It is staff experience that most informal service users are willing to waive their right to this until it is assessed that it is appropriate and safe for them to have one. If a service user were to insist on having an access/exit card (which enables them to come and go freely) it would prompt staff to undertake an assessment of their status and consider whether or not compulsory detention was required to enable a safe and effective assessment to occur.

This system it seems does enable LPFT to provide a balance between patient rights, patient safety and the Trust's duty towards public safety. The Trust does conduct audits of the numbers of missing persons and a 'missing person' is a reportable incident for Trust employees. Recent figures suggest that there has been a reduction in the numbers of missing persons from the Becklin Centre which is encouraging.

Had the above stated standard and system been in place in July 2005 the incident involving the MHSU would not have happened.

6.0 ACTIONS TAKEN BY LMHTT/LPFT TO ADDRESS ISSUES RAISED IN ITS OWN INVESTIGATION REPORT

The specialist mental health Trust in Leeds has worked tremendously hard since 2005 to improve its adult services. In fact plans were already underway to implement a service-wide improvement plan in advance of the incident involving this MHSU. The principal change occurring at the time was the deployment of the functional model across all services. This meant that each in-patient ward had dedicated consultant input and each community mental health team had dedicated consultant input. This change meant that the organisation of all inpatient ward teams had to change, not just Ward 1. It is important to note that Ward 1 as it was in 2005 no longer exists.

This section therefore sets out what has changed since July 2005. The changes are far more extensive than those recommended in the internal investigation report.

Recovery plan to improve performance of Ward 1

As already noted Ward 1 at the Becklin Centre in July 2005 does not equate to the current Ward 1 at the Becklin centre. There have been a number of organisational changes to the wards in the last four years the most significant changes relate to the introduction of the adult service model including changes to care coordination responsibilities, the change of the wards to single sex accommodation and the transfer of wards within the Becklin Centre.

In September 2007 a review of all wards at the Becklin Centre was undertaken by the associate director, clinical team manager (acute inpatients), director of service delivery and medical director focusing specifically on the safety and efficacy of the inpatient wards.

An action plan was produced with clear goals and timescales and an immediate decision was taken to stop the use of "leave beds"¹¹. The action plan was provided to the Investigation Team as evidence of the actions taken. One component of this was that a significant investment in staff was agreed equalling £1.1 million. This has subsequently been delivered, with ward staffing establishments increased. As a result the skill mix on the wards has been enriched and staffing numbers increased with the employment of four additional band 6 nurses and a doubling of the numbers of Band 5 nurses to 11 whole time equivalent staff.

In 2007 the Becklin centre (all wards) embarked on a project to achieve stage 2 accreditation as a Practice Development Unit (PDU) which was achieved in November 2008. The programme provides recognition for clinical teams who can demonstrate patient centred care that is leading edge, evidence based and innovative. The Becklin centre was the first

¹¹ This is a bed that has been allocated to a patient who is currently 'on leave' for a defined period of time.

mental health inpatient unit in the country to achieve this and remains unique in attaining this. This achievement is commendable. The Practice Development Unit award is accredited by the University of Leeds.

Efficacy of the new access/egress system.

There is no doubt that the new access/egress system utilised by the Becklin Centre is having a positive impact on reducing the numbers of service users going absent without leave (AWOL). Information from the police regarding the numbers of AWOL service users reported to them from the Becklin Centre, and also the personal safety and security advisor report on the numbers reported on the incident reporting system for all clinical areas within the Trust evidence this. The air lock system (that is only one entry/exit door open at a time) has also impacted on the reduced numbers.

There was an overall discrepancy in the numbers of reported 'AWOL's' logged onto the Trust incident reporting data base and the number reported to the police. The importance of completing a Trust incident form as well as advising the police is being emphasised across the Adult Services Directorate.

Comment: It would be useful if the Trust's missing person report provided information relating to the status of those service users going AWOL. For example:

- Level of observations (e.g. general, timed).
- Assessed risk level for absconding.
- Informal or detained patient.
- Missing from ward, or 'missing following agreed leave'.

It is not possible to prevent all AWOLs, however more information in the missing persons report in relation to the service user's status at the time would enable the leaders of the adult service to target any further remedial action more effectively.

Observation policy audits

In 2005 when the MHSU was admitted to Ward 1, there did not appear to be a proactive approach to staff observation of him in spite of a dynamic observation policy being in place. This said:

"The admitting nurse and/or member of professional team with the admitting doctor will complete a joint risk assessment (FACE) which will be based on recent history, past history, presenting needs and incorporate assessments of other key professionals involved in the patients/service users care (i.e. psychiatrist, CPN, GP, etc.). This level of assessment should culminate in an observation level being jointly agreed between nursing and medical staff. The assessment will also include the patients/service users and significant others (carer, partner, parent, etc.) perspectives of risk and vulnerability. It is essential that each inpatient ward will have use of risk assessment tools, which are specific to their environment, with which all members of the multidisciplinary team are familiar."

The observation records available suggest that this MHSU was on general observations only, that is he was included in the hourly head count conducted.

However this is an area of practice that the Trust has paid attention to in the years subsequent to the investigation.

The Trust has developed a detailed observation audit tool that is used on a non-participant observer basis (i.e. an individual or individuals observe the practice of inpatient ward staff and assess the quality of the documentation). This in itself is commendable. Data from the 2007 and 2009 audits was provided to the Investigation Team. The 2009 audit showed an overall improvement in practice during this period. However a number of aspects of practice continue to require improvement which is self evident in table 1 below.

Table 1

Documentation/ activities relating to observation	Yes	No	Not stated	2007 %	2009 %
Current risk assessment	136	13	0	96%	91%
If 'Yes', is this a FACE (n=136)	136	0	0	100 %	100%
Trust observation plan completed	99	48	2	68%	66%
Observation level clearly identified	138	10	1	70%	93%
Clear reasons for current observation level	128	21	0	56%	86%
Correct terminology used	123	24	2	53%	83%
SU mental health state assessed on a daily basis	101	46	2	88%	68%
Evaluation of SU mood and behaviour associated with risk	121	25	3	94%	81%
Therapeutic activity, interaction and engagement being used as part of observation	95	52	2	80%	64%
Weekly MDT review (n=140)	84	56	0	51%	60%
If 'Yes', are all staff involved (n=84)	80	4	0	79%	95%

The audit also assessed the level of service user engagement in the observations undertaken and the data in table 2 shows clearly that significant improvement has been made in relation to this.

Table 2

Service user involvement	Yes	No	Not stated	2007 %	2009 %
Aware of current level of observation	125	24	0	46%	84%
Involved in discussion/ decision making	94	55	0	43%	63%
Informed of reason for observation	48	101	0	28%	32%
Informed of duration of observation	32	117	0	5%	21%
Informed of what will happen during observation	65	84	0	18%	44%
Informed of any changes to observation level (n=106)	62	43	1	35%	58%

Risk assessment

As already highlighted in this report the directorate has implemented a team based risk assessment training programme for all clinical teams. The CRHT and the acute inpatient teams have been prioritised within this, and training is due to complete by the end of summer 2009 for all teams within the directorate. The training comprises a one day team training event with a half day follow up session held to review changes in practice following the training.

The training is mandatory for all clinical staff and this is documented in the directorate training needs analysis. Responsibility for attendance of team members lies with the clinical team manager and clinical services manager. At the time of writing the lead for clinical risk assessment reports that with the exception of sickness all staff are attending for the training as booked. This represents a marked improvement in practice. From 2005 up until 2007 the training records showed significant non-attendance and workshops that had to be cancelled as under subscribed. The Trust has done well to effect a culture change here. Risk assessment training is also discussed monthly at the directorate risk forum.

Therapeutic engagement and assessment of service user care on ward 1

The Adult Services Directorate now has a standardised service user satisfaction questionnaire given to all service users upon discharge to monitor their views. The questionnaires are monitored and audited by the “recovery and social inclusion” workers who will be working with ward and other relevant staff to ensure that the views of service users are included in changes to service delivery and service planning.

