



Safeguarding Adults Review and a mental healthcare related homicide independent investigation into the care and treatment of B and A.

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1 Summary

- 1.1 This Safeguarding Adults Review and mental healthcare related homicide independent investigation examines the care and treatment of B and the circumstances surrounding her death in an independent hospital in the north of England on 2 August 2014 and the care and treatment of A by mental health services leading up to the death of B.
- 1.2 Niche Patient Safety Ltd was commissioned by NHS England (North) to carry out this investigation. We would like to thank the families for their invaluable contribution to our investigation.

The incident

- 1.3 A and B were both patients in a psychiatric intensive care unit (PICU) in an independent hospital in the north of England. Both B and A were to be observed every 15 minutes as part of their care plan.¹
- 1.4 At 05.00 on 2 August 2014 the nurse completing 15 minute observations found B to be unresponsive. Paramedics were called and pronounced B dead at 06.20. The nurse in charge stated that the patient B had been checked at 04.45 and appeared to be asleep having been given medication to help her settle earlier on during the night shift.
- 1.5 At approximately 07.00 patient A approached staff stating that she had ‘done something’. She then informed staff that she had killed B. A was arrested by police and transferred to another secure hospital.
- 1.6 The independent investigation follows the NHS England Serious Incident Framework² (March 2015). Under the 2014 Care Act, Safeguarding Adults Boards (SABs) are responsible for Safeguarding Adults Reviews (SAR). A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support where there is concern about how services worked together to safeguard the adult, and where the adult had died, or where the adult experienced serious abuse or neglect.³
- 1.7 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify other areas where changes to practice may be required to improve the quality of the service.
- 1.8 The underlying aim of both the SAR and the independent investigation is to identify common risks and opportunities to improve safety, and make recommendations for organisational and system learning.

¹ A should in fact have been on 30 minute observations, as agreed in the ward round on 30 July, but her care plan had not been updated

² NHS England Serious Incident Framework March 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framework-upd.pdf>

³ Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf

B's mental health history

- 1.9 B was a married woman who had suffered with ill health for much of her married life. She had been known to mental health services in Trust D for many years and spent a considerable amount of time in residential care. On 31 July 2014 B was transferred to a Psychiatric Intensive Care Unit (PICU) at a nearby independent hospital under Section 3 Mental Health Act 1983^{4 5} (MHA). B found it difficult to settle in the PICU. The police analysis of the CCTV footage reports that she was seen wandering the corridors, waving her arms about and being vocally loud. B was found dead following routine checks by the night shift at 05.00 on the morning of 2 August 2014.

A's mental health history

- 1.10 A had limited contact with mental health services. Just before midnight on 20 July 2014 A was detained on Section 136 MHA⁶ by Trust C after the police were called to an incident. A was detained under Section 2 MHA for a period of assessment. It was agreed by the assessment team that due to the nature of the incident and A's unpredictability she required a PICU bed. A was admitted to an independent hospital in the north of England. According to the notes, throughout her time in the PICU A presented no challenging behaviour or violence until B's death.
- 1.11 On the morning of 2 August 2014 A reported to a member of staff that she had killed B. She was arrested on suspicion of murder and was transferred to another secure hospital. A pleaded guilty to manslaughter of B on the grounds of diminished responsibility and was placed on a Section 37 MHA hospital order with a Section 41 MHA restriction order.

Internal Investigation

- 1.12 The provider undertook an 'Initial Review'. The provider's senior management reported that the police prevented them from investigating the incident more fully immediately after the incident due to the ongoing police investigation (see Section 8). The report gives a brief description of the incident as per the serious incident notification form and details of both patient's background and care plans whilst in the care of the provider. The report is dated 19 May 2015.
- 1.13 The report notes that at 04.59 on 2 August 2014 a check was carried out by staff and the room of B was entered and exited. The room was then entered by 2 members of staff who left at 05.08. There is no evidence that any resuscitation was commenced during this time. Staff telephoned the on-call