The directorate also has a clear procedure for investigating and responding to service user complaints which can give an indication with regard to service user satisfaction. There is a dedicated team within the strategic care pathway development service who undertake these investigations, and ensure that learning is implemented through working with colleagues in all service areas. This includes the work of the Patient Advice and Liaison Service (PALS) who attend the monthly directorate clinical governance council and provide reports on feedback received from service users.

Assessment of the views of community teams

As noted above significant changes in ward structures occurred between 2005 and 2007. Furthermore the geographic relationship between teams and wards which was in place in 2005 was changed with the introduction of the functional based adult service model and the dedicated ward consultants. For this reason LMHTT considered it essential that it looked at the general relationship between community and in patient services, rather than solely at a team that was to cease to exist because of the already planned changes.

Furthermore there is now a clear escalation process in place within the Adult Services Directorate, if disagreement or dissatisfaction exists between services, where initially the clinical team managers will liaise to resolve the issue. Where this is not possible the concern will be escalated to clinical service managers and if necessary to the associate director and associate medical director for the directorate.

In addition to the above a clear commitment has been made to developing clear service and care pathways. This work has contributed to service redesign in psychological therapies and rehabilitation and recovery services.

7.0 CONCLUSIONS OF THE INVESTIGATION TEAM

The independent Investigation Team supports the findings and main conclusions of the LMHTT internal investigation report (June 2006) in every respect except for its assertion that the attack that occurred was predictable and preventable.

What is indisputable is:

- The MHSU was graded as medium risk of harm to others by virtue of past behaviours and the fact that he had secreted knives in his bedroom at his supported accommodation.
- The MHSU was not on any closely timed observations when admitted to Ward 1.
- That the level of concern about the MHSU when he was on Ward 1 was not as it should have been, to the extent that there was consideration of discharging him back to his supported living accommodation within 24 hours of admission. This was prevented by intervention from the consultant psychiatrist who maintained responsibility for the MHSU's management in the community. The staff at the supported accommodation also voiced their unwillingness to take the MHSU back so soon.
- The Becklin Centre, like many mental health inpatient units, operated an open door policy at the time. This enabled service users to freely come and go from the ward.
- CCTV footage showed that the MHSU was absent from Ward 1 for a very short period of time, eight minutes.

What may have made a difference in this case?

Both this independent Investigation Team, and the original LMHTT Investigation Team, believe that had any one or a combination of the following factors occurred then it is possible that the unprovoked attack on the victim may have been prevented:

- Had the in-patient nursing and medical staff undertaken a fuller assessment of the MHSU that gave more credence to the risk assessment detailed by staff at Alexander House and the information recorded on the holistic assessment form by the CRHT, then it is inconceivable that they would not have developed a risk containment plan with the MHSU. This may have included a negotiated curtailment of his right to come and go from the ward as he pleased, and/or consideration of the use of Section 5.4 of the mental health act by the nursing staff if he tried to leave the ward. This would therefore have reduced the risk of his being able to leave the ward between 17.31 and 17.39hrs on 27 July 2005.

- ❑ Had the unit not operated an open door policy and instead kept its doors to the unit locked.
- ❑ Had the MHSU had been placed on a closer level of observation.
- ❑ Had the inpatient consultant sought information from the consultant psychiatrist caring for the MHSU in the community as soon as it became apparent that he was difficult to assess.

Absolute preventability?

This Investigation Team does not believe that one can say categorically that this incident was preventable had the assessment and management of the MHSU been better. We have discussed our perspective with the investigation lead for the original investigation and have reached agreement on this point.

Our reasoning for questioning absolute preventability is the variables that could have still enabled the MHSU to have left the ward unnoticed even if his management had been optimal.

These variables were:

- ❑ The open door policy at the time. This means that the ward was unlocked and even if the MHSU had been on more closely timed observations he still could have left the clinical area unnoticed and been back on the ward before he was missed.
- ❑ The period of time for which the MHSU was absent from the ward. It is significant that he was only absent for a period of eight minutes. For staff to have known where the MHSU was at all times would have required 'within eyesight', or 'within arm's length' observation. Even with optimal management this MHSU would not have attracted this level of observation.
- ❑ The MHSU was an informal patient and technically was free to leave the ward.

Could a similar incident occur in Leeds today?

Although one would be foolish to assert that a service user will not ever leave a ward and harm another again, if LPFT

- ❑ ensures that the standard of 'no ground leave' in the first 72hrs following admission is robustly upheld in all inpatient areas;
- ❑ continues with a more robust approach to risk assessment training;
- ❑ continues to undertake meaningful analysis of absconding incidents; and
- ❑ continues with its commitment to develop effective and healthy working relationships with third sector agencies which includes the respect of their time served experience and knowledge of a service user,

then a similar incident should not occur again.

The Trust has made considerable investments in the security of its acute inpatient building, numbers of staff employed and staff skill mix as well as in embedding strong governance arrangements. The models and approaches to care are significantly different to those in place in 2005 across the whole of the Adult Services Directorate. Ward 1 as it was in 2005 no longer exists and the new Ward 1 has effective and dynamic leadership. In spite of the horror of this incident for the victim who continues to live with her injuries today, the Trust does deserve recognition for the commitment it has made to improving its service.

8.0 RECOMMENDATIONS

The systems and processes relating to:

- supervision;
- risk assessment;
- nursing observation; and
- service users' ability to enter and leave an inpatient ward at will

have developed significantly since 2005. The Investigation Team therefore has no recommendations to make with regard to these. However there is work that remains to be done in respect of the working relationship between third sector agencies and the specialist mental health service at 'grass roots' level.

There is no question about LPFT's commitment to working effectively and in partnership with third sector agencies, and this point was made firmly by all sample agencies that contributed to this investigation. The concerns are targeted at practitioner level. Consequently the following recommendations are made in an effort to support both LPFT's commitment to effective partnership working with third sector agencies, and the commitment of third sector agencies to working effectively with LPFT.

For LPFT

Recommendation 1: LPFT is encouraged to explore the potential for named third sector agencies to be awarded direct referral rights to CMHTs without having to go via the GP. If this suggestion is considered at all feasible LPFT is encouraged, with the support of Volition, to run a pilot project over a defined period of time for example six months, with clear auditable outcomes.

Recommendation 2: For Adult Services Directorate LPFT, Volition and Supporting People to explore the feasibility of having named individuals at a sufficiently senior level to act as the central conduit of information relating to the availability of beds within the third sector. The third sector agencies are convinced that such a system would improve communications and optimise bed usage.

Recommendation 3: Although LPFT have engaged in a number of initiatives with Volition to improve the effectiveness of working relationships between the specialist mental health service and third sector agencies the consistent feedback received from the sample agencies the Investigation Team met with was that at 'grass roots' level difficulties continued to be encountered.

It is essential to the delivery of safe and effective mental health care that professionals from both sectors are able to work effectively together, and that each has a rounded perspective of the skills and

knowledge of the other. It is also important that each sector understands the challenges and complexities of each other's work for there to be realistic expectations of each other.

It is therefore recommended that the Director of Service Delivery – Chief Nurse of LPFT and the Chief Officer of Volition meet to discuss the findings of this investigation and develop a detailed action plan, preferably utilising a multi-pronged approach, to achieve further improvement in the grass roots relationships between LPFT staff and third sector agencies working substantially with mental health service users. It is expected that addressing the reported ineffectiveness of the current shadowing arrangements will form part of the action implementation plan.

Any plan agreed must be shared with the SHA and the commissioners and have measurable objectives so that the impact of the agreed action implementation plan can be monitored in the short, medium and long term.

Recommendation 4: As LPFT develops PARIS, and its CPA and FACE risk assessment tools the Trust needs to look at how information about third sector agencies, who are providing a service to individual service users, can be best incorporated so that:

- the degree of their involvement is clear;
- the contact details of the key worker are readily available;
- the wishes of the service user with regards to information that can be shared with the voluntary agency are recorded; and
- whether or not they are to be invited to CPA discharge planning and CPA meetings generally is stated.

Recommendation 5: The training provided to LPFT care coordinators needs to highlight the valuable role of the third (voluntary) sector in supporting the provision of an effective mental health service.