⁴ Mental Health Act 1983: The provisions of this Act shall have effect with respect to the reception, care and treatment of mentally disordered patients, the management of their property and other related matters. <http://www.legislation.gov.uk/ukpga/1983/20/section/1>

⁵ Section 3 MHA: A patient may be admitted to a hospital and detained there for the period allowed by the provisions of this Act in pursuance of an application. <http://www.legislation.gov.uk/ukpga/1983/20/section/3>

⁶ Section 136 MHA: Powers of police with regard to mentally disordered persons found in public places. <http://www.legislation.gov.uk/ukpga/1983/20/section/136>

doctor and the ambulance service at 05.20, and at 05.27 a member of staff arrived with the 'crash bag'. None of this is documented in B's notes.

- 1.14 Incident analysis does not identify any concerns in relation to any difficulties between B and A. Discrepancies between checks recorded on the observation records and CCTV evidence are noted. The Initial Review records 'checks carried out according to Policy'. The Engagement and Observations Policy CPF 2 05⁷ states that when reviewing service users whilst sleeping

"staff should not assume a service user is sleeping. If staff have not observed the service user moving/breathing etc. they will ensure the individual is alive by: increasing lighting, getting close enough to observe breathing, checking for a pulse, rousing the service user. While the service user is sleeping, a sign of life observation must be made and recorded."

- 1.15 The conclusion of the initial investigation report identifies that at the time of initial review the case was still under police investigation and that staff involved were also under investigation and had been reported to NMC⁸ accordingly. These members of staff were taken through a disciplinary process by senior management. One member of staff was able to resume their post at the conclusion of those procedures. This member of staff was interviewed for this independent investigation, but those reported to the NMC were not interviewed.
- 1.16 There is no explanation for the significant delay in producing the internal investigation report, which is dated May 2015.
- 1.17 There are three recommendations within this initial internal report:
- observation anomalies were identified and the senior management were to consider invoking the disciplinary procedure for the staff concerned;
 - a review of the Immediate Life Support (ILS) training and simulations;
 - a corporate review of Resuscitation policy.
- 1.18 None of these three of these recommendations could be considered to lead to a measurable outcome. It would be possible for the provider to have considered disciplinary policy and reviewed life support training and resuscitation policy without making a single change to practice. Fortunately they have made changes to practice including much greater focus on and practice in intermediate life support following patient collapse. We have seen the action plan for increased training in ILS and improvement of resuscitation, including mock resuscitation drills.
- 1.19 We are aware from information shared during the investigation process that disciplinary and professional conduct processes for not complying with the

⁷ CPF 2 05 Engagement and Observations Policy

⁸ The Nursing and Midwifery Council is the professional regulatory body for nurses and midwives in the UK

Engagement and Observation policy were undertaken whilst the police investigation was in progress.

- 1.20 However, there are areas that we believe the internal review missed.
- 1.21 Not one observation record for A during her entire stay on the PICU complied with policy, and we have made recommendations about this. There was an absence of engagement of A which led to a lack of thorough assessment and risk assessment which was not identified. There are no records of staff attempting to discuss with A how she was feeling, if she was still paranoid, and her thoughts about the incident before admission.
- 1.22 The care given to B after she was found to be unresponsive, including attempts at life support and contacting emergency services, has not been recorded in her notes. This is not addressed by the internal review. We consider that the absence of a comment about the lack of documentation, and no review of the emergency response and resuscitation attempts is a serious omission in a report about the death of an inpatient.