Advisory Note

The Executive Management Team at LPFT, and in particular those responsible for the commissioning and quality assurance of serious untoward incident investigations and the accompanying investigation reports are strongly advised to refer to Appendix 1 and to note the comments made about the strengths and weaknesses in the 2880 investigation previously commissioned. It would be prudent for LPFT to bear in mind these observations when quality assessing future internal investigation reports.

Recommendations for Volition and commissioners of mental health services

Recommendation 6: All third sector agencies registered with Volition who work on a regular basis with LPFT should consider using the FACE risk assessment. Ideally where possible these third sector agencies need to fund attendance of their staff at LPFT's risk assessment training workshops. Volition should take the lead in exploring how a common approach to risk assessment in its member agencies can be achieved.

Recommendation 7: There needs to be a clear pathway to enable workers in the voluntary sector to be able to access relevant specialist mental health services appropriately. It is recommended that LPFT and Volition work jointly with commissioners to achieve this.

Recommendation 8: Commissioners of mental health services in Leeds need to consider the value to the delivery of safe and effective services of supporting financially the development of, and delivery of, a single training programme for risk assessment of mental health service users across the secondary and third sectors. Clearly should such an initiative be considered sensible then careful consideration will need to be given to which third sector agencies should be included as a matter of course, and those for whom automatic training provision is not considered an appropriate use of the training resource.

Recommendation 9: To assist appropriate information sharing between third sector agencies and the specialist mental health service in Leeds. It is recommended that the Chief Officer for Volition initiate a meeting with those third sector agencies who work most closely with specialist mental health services and assess the feasibility of using a common design, or content specification, of consent form. This form would not only seek the consent of third sector clients to share appropriate information with specialist mental health services where both sectors are engaged in care and management, but also the consent of the client for the third sector agency to receive information from specialist mental health services in relation to:

- the treatment plan
- CPA
- Risk Assessment

In the interests of completeness the validity of the consent should be checked periodically. The Investigation Team suggests that the advice of the legal advisors to NHS Leeds or Yorkshire and the Humber SHA should be sought regarding pragmatic time periods for this.

APPENDIX 1 – THE FULL DETAIL OF SECTION 5.1. THE COMPLETENESS AND QUALITY OF THE INTERNAL INVESTIGATION COMMISSIONED BY THE THEN LEEDS MENTAL HEALTH TEACHING TRUST (LMHTT).

5.1.1 Were the terms of reference of the investigation reasonable and has does the investigation report evidence that these have been addressed?

The Trust's investigation team were appropriately asked to "review the care and treatment of the MHSU.....taking into account past care and treatment, and any other factors that seem relevant; to provide a report and to make such recommendations as seem appropriate".

Given the growing emphasis on undertaking root cause analysis investigations since 2002, and the national expectation for this in national risk management standards since 2004 one might have expected a more comprehensive terms of reference.

For example:

- ❑ To establish the full details of the MHSU's care and treatment within Leeds Mental Health Teaching Trust, and where possible other NHS, voluntary or statutory agencies.
- ❑ To identify the aspects of the MHSU's care and treatment that were reasonable.
- ❑ To identify and clarify any areas where the MHSU's care and management fell below the standard expected.
- ❑ Where care fell below the required/expected standards, to explore and understand the reasons for this.
- ❑ To identify the 'root causes' or most significant influencing factors as to why care fell below the expected standard for each identified care delivery concern.
- ❑ To make recommendations to address the root causes of the problems identified.
- ❑ To identify additional learning opportunities that have arisen by virtue of undertaking the investigation.
- ❑ To write and present an investigation report to 'XX' which sets out the investigation team's findings in relation to the above.

It is the experience of Consequence UK that it is generally helpful to NHS staff, asked to lead investigations, if the terms of reference agreed guide them through a structured investigation process. This does seem to lead to greater consistency in analysis of any identified slips in care or service and can facilitate the delivery of a clearly structured investigation report. It is therefore suggested to Leeds Partnerships NHS Foundation Trust that it develops standing terms of reference for

all of its serious untoward incident investigations, that can be personalised on a case by case basis.

5.1.2 Have all key facts been identified in the LMHTT report based on independent analysis of the clinical records?

LMHTT's investigation report provides a detailed overview of the chronology of the MHSU's care and treatment, from when he was admitted to High Royds Hospital under Section 2 of the Mental Health Act in 2002, to his admission to Ward 1 at the Becklin Centre on 27 July 2005 and his subsequent arrest there on 1 August 2005.

The LMHTT report makes clear that the investigation team accessed the MHSU's:

- medical and community records; and
- records held by Alexander House.

Information was also gathered from key staff who had worked effectively with the MHSU in the period pre-dating his admission to Ward 1.

It does not appear that the GP records were accessed, or records for the homeless team. This however is not significant given the timing of the critical period of care under investigation.

5.1.3 Have the diagnosis and adequacy of care of the MHSU, including key issues of concern, been appropriately explored?

LMHTT's investigation report confirms the MHSU's diagnosis of paranoid schizophrenia, and that this was complicated by his misuse of street drugs and his anti-social personality disorder traits.

The trust's analysis of the MHSU's care 1 July – 1 August 2005

The LMHTT report is appropriately complimentary of the care and treatment the MHSU received from LMHTT staff, Community Links staff and primary care workers. Sections 9.0 and 9.1 (page 20) of this report say:

*"The MHSU*¹² *was well known to Dr B and other staff in the homeless health team.*

*They had invested considerable time and effort in establishing a relationship with him, recognising from experience that the sort of chaotic lifestyle that he had, plus regular street drug use, would exacerbate his underlying schizophrenia. The lengthy admission to Ward 3 from December 2003 to September 2004 was in the Becklin Centre, to beds that Dr B. had admission rights for. The ward staff there were becoming used to dealing with similar types of presentation, and knew that engaging with *the MHSU*, and gaining his trust, would take*

¹² Italics are used to denote necessary word changes in the interests of the anonymity of the service user.

time. Dr B. and his team knew *the MHSU's* background, and knew that when unwell, he could become aggressive and violent. A key part of the care plan for *the MHSU* was close support, and careful monitoring of his condition to spot signs of emerging psychosis or use of street drugs.

9.2 After his discharge from Ward 3, *the MHSU* had intermittent contact with the homeless team and Dr B. When they knew of his release date from HMP Armley, they knew that they had an opportunity to manage his care. They arranged his admission to Alexander House. *The MHSU* did well at Alexander House. For the first time, he had a settled place to live, and was keeping free of street drugs. The active clinical engagement with *the MHSU* pursued by the staff there clearly benefited *him*. In this supportive and therapeutic environment he prospered, to the extent that he was offered a long term placement. It would be easy to underestimate the substantial amount of hard work and commitment to *the MHSU* that had produced this improvement in him. For *the MHSU*, the future was looking positive.”

The LMHTT investigation report also details the events leading to the MHSU's admission to Ward 1 of the Becklin Centre and highlights the appropriateness of the care and management he received in Alexander House leading to this. Furthermore the LMHTT report also notes that the then Crisis Team for LMHTT supported a short term admission for the assessment of the MHSU so that it could be established whether or not he was becoming psychotic¹³. The report specifically states (pages 20 – 21):

“In the days leading up to his admission on 27th July, *the MHSU* began to show signs of deterioration. Whether this was due to his forthcoming short move to Oakwood Hall is not clear, but staff at Alexander House knew him well enough to spot the changes in his condition. These changes were brought to the attention of Dr B., who changed his medication, and agreed that he would support Alexander House staff in their attempts to limit and manage his emerging psychosis. They went to considerable lengths to manage *the MHSU* where he was; providing extra staff, engaging *the MHSU* in discussions about his behaviour, confronting his inappropriate behaviour with female residents. The discovery of the knives raised their concerns to a higher level, and with Dr B.'s agreement, felt that a period of assessment as an inpatient was necessary. Had Dr B. still had direct access to beds on Ward 3, *the MHSU* would have been immediately admitted there.

9.4 Alexander House and Dr B. followed correct procedures under the new functional service system. Accordingly, the Crisis Team assessed *the MHSU*, and agreed that he needed to be in hospital. Had

¹³ It is important for the reader of these reports to realise that admission purely to contain aggressive and increasingly violent behaviour that is unrelated to a mental health crisis is not appropriate. A short admission period would enable staff to determine whether or not the MHSU's deteriorating behaviour was as a result of increasing mental ill health or not.

he not agreed to admission, they would have commenced assessment for compulsory admission. They were sufficiently concerned to arrange transport by ambulance, believing they would be at risk if they used their own cars to take *the MHSU* to hospital.

9.5 The Crisis Team use the FACE risk assessment tool on all referrals as part of their assessment procedures. A FACE assessment had been undertaken by Alexander House staff earlier that afternoon. The Crisis Team judged it to be of sufficient quality that they did not need to undertake one of their own. The FACE assessment indicated that *the MHSU* presented a clear and present risk to others.”

The LMHTT report proceeds to recount the course of the MHSU’s care and treatment on Ward 1 between 27 July and 1 August. It does not however set out the rationale, as the investigation team understood it, for:

- Ward 1 placing the MHSU on 15 minute rather than ‘within eyesight’ or at least 5 minute observations.
- Ward 1 medical and nursing staff not taking sufficient note of the concerns of the staff at Alexander House at the time of admission.
- Why the medical staff on Ward 1 believed that it was reasonable to suggest discharge back to Alexander House within 24 hours following admission when the MHSU had been admitted for real and escalating concern.
- Ward 1 medical staff and nursing staff not proactively liaising with ‘Dr B’ who had in-depth knowledge of the MHSU and could have provided valuable information with regards to his behaviours and the challenges of conducting an assessment of him. This consultant contacted Ward 1 following information provided to him by Alexander House staff of Ward 1’s intention to discharge the MHSU.
- Why there was no ward based risk assessment, or clear risk management plan, of the MHSU between 27 July and 1 August when he was arrested.

To fully understand the significant errors of judgment collectively displayed by the medical and nursing staff working on Ward 1 at the time of the MHSU’s admission, discovering the contributory factors to the above was required.

The LMHTT investigation team did however set out clearly that it believed that the staff on Ward 1 did not provide a reasonable standard of care to the MHSU. Its report (10.4 page 25) says:

“The ward staff allowed *the MHSU* more or less complete freedom to come and go as he pleased. They did this on the basis that he was not floridly ill, that he was down for early discharge and he was an informal patient. These assumptions are no substitute for a proper and formal risk management plan. The ward staff’s failure to undertake any sort of assessment of risk is a grave failing in clinical competence.”

The investigation team for LMHTT also says (10.6 pages 25-26):

“Given the information available to ward staff; the level of concern expressed by CRHT staff and Alexander House staff; the concern expressed by Dr B. when he visited the ward on the afternoon of the 27th July - with the specific purpose of warning of the risks that *the MHSU* posed - we think it is inconceivable that had the ward staff undertaken their own risk assessment, they would not have restricted *the MHSU*’s movements. Had they done so, the attack would not have happened on that day. We therefore conclude that because the risk was so apparent, and so clearly highlighted in documents and through conversations, that the attack was predictable and preventable.”

The Consequence UK team agrees with the criticisms made by the LMHTT investigation team of the care and treatment afforded the MHSU. It would however have been helpful to LMHTT if the perspectives and perceptions of inpatient staff had been more fully presented within the report.

5.1.4 Have issues such as

- ❑ risk assessment (including risk management and relapse planning);
- ❑ care planning;
- ❑ Care Programme Approach;
- ❑ clinical supervision;
- ❑ interagency and inter-team communications;

- ❑ housing;
- ❑ support for carers/families including Carers Assessment;
- ❑ team performance and leadership; and
- ❑ service culture

been adequately explored?

Risk assessment

The LMHTT report sets out clearly its perspective, in relation to the risk assessment and risk management care planning, for the MHSU in the period leading up to his admission on to Ward 1 and also following this admission.

The Consequence UK team concurs with the LMHTT team that the risk assessments undertaken by Alexander House staff, prior to the MHSU's admission, were of a good standard and that there was a lack of risk assessment and risk management planning when he was on Ward 1.

What is not presented in the LMHTT report is:

- ❑ The prevailing approach to undertaking risk assessments on the inpatient wards at the time.
- ❑ The training provided to staff in the undertaking of risk assessments.
- ❑ The requirements of the Trust's risk management policy as it pertained to the risk assessment of service users, or the operational policy for inpatient services.
- ❑ The role and responsibility of the clinical team manager on the inpatient wards for ensuring that acceptable clinical practice standards were delivered.
- ❑ What any contemporary audit of risk management practice was revealing more generally about staff commitment to this safety-critical process.

Care planning

The LMHTT report focuses on the care planning of Dr B, the homeless team and Alexander House staff. The report is appropriately complimentary of this.

The LMHTT report also mentions the decision of Ward 1 staff to place the MHSU on 15 minute observations but does not comment on the appropriateness of this. More importantly the report does not comment on whether or not the staff were aware that the MHSU had left the ward on the day of the incident, or for how long he was absent. The fact that he was an informal patient is immaterial to the staff's awareness of where their patients are.

Based upon this Investigation Team's analysis of the records, timed observations at 15 minute was reasonable. Although the MHSU had been assessed at medium risk of harm, the purpose of his admission was to enable observation and assessment to determine what was happening with him. There was nothing in the information communicated to Ward 1 that suggested that he posed an immediate risk to others. Risk of assault however was known to occur when the MHSU was in relapse.

Care Programme Approach

The LMHTT investigation report does not present any analysis of the MHSU's management in relation to compliance with CPA. Because the critical period of care in relation to the incident is 27 July – 1 August 2005 we do not see this as a weakness in the investigation report.

Clinical supervision

There is no comment about clinical supervision in the LMHTT report. In light of the serious lapse in practice on Ward 1 we would have expected the leadership and supervision of staff to have been commented on.

Inter-agency and inter-team communications

The LMHTT report says in section 8.14 (page 18):

“We were told that some staff felt that the admission was “inappropriate” and that *the MHSU* did not require acute ward care. There was a view that Alexander House were unable to cope with *the MHSU*s level of disturbance. There also seemed to be a general view amongst some staff that Alexander House could not cope with patients who showed any signs of disturbance.”

However the report does not provide any additional insights into the working relationship between Alexander House staff and inpatient services at the Becklin Centre. The LMHTT report does however show that the Alexander House staff made clear to the Ward 1 staff their concerns about the MHSU and their discontent at the plan to discharge him the day after admission. The concerns of the Alexander House staff were supported and endorsed by Dr B.

Although not mentioned in the LMHTT report, Dr B also made clear his dissatisfaction to Ward 1. His report to the MHSU’s solicitors in November 2005 says:

“On arrival on the ward at around 17.30 I spoke with his key nurse. I learnt that the Crisis Intervention Home Treatment Team had phoned Ward 1 at 9am asking if the MHSU could possibly be discharged.

I then gave a detailed history of the MHSU and the concerns around him to the key nurse, who was very receptive to this information. She told me that it had been suggested that he was going to be discharged and that indeed the MHSU had been informed that he was going to be discharged sometime in the afternoon. She did say however, that this decision had been changed and that the MHSU was not to be discharged. She said that having heard the history I gave, much as I have given it in this report, that it was important that this information should be taken into account before the MHSU was discharged.

I was quite clear to the key worker that I felt the whole situation was unstable, that this psychotic sleep deprived man merited a longer inpatient assessment and that [by] not giving a full assessment exposed everyone to danger. In the last 24hrs he had been found secreting knives and although he was willing to stay informally he nevertheless had many risk factors that warranted very careful assessment.”

The information provided by Dr B echoes that which was available to the nursing and medical staff on Ward 1 at the point of admission. It therefore further highlights the lack of effective cross team and interagency communications in this case.

Because the interagency communications, and the reported attitudes of Ward 1 staff towards Alexander House, are so significant in this case, the contemporary perspective of LPFT and voluntary agency staff are presented in Section 5.3 (page 28) of this report.