2 Joint independent review

Approach to the review

- 2.1 This independent investigation has studied clinical information, police information, interview transcripts, meeting notes and policies. We have interviewed clinical staff who had been in direct contact with A and B, and also senior managers and clinicians from Trust C, Trust D, CCG F, CCG G and also officers of the local Safeguarding Adults Board. These interviews were conducted in November, December of 2015 and January of 2016.
- 2.2 We made contact with family members of A and B at the start of the investigation, explained the purpose of the investigation and offered to meet with them to share the report prior to publication. We remained in contact throughout the investigation to ensure the family was updated on the progress of the investigation and had an opportunity to ask questions. We were able to meet A to share the report findings.
- 2.3 The draft report was shared with the independent provider, Trust C, Trust D, CCG F, CCG G, local Safeguarding Adults Board Chairperson and NHS England prior to publication.
- 2.4 We have made 20 recommendations to improve practice. The recommendations from our independent investigation focus on the improvements that we consider should be made across the whole system.

3 Overall analysis

- 3.1 Predictability is 'the quality of being regarded as likely to happen, as behaviour or an event'.⁹ An essential characteristic of risk assessments is that

⁹ <http://dictionary.reference.com/browse/predictability>

they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.¹⁰

- 3.2 Apart from records of ward rounds, we were concerned that there is little evidence of any attempt to understand A's mental state or to explore her paranoia and belief system. Instead the notes indicate a heavy reliance on behavioural observation. As A was obviously very quiet and guarded in her demeanour, there should have been much greater efforts made to more fully understand A's thought processes as part of her assessment.
- 3.3 The referral notes faxed to the independent provider from Trust C also note the need for a forensic assessment as part of the overall assessment. There is no evidence that this was ever considered by the team on the PICU, or followed up by the Trust C referring team.
- 3.4 There had been two previous risk incidents in relation to A, both of which appear to have been in response to psychotic phenomenon. The panel believe that the nature and clinical significance of these two incidents was not fully appreciated by the clinical team. Evidence in the Mental Health Tribunal report for A written two days before the incident identified remorse for her actions in the incident prior to admission, but highlighted that the hearing of voices had played a part in her actions.
- 3.5 Based on the absence of any further violence from A since the initial incident, and ten days of appearing to be quite settled and remorseful, the investigation panel do not consider that it was predictable that A would kill another patient.
- 3.6 Prevention¹¹ means to '*stop or hinder something from happening, especially by advance planning or action*' and implies '*anticipatory counteraction*'; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.
- 3.7 Even if the observations had been carried out as required in the policy it is still possible that this would not have prevented the death of B.
- 3.8 The investigation panel believe that the only way that A could have been prevented from killing B was by ensuring a permanent staff presence on the corridor all night.
- 3.9 Nonetheless, we consider that a significant contributory factor was poor compliance with the Engagement and Observation Policy¹² which led to an incomplete assessment of A based on behavioural observations only.

¹⁰ Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry (2000)176: 116-120

¹¹ <http://www.thefreedictionary.com/prevent>

¹² NPSA 7Steps: Representing Contributory Factors: Fishbone Diagrams and other formats. https://report.nrls.nhs.uk/.../Tools_Representing_Contributory_Factors.

- 3.10 B had been admitted due to her manic presentation and it is well documented that this included her being loud and invading other people's personal space. As a result B was managed on 15 minute observations to keep her safe.
- 3.11 The panel believe that there is an inherent risk of having patients with chronic mental illnesses being cared for alongside patients with acute, poorly understood mental illness who have committed serious, often impulsive offences. These risks are compounded when patients are admitted several hundred miles from home, at all hours of the day, and there is the potential for limited information being passed from referrer to provider. We have made a recommendation that NHS England should urgently review the commissioning and use of PICU beds including patient mix.

4 Recommendations

Recommendation 1.

Cygnnet Health Care should ensure that clinical risk assessment and management tools are used consistently and that clinicians have the skills and competency required to use them, to include formal training in their use.

Recommendation 2.

Cygnnet Health Care and Avon & Wiltshire Mental Health Partnership NHS Trust should ensure that where the requirement for forensic assessment as part of the overall assessment process is identified, this should be clearly handed over, acted upon and followed up, or the reasons for not doing so are clearly documented in the clinical notes and formulations.

Recommendation 3.

Cygnnet Health Care should ensure that care plans are routinely audited for appropriateness of content based on a robust assessment and risk assessment. Care plans wherever possible should be co-produced with service users and carers.