Housing:

Housing was not a particular feature of this case although it is notable that the MHSU was appropriately housed at Alexander House. Indeed the LMHTT report says, in section 7.5 page 13:

“The placement at Alexander House was going well, to the extent that a longer term placement was offered. Owing to a shortage of spaces, before this longer term placement could be taken up, *the MHSU* would have to go for one week to another house (Oakwood Hall) run by Community Links. It is not possible to be certain whether this disruption would have had an effect on his mental health, given that Alexander House probably provided the first settled accommodation of his adult life.”

Support for carers

The issue of carer engagement and support was not relevant to the LMHTT investigation.

Team performance and leadership

This is not commented on in the LMHTT report. It would have added significant value to the LMHTT report if it had presented information pertaining to the clinical leadership (medical and nursing) on Ward 1, and the overall leadership of inpatient adult services at the time.

Service culture

This is not addressed within the LMHTT report. It would have been useful to have had at least a cultural insight to the working relationship between specialist mental health services and third sector agencies in Leeds in 2005.

5.1.5 Are the conclusions of the Trust's investigation report congruent with the facts and are they reasonable for the case investigated?

The LMHTT investigation report says:

“10.6 Given the information available to ward staff; the level of concern expressed by CRHT staff and Alexander House staff; the concern expressed by Dr B. when he visited the ward on the afternoon of the 27th July - with the specific purpose of warning of the risks that *the MHSU* posed - we think it is inconceivable that had the ward staff undertaken their own risk assessment, they would not have restricted *the MHSU's* movements. Had they done so, the attack would not have happened on that day. We therefore conclude that because the risk was so apparent, and so clearly highlighted in documents and through conversations, that the attack was predictable and preventable.

10.7 We do not subscribe to the view that informal patients cannot be restricted from leaving the ward. The most effective way to manage risk is to involve the patient in clear discussions and seek their co-operation in limiting their movements. Provided effective arrangements are in place to control access and exit from the ward, if the patient attempts to leave, nurses have available a six hour holding power, Section 5(4) of the Mental Health Act (1983), to prevent those they think a risk to themselves or others from leaving the ward. This power was introduced to respond to concerns of nurses that they would be open to legal challenge if they attempted to prevent an informal patient leaving the ward.

10.8 The ward staff may have believed that their approach was consistent with advances in patient rights and freedoms. There is no place in modern mental health care for over restrictive approaches, and unnecessary limitations. But in-patient wards aspire to offer expertise in the management of those who cannot be managed elsewhere. In the case of *the MHSU*, the failure of the ward staff to undertake any assessment of the risk *the MHSU* presented constitutes a systemic and professional failure. As it has transpired, the inability of the ward staff in Ward 1 to undertake basic professional care has resulted in permanent facial damage to the victim. Her rights to go about her business unmolested were not served by the actions of the trust staff.”

Comment by the Consequence UK team

Consequence UK broadly agrees with the conclusions of the LMHTT investigation team.

However, there are two elements of the LMHTT conclusion that Consequence UK feels could have been more measured. These are

1. “we think it is inconceivable that had the ward staff undertaken their own risk assessment, they would not have restricted *the MHSU*’s movements. Had they done so, the attack would not have happened on that day.”

and

2. “the failure of the ward staff to undertake any assessment of the risk *the MHSU* presented constitutes a systemic and professional failure. As it has transpired, the inability of the ward staff in Ward 1 to undertake basic professional care has resulted in permanent facial damage to the victim. Her rights to go about her business unmolested were not served by the actions of the trust staff.”

The Investigation Team believes that although an observation level of every 15 minutes was not unreasonable, it does agree with the LMHTT Investigation Team that a more prudent team might have opted for a closer level of observation. Whether or not this would have enabled the staff to have prevented him leaving the ward is questionable. The Becklin Centre operated on an open-door policy at the time and even observations at five minute intervals allows ample opportunity for someone to leave the ward unnoticed, even if restriction of movement had been agreed with the MHSU.

We do however agree with the LMHTT investigation team that the MHSU should have been expected to stay resident on the ward unless accompanied, that is given escorted leave only. Had this occurred, coupled with an enhanced level of observations, then this would have reduced significantly the risk of such an incident occurring. However, we do not believe that one can say with certainty that the incident was preventable because of the ‘open door’ policy at the time.

The Independent Investigation Team accept what the LMHTT report says about the use of section 5(4) of the Mental Health Act 1983 but the LMHTT report does not set out in its discussion section any information that reveals staff understanding of the use of Section 5(4), or their experience of using it to prevent informal patients from leaving an inpatient environment. However, without a doubt it would have been prudent for the use of Section 5(4) MHA to have been a key component of the MHSU’s risk management plan. We reassert however, that in the absence of a closer level of observations the MHSU could still have slipped off the ward unnoticed.

In respect of the LMHTT report’s comments on the serious lapse in practice in relation to risk assessment and risk management between July 2003 and 15 July 2005, the Trust had made available 14 multidisciplinary training workshops in the use of the FACE risk assessment. Of these five workshops were cancelled due to a lack of staff booking on to the workshop programmes. It would seem that there may have been issues that needed to be addressed throughout the directorate.

5.1.6 Did the recommendations made appear to be appropriate based on the findings of the Trust's own investigation? Furthermore, will they, if implemented, reduce the risk of a) the incident occurring in the future and b) the occurrence of care management concerns similar to those identified in this case?

The LMHTT report made one major recommendations to LMHTT. This was:

“That the trust instigates an immediate and comprehensive recovery plan to improve the performance of Ward 1 in the Becklin Centre, ensuring that all clinical and managerial staff are aware of their responsibilities to provide care which is professionally competent, clinically sound, accords with trust policies and procedures and is safe for patients, staff and the public.”

The LMHTT report stated that the recovery plan should include action plans on the following areas:

- “Risk assessment and management.
- Therapeutic engagement with service users.
- Education for clinical teams on the balance between user rights and the trust's responsibilities to provide care which safe guards other users, staff and the public.
- Assessments of users' experiences of care within Ward 1.
- Assessments of carers' views on the performance and responsiveness of Ward 1 staff.
- Assessments of the views of community teams on the performance and responsiveness of Ward 1”.

The Consequence UK Team fully endorses the recommendation made. However the LMHTT investigation team could have reasonably taken its recommendation further and asked for a complete review of the listed issues across the whole of the Adult Services Directorate, including an assessment of the leadership and management of the directorate at the time. It is unusual to have one area that is performing poorly and for there not to be systemic concerns elsewhere in the infrastructure. The numbers of risk assessment training workshops that needed to be cancelled (3 out of 4 in 2005) is indicative of this.

5.1.7 Was there evidence of a systems based approach to the Investigation?

It is an omission in the LMHTT report that there is little exploration of the key systems and processes where the critical care and management concerns were identified. Namely:

- ❑ Admission, assessment and care planning.
- ❑ Nursing observation practice.
- ❑ The open door policy on the Trust's inpatient wards at the time.
- ❑ The lack of credence given to the concerns of the Alexander House staff in spite of their long experience of the MHSU.
- ❑ The lack of effective communication with Trust employed professionals who had an in-depth working knowledge of the MHSU and had supported his admission to hospital.

5.1.8 Where the LMHTT Investigation identified care concerns, how satisfied was the independent Investigation Team with the quality of the analysis of these based on the information documented within the report?

Although the LMHTT investigation report lacks some depth of analysis, it very clearly articulates where the MHSU's care and management fell below acceptable standards and the immediate acts of omission leading to this. One is left in no doubt as to what areas of practice needed to be improved. However, if this incident were to be investigated for the first time today we would expect to see clear evidence of the following having been addressed by the Trust's internal investigation team:

- ❑ The usual process by which new admissions are assessed, including the usage of information provided by community staff and voluntary agencies integral to the care package for the service user.
- ❑ An assessment of the overall quality of risk assessments and risk management plans on the ward involved, and at least one other in-patient ward to provide balance in the data and assessment process.
- ❑ Exploration of the working relationship generally between Alexander House and other third sector agencies working regularly with the specialist mental health service.
- ❑ The level of training and expertise in risk assessment on the inpatient wards.

- The frequency with which service users could leave the in-patient ward unchecked by any member of staff. (This would have required a non-participant observer study over a number of days, on at least two wards.)
- An assessment of how staff conduct their observational responsibilities for service users on timed observations and how this activity is recorded. (This would also require some degree of non-participant observer work targeting service users who were on timed observations).

5.9 Reflection Points for LPFT

Although the investigation commissioned by the LMHTT in 2005/2006 was reasonable, it did not meet the expected standards in relation to root cause analysis at the time. This was largely due to the lack of detail in the terms of reference provided to the LMHTT independent investigation team. The following detail is intended therefore to assist the Trust in delivering high quality serious untoward event investigations in the future, and investigation reports that evidence the quality of the investigations undertaken and that a root cause analysis approach has been applied where appropriate.

The Trust needs to:

- critique its current investigation guidance to staff, (not its adverse incident management guidance), and check to ensure that this is clear and unambiguous, including ideas and suggestions on the different approaches one can take to the investigation process. These include:
 - Traditional style investigation with face to face interviews with staff members.
 - Round-the-table clinical review meetings with an independent¹⁴ facilitator and independent clinical advisor.
 - A blended approach – face-to-face interviews and round-the-table review.

The guidance should also provide staff with an outline of the available investigative techniques that the Trust supports and direct them where to learn more about their application. These include:

- Structured and simple timelining.
- Control/barrier analysis.
- Failure modes and effects analysis.
- Investigative/cognitive interviewing.
- ‘Brain Writing’.
- Affinity mapping and content analysis.

¹⁴ By independent we mean independent to the team and locality involved in the incident.

- Ensure that it has standing terms of reference for serious untoward incident investigations that is applied to all high impact (code red) investigations¹⁵ commissioned by the Trust's executive directors or by the associate medical directors and associate directors for each directorate (see page 53 of this report).

With regards to investigation reports, the National Patient Safety Agency issued guidance for NHS Trusts in 2008. The following simplifies this:

Use of person-identifiable information

As a matter of principle neither the initials of staff members, nor that of the service user, or their family should be used. In this respect the report should be completely anonymous.

Coded terms such as;

- "Consultant Psychiatrist 1 (Cons P1)";
- "Consultant Psychiatrist 2 (Cons P2)";
- "CPN1";
- "CPN2";
- "SHO1";
- "SHO2";
- "The Service User (The SU)",

are much safer, and more appropriate if the focus of the investigation is to learn lessons for improvement rather than to 'name and shame'.

In the Investigation Management file however there does need to be a list that identifies the individuals to whom the codes refer.

Formatting:

The original LMHTT report would have benefited from:

- An executive summary.
- More precise terms of reference. Note: the terms of reference should provide an investigation framework for the appointed investigators (see page 53 appendix 1).
- A more detailed investigation methodology.
- Robust proof reading.
- A structure that ensured that the 'main findings' are stated with clarity and before the full and detailed chronology is presented. The full detail of a service user's history can be placed in an appendix providing that it is clearly signposted within the report. This enables the report to feel less text heavy and brings to the fore the most important information in the report, i.e. the investigation team's findings.
- A clear front facing page and index.

¹⁵ Clearly such terms of reference can be amended if particular investigations require this. Having core terms of reference will support consistency in the standard of investigations undertaken in the Trust.

Investigation report structure

The Investigation Team suggests that at a minimum the following sections need to be included in any investigation report:

- Facing front cover.
- The names and professional status of the investigation team members.
- Acknowledgements.
- Index.
- Executive summary.
- Introduction (why the investigation was commissioned and an outline of the service user's contact with the specialist mental health service, any key issues, the service user's forensic history, and the incident and post incident management).
- Terms of reference.
- Outline methodology (this could go in an appendix).
- Contact with the service user, the service user's family, and the family of the victim.
- Findings of the investigation:
 - Positive feedback – what was managed well.
 - Main care delivery/management concerns (CMCs), and service delivery concerns (SDCs) (each should be clearly articulated.)
 - The most significant contributory factors to the main care delivery/management concerns. This information comes from undertaking a systems focused (root cause analysis) investigation.

Note i: Where the analysis of the care concerns generates a lot of data and repetition of data, placing this information in a signposted appendix is sensible.

Note ii: Sometimes there are no care management or service delivery concerns that relate directly to the case under investigation. In such instances "critical questions" can be used instead of CMCs and SDCs.

- Additional learning opportunities arising from having done the investigation. This section contains the 'added value learning' that should emerge from the investigation process, but which is not directly linked to direct care management concerns identified.
- Conclusion – this should address the terms of reference and/or predictability and preventability of the incident. It should also acknowledge any significant improvements implemented prior to the completion of the investigation.
- Recommendations. These should address the main contributory factors to the main care concerns before all else.
- Appendices:
 - Detailed chronology for the service user.

- Sources of information used to underpin the investigation team's findings and recommendations.
- Detail of the systems analysis of each main care management concern using the NPSA's human factors framework or similar if the data is too voluminous for the main body of the report.
- Glossary.

APPENDIX 2 – CHRONOLOGY OF THE MHSU's CONTACTS WITH MENTAL HEALTH SERVICES

This chronology gives a comprehensive picture of the MHSU's contacts with Mental Health Services between 1999 and July 2005.

History of the MHSU's contact with Mental Health Services

1999 and 2001: The MHSU first had contact with psychiatric services during this three year custodial sentence for car theft and dangerous driving. The MHSU was a passenger in the car and a pedestrian was seriously injured. At this time he was noted to be suffering from anxiety and was prescribed trifluoperazine for a period of three weeks.

March 2002: The MHSU's first psychiatric admission was to High Royds Hospital under Section 2 of the Mental Health Act 1983 (MHA). He displayed clear signs of psychosis immediately prior to this admission. The precipitating event was his self-presentation at Killingbeck Police Station stating there was a warrant out for his arrest. He also hit the female receptionist in the face. On assessment by the duty psychiatrist he said the television had eyes, and that he had been taken over by the Jews and that a microphone was fitted to his body.

7 April 2002: The MHSU's period of detention came to an end and as he was unwilling to remain in hospital he was discharged.

It is notable that during his admission:

- ❑ He punched a nurse without provocation or warning.
- ❑ On 26 March he was noted to be deluded and paranoid and was commenced on olanzapine 5mg once a day. Prior to this he had been prescribed chlorpromazine 50mg twice a day.
- ❑ During this admission the MHSU's parents revealed that prior to going to prison he had been well. It was during his custodial sentence that they noticed his letters becoming increasingly bizarre and meaningless. On his release they found his behaviour to be bizarre including washing his hands in bleach until they bled.
- ❑ The olanzapine did have a positive effect for the MHSU. Over time his mental state did improve.
- ❑ The MHSU was offered anger management training which he declined.
- ❑ The MHSU's diagnosis at this time was "borderline personality disorder and drug-induced psychosis".
- ❑ Following discharge the MHSU did not attend any of his outpatient appointments.

4 July 2003: The MHSU self-presented to the Accident and Emergency department at Leeds General Infirmary. The precipitating cause was a friend's snake biting him two months previously causing his arm to go white and then yellow. He also stated that no oxygen was getting to his

head and that a “black man had been sticking leeches on his body”. He was admitted to the psychiatric in-patient unit (Ward 5, the Newsam Centre). At this admission the MHSU said he had been using £40.00 worth of heroin a day which he had been injecting. He was commenced on zuclopenthixol 4mg twice a day on the same day. Owing to the continued presence of delusional and psychotic symptoms this was increased to three times a day.

21 July 2003: He was eventually discharged from the ward for the continual use of cannabis on the ward.

24 August 2003: The MHSU was readmitted to the Newsam Centre. He had again self-presented to accident and emergency complaining of people putting leeches on him and also the poisoning of his food with the same. Zuclopenthixol 10mg nocte was continued.

29 August 2003: The MHSU was discharged. He did not attend for outpatient follow up on 1 September.

7 December 2003: The MHSU was again assessed in A&E. This time at St James Hospital. He was brought to A&E by the police having exhibited odd behaviour such as ‘dropping his pants’ and talking to himself. Admission was delayed owing to the non-availability of beds. He was however admitted on 9 December to Ward 3 of the Becklin Centre under the care of Consultant Psychiatrist 1.