Recommendation 4.

Cygnnet Health Care should ensure that any care plans regarding restrictive practice are compliant with the MHA Code of Practice (revised 2015).

Recommendation 5.

Cygnnet Health Care should ensure that all patients in their hospitals have the facility to lock their bedrooms and secure their belongings.

Recommendation 6.

SWYPFT should review its procedures for the transfer of patients to other care settings to ensure that any risks associated with transfer to other providers are mitigated and to ensure the full handover of all needs and risks, including any physical health concerns.

Recommendation 7.

Cygnnet Health Care should ensure that hospitals comply with the policy on routine monitoring of physical healthcare checks for patients on anti-psychotic medication.

Recommendation 8.

Cygnnet Health Care should ensure that where there is evident concern about a patient's mental capacity, any assessment of capacity should be clearly recorded and a care plan developed.

Recommendation 9:

Cygnnet Health Care should identify a suite of safeguarding indicators including the use of supervision that should be reported through their governance system and used by commissioners to monitor quality in safeguarding.

Recommendation 10.

Cygnnet Health Care should ensure that all staff involved fully understand what constitutes a safeguarding event, and that all potential safeguarding incidents are reported and investigated and be monitored routinely by commissioners.

Recommendation 11.

Cygnnet Health Care should ensure the policy on levels of observations is clear and understood by staff, and routinely audit engagement and observation records to ensure full compliance with their policy. This audit performance should be reported to local and corporate clinical governance meetings, and at quality performance meetings with local and national commissioners.

Recommendation 12.

Cygnnet Health Care should review the location and size of their PICU provision and take steps to ensure that it is compliant with national guidance.

Recommendation 13.

Cygnnet Health Care should review the levels of senior clinical cover out of hours to provide more robust support in the assessment and acceptance of referrals, and look to reduce the number of night time admissions.

Recommendation 14.

Cygnnet Health Care should ensure that the new Quality Dashboard fully supports the application of integrated governance by triangulation of a range of reports and quality performance data, to enable the Board to assure itself that the organisation has a grip of quality performance at from local hospital to corporate body.

Recommendation 15.

NHS England should ensure that arrangements and responsibilities for the monitoring of quality performance with independent sector providers as outlined in the Memorandum of Understanding is clear in terms of expected accountability and is understood by all CCGs, including the need for diligence before placement. In this respect, Commissioners should liaise with CQC to gain an understanding of any issues affecting quality of placements before patients are placed in spot purchased beds.

Recommendation 16.

NHS England should ensure that the local oversight and information on the quality performance on all non-specialised commissioned services in the independent provider is routinely shared with commissioning CCGs and placing Trusts. CCGs should use an assurance mechanism for quality performance with the independent sector providers in their respective CCG area.

Recommendation 17.

NHS England should provide assurance to local Safeguarding Adults Boards that the local arrangements for commissioning services in PICUs and specialist and non-specialist Mental Health services ensure safety and adequately manage safeguarding risk.

Recommendation 18.

There is an urgent need for NHS England to review the commissioning of PICU beds, to fully understand the demand and available capacity, pattern of need and referral, and issues affecting quality of care and patient mix, and to work with commissioners and providers to increase local capacity to reduce out of area placements.

Recommendation 19.

Cygnnet Health Care, NHS Bradford Districts CCG and NHS England Specialised Commissioning should ensure that relevant Serious Incident investigation policies adhere to the framework of the Memorandum of Understanding to ensure that in future, in any incident where there is an ongoing police investigation, the health service providers are able to investigate the incident in line with the timescales outlined by the revised NHS Serious Incident framework.

Recommendation 20.

Cygnnet Health Care should ensure that the organisation policy on managing and investigating serious incidents complies with national guidance, and that all completed investigation reports are checked for the robustness and quality of the investigation to ensure that appropriate actions can be implemented and organisational learning take place so as to reduce the likelihood of future harm.