9 December 2004: At the time of this admission the MHSU’s parents reported that he repeatedly washed his hands, rubbed the floor and spoke to the taps. He also repeatedly went out to touch the lamp post behind their house and stated he had been poisoned by the “Chinese Emperor’s son”.

On admission it was noted that he did exhibit odd behaviour and his fixation with leeches noted on previous admissions continued. He was commenced on risperidone 2mg once a day. This dose was slowly increased. His odd behaviours continued and on 27 December he was placed on Section 2 of the MHA 1983 as he wanted to leave the ward.

29 December 2003: Because of medication non-compliance he was prescribed risperidone in a quick-dissolving form. There was also concern that he was using illicit drugs. Continued concern regarding medication compliance resulted in a prescription of injectable risperidone 25mg.

5 January 2004: The MHSU was noted to have a possible dystonic reaction to chlorpromazine.

16 – 21 January 2004: Following a self harming incident on 14 January the MHSU absconded from the ward on 16 April. He turned up at the Newsam Centre and faxed Ward 3 a letter that gave the

impression of clear thought disorder. He was subsequently assessed at Killingbeck Police Station, he was detained under Section 3 of the MHA 1983 and transferred to Ward 1 psychiatric intensive care unit (PICU) at the Newsam Centre under the care of Consultant 3 on 22 January.

6 March 2004: The MHSU was transferred from PICU back to Ward 3 Becklin Centre.

23 April 2004: The MHSU remained under Section 3 of the MHA until 23 April 2004. At this time his Social Worker from the 'No Fixed Abode' (NFA) team began to look for accommodation for him.

Note: Throughout this admission there was concern regarding the MHSU's use of illicit drugs.

16 September 2004: A FACE risk profile undertaken revealed:

- Low risk of harm to others.
- No risk of suicide.
- Low risk of accidental self harm.
- No risk re. physical health e.g. stroke.
- No risk to children.
- Low risk of severe neglect.
- No risk of vulnerability/exploitation.

15 October 2004: The MHSU was referred to the Continuing Treatment and Recovery Service by Consultant Psychiatrist 1 and his team.

9 November 2004: The MHSU is noted to have taken a possible heroin overdose. He denied this but there was a fresh 'track mark' on his right arm. His respirations were also low at 9 breaths per minute. He was increasingly unresponsive. He was transported to A&E as Ward 3, the Becklin Centre, had no naloxone.

11 November 2004: The MHSU is on the waiting list for a bed at Alexander House. A visit is planned for 22 November. On this same day the Continuing Treatment and Recovery Service advise that it cannot take the MHSU onto its caseload as he had made it very clear that "he did not wish to engage with the rehabilitation process and was reluctant to consider further interventions with *our* service".

19 November 2004: The MHSU was discharged. Admission period stated as 9 December 2003 – 19 November 2004. Diagnosis was stated as "paranoid schizophrenia and opioid dependence".

Medication at discharge was:

- Fluoxetine 20mg once a day.
- Procyclidine 10 mg twice a day.
- Pipothiazine 150mg IM four weekly.
- Flucloxacillin 250mg four times a day to stop on 23 November 2004.

4 December 2004: The MHSU attended at outpatients with his social worker. He was drowsy and difficult to engage in conversation. He stated that his mood was good and that he had no suicidal thoughts or plans to harm himself or others. The MHSU was noted to be satisfied with his accommodation at Bracken Court. His social worker however advised that the MHSU had previously stated his dislike of Bracken Court and alternative accommodation was being pursued.

22 December 2004: The MHSU was reviewed at outpatients. There was no evidence of delusions or abnormal perceptions. He denied using any illicit drugs. His depot medication continued. The plan was to review him in one month's time.

THE YEAR OF THE INCIDENT

26 January 2005: The MHSU did not attend for his outpatient appointment. It appears that he was 'a missing person' at the time.

3 March 2005: The MHSU did not attend for his outpatient appointment with Consultant Psychiatrist 1. He was however being seen regularly by his social worker. Consultant Psychiatrist 2 advised the MHSU's social worker that there seemed little point in sending the MHSU outpatient appointments when he did not attend. However, Consultant 3 made clear in his correspondence that he would keep the MHSU on his caseload and was "happy to see him at any time at all if you want to bring him down. I will leave it to you to try and coax him to attend".

21 April 2005: Consultant Psychiatrist 2 wrote to a member of the Centre of Health for the Homeless. This individual is one of three who were actively engaged in supporting the MHSU. The letter reconfirmed Consultant 3's willingness to provide whatever support he could in the care and management of the MHSU and highlighted the problems that his illicit drug use caused to the maintenance of his mental health. The consultant also highlighted that his depot pipothiazine 150mg four weekly genuinely improved his mental state. The MHSU was noted to be "more sociable, less withdrawn, and less looking as if he was paranoid." Consultant Psychiatrist 2 also notes that the MHSU did not seem to want his drug problem treated at all. Consultant Psychiatrist 2 seemed to support the 'gentle and supportive' approach he was receiving from the homeless team and his social worker.

22 June 2005: The MHSU was assessed in outpatients by the SHO to Consultant 3. The MHSU had moved to Alexander House a few weeks before and had also recently been released from HMP Armley following a custodial sentence for petty theft. Whilst in Armley he received detox from heroin and had been started on buprenorphine. The SHO's letter to the GP notes that the MHSU had stopped his depot and did not want to recommence it. It is also noted that he was at Alexander House for a period of assessment and that he had not used opiates since coming

out of prison but that he has used cocaine once. The MHSU was provided with another outpatient appointment for three weeks time.

7 July 2005: The MHSU attended for his outpatient appointment. He was assessed by Consultant Psychiatrist 2. The consultant notes that the MHSU “looked quite awful”. He also noted that the MHSU “looked free of street drugs”. Consultant Psychiatrist 2 did find the MHSU guarded still, but he was not sure what about. The consultant notes that the MHSU did not admit to any psychotic phenomena but that: “I am not entirely sure he does not harbour some underneath”. The consultant notes that the staff at Alexander House were “very on the ball”. He planned to assess the MHSU again in four weeks when he would reassess his ‘guardedness’. If it had not settled he noted that he ‘would think of prescribing an anti-psychotic again’.

25 July 2005: Consultant Psychiatrist 2 was asked to assess the MHSU at Alexander House. The MHSU’s mental state was unusual for him. He was quite chatty which was not the norm. The history obtained from the Alexander Staff was that the MHSU had had a week of restlessness and caginess. On examination he displayed his usual guardedness. Unusually he was noted to offer to make a cup of tea for everyone. The Consultant noted in his report to Henry Hymans Solicitors, of 15 November 2005, that the MHSU was not overtly suicidal or homicidal – but it was “difficult to gauge exactly what was going on in his head”. At this stage the consultant agreed with the staff at Alexander House that the situation appeared to have deteriorated but not to the point of being intolerable. A decision was made for the MHSU to remain at Alexander House with the staff there receiving support, especially as the MHSU was taking his medication.

26 July 2005: Consultant Psychiatrist 2 received another call from Alexander House as two knives had been found in the MHSU’s bed room. Consultant Psychiatrist 2 asked for urgent assessment by the Crisis Intervention Team, as he felt that admission to hospital would be most appropriate to make the situation safe. Assessment and admission did subsequently occur.

A FACE risk assessment was completed with the following risk status identified:

- Significant risk of harm to others.
- No risk of suicide.
- Low risk of accidental harm to self.
- No risk to children.
- No risk re. physical health.
- Low risk of severe self neglect.
- Low risk of vulnerability/ exploitation.

The risk assessment states: “The MHSU is currently displaying relapse signatures that in the past have come before acts of assault and relapse.” A copy of the FACE assessment was provided to the CRHT.

The preadmission CRHT holistic assessment states: "Due to risk history and presentation an informal admission to Ward 1 Becklin Centre for further assessment and treatment. To be considered for early discharge assessment by CRHT to facilitate discharge back to Alexandra House."

27 July 2005: Admitted to Ward 1 Becklin Centre. The progress notes at 11.50hrs note that the MHSU feels "stressed out" and "sick" but there are no reported ideas of reference from the TV as on previous admissions. The MHSU is also noted to say that he "has a feeling to hurt himself but no plans nor any ideas to harm others". A team member from Alexander House contacted the ward to confirm the MHSU's current medication regime. It is noted that the staff member from Alexander House reports that the MHSU "has presented as increasingly confused, agitated and bizarre in his behaviour over the last four weeks. Obsessively washing hands, touching the road and kissing staff and peers at Alexander House." It is also noted that the staff at Alexander House would not be happy to support discharge back to Alexander House "at this moment".

Following a ward round with Consultant Psychiatrist 4, the nursing records note that this consultant was content to discharge the MHSU back to Alexander House. Alexander House staff were advised of this and it is again noted that they had concerns. The nursing progress notes also record the fact that Alexander House staff advised Ward 1 staff that knives had been found in the MHSU's room.

The progress notes record that Consultant Psychiatrist 2 attended Ward 1 and "fully informed staff of his concerns about the MHSU and that he has known the MHSU for a period of time as his community psychiatrist". As a result of the additional information provided a decision was made to keep the MHSU on ward 1 for a fuller assessment, and for there to be liaison between the CRHT, Consultant 3 and Consultant 4.

27 July 2005 5 – 5.30pm: Between the hours of 5pm and 5.30pm a gentleman meeting the description of the MHSU made an unprovoked attack on a female. She suffered a one inch by two inch neck wound that damaged her facial nerves and required a number of bags of blood to compensate for her blood loss.

The subsequent progress notes between this date and the 20.20hrs on 30 July 2005 show that the staff on Ward 1 were not aware of the MHSU having left the ward on 27 July. His potential involvement in the assault came to light because a member of staff from Ward 3 contacted Ward 1 to advise that the MHSU had confided in one of their service users that he had stabbed someone in the last few days. Ward 3 staff did inform the police and following interview with the informant the MHSU was taken into custody from Ward 1. On police advice the MHSU's room was locked pending further police examination.

APPENDIX 3 - Sources of information used to inform the investigation's findings

The sources of information used to inform the investigation's findings were:

- The MHSU's clinical records¹⁶ and the original investigation report commissioned by LMHTT completed in 2006.
- Telephone conference with the Trust's independent lead investigator.
- Meeting with and telephone conference with LPFT's current lead for client-focused clinical risk assessment.
- A survey of a randomised sample of record keeping across three in-patient wards, three CMHTs and the CRHT.
- A semi-structured survey instrument sent to:
 - in-patient clinical team managers (CTMs) on Wards 1,3, 4 and 5 of the adult inpatient services and the clinical service manager;
 - the CTM and clinical services manager for the CRHT; and
 - the CTMs for CMHTs in central, north-east, east, south, and north-west Leeds.
- A 'round-the-table' meeting with 12 members of staff working in adult inpatient services bands 5-7.
- Verbal and written information and evidence of change provided by LPFT staff.
- A meeting with the MHSU.
- LMHTT policy documents:
 - CMHT operational policy document 2004 – 2005.
 - Admission process for in-patient services (last updated October 2008).
 - Clinical risk management policy and guidance for staff (2007).
- LMHTT CPA policy 2003.
- CMHT operational policy (2004/05).
- Operational policy community sector (2005/06).
- Face-to-face meetings with three third sector agencies.
- Telephone meeting with Volition.
- Inspecting Informing and Improving. The Healthcare Commission Patient Survey Report 2007.
- Psychiatric report prepared by Dr B for the MHSU's solicitors in November 2005.
- Police records of the incident and statements from the victim and MHSU.

¹⁶ Note: Because the principal issues were identified in LMHTT's original investigation report, the Investigation Team did not consider it appropriate to re-interview staff involved in the MHSU's care.

APPENDIX 4 - GLOSSARY

Care Programme Approach (1995 – 30 September 2008)

The Care Programme Approach has four main elements as defined in 'Building Bridges: A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people'. DH (1995) London HMSO.

These are:

- ❑ Assessment: Systematic arrangements for assessing the health and social needs of people accepted by the specialist mental health services;
- ❑ A care plan: The formation of a care plan which addresses the identified health and social care needs;
- ❑ A key worker: The appointment of a key worker (now care co-ordinator) to keep in close touch with the patient and monitor care; and
- ❑ Regular review: Regular review, and if need be, agreed changes to the care plan.

The cornerstones of the CPA

These four principles, of assessment, care plan, care co-ordination and review are the cornerstones of the Care Programme Approach. Implicit in all of them is involvement of the person using the service, and where appropriate, their carer.

Modernising the CPA

In 1999, the Government undertook a review of the CPA which was considered timely for a number of reasons including:

- ❑ the introduction of the National Service Framework for Mental Health, published in September 1999;
- ❑ the lessons learnt through research, reviews and inspections; and
- ❑ the need to listen to professionals' views about the CPA. The review resulted in the publication of 'Effective Care Coordination in Mental Health Services, Modernising the CPA', published in October 1999.

Key changes

This confirmed the Government's commitment to the CPA for working age adults in contact with secondary mental health services and introduced changes to the CPA. The key changes are:

- ❑ Integration of the CPA and care management — the CPA is care management for people of working age in contact with specialist mental health services.

- ❑ Appointment of a lead officer — Each health and social services provider is required to jointly identify a lead officer to work across both agencies.
- ❑ Levels of the CPA — two levels of the CPA must be introduced — Standard and Enhanced.
- ❑ Abolition of the supervision register — from April 2001, supervision registers can be abolished providing the Strategic Health Authority is satisfied that robust CPA arrangements are in place.
- ❑ Change of name — key worker to be referred to as care co-ordinator.
- ❑ Reviews of care plans — the requirement to review care plans six-monthly is removed. Review and evaluation should be ongoing. At each review the date of the next meeting must be set.
- ❑ Audit — regular audit is required looking at qualitative implementation of the CPA.
- ❑ Risk assessment/risk management — risk assessment is an ongoing part of the CPA. Care plans for people on enhanced CPA are required to have a crisis plan and contingency plan.

Standard CPA

Standard CPA is for people who require the support of only one agency. People on standard level will pose no danger to themselves or to others and will not be at high risk if they lose contact with services. The input of the full multidisciplinary community health team will not be required – service users on standard CPA will generally require the support of one or two members of the team.

Enhanced CPA

Enhanced CPA is for people with complex mental health needs who need the input of both health and social services. People on enhanced CPA generally need a range of community care services. This group of people may include those who have more than one clinical condition and also those who are hard to link with services and/or with whom it is difficult to maintain contact. Some people on enhanced CPA are thought to pose a risk if they lose contact with the services. Generally speaking, enhanced CPA tends to apply to people with more severe mental health problems such as schizophrenia or manic depression. In some cases, enhanced CPA can gain you better access to services.

From 1st October 2008, the term CPA will describe the approach used in secondary mental health care to assess, plan, review and co-ordinate the range of treatment, care and support needs for people in contact with secondary mental health services who have complex needs.

From October 2008 the term CPA will no longer apply to individuals in contact with a single professional.

FACE (<http://www.face.eu.com/whatisface.html>)

'FACE' stands for The Functional Analysis of Care Environments and is the product of 17 years development work involving thousands of practitioners. FACE provides a vision of how information collected within a multi-agency care delivery system can be brought together for purposes of assessing individual needs and progress, measuring outcome and ensuring high quality of care.

FACE is an outcomes focused approach to personal information designed to integrate the requirements of:

- ❑ Multi-professional, multi-agency working.
- ❑ Holistic, multi-disciplinary assessment and care planning.
- ❑ Involvement of service users and carers.
- ❑ Care planning.
- ❑ Outcome measurement.
- ❑ Continuous quality improvement.
- ❑ Clinical governance.
- ❑ Evidence-based practice.

Volition

Volition - Leeds is an alliance of voluntary sector organisations that either provide mental health services for or work with people who have mental health needs.

Volition exists to:

- ❑ promote the contribution of the voluntary sector in strategic planning and development of services
- ❑ encourage co-operation and partnership between agencies and across sectors
- ❑ inform and resource voluntary sector organisations to enable them to better meet the mental health needs of the people using their services.

Volition has over 60 members from all areas of the voluntary sector providing services to people in Leeds. Members include agencies that directly provide mental health services as well as those who have an interest in mental health.