An independent investigation into the circumstances surrounding two separate but related incidents involving Norbury patients on Spring Ward on the night of 1st October 2012

Commissioned by South London and Maudsley NHS Foundation Trust

FINAL REPORT - SUMMARY

10th MAY 2013

1. Introduction

This is the report of an Independent investigation commissioned by South London and Maudsley NHS Foundation Trust, following two separate but related patient incidents on the night of 1st October 2012, involving Norbury patients on Spring Ward.

This report refers to ten patients, whom for the purposes of confidentiality have been anonymised (referred to as patients A to J), as have staff and other individuals referred to in this report.

The Independent investigation was guided by the Terms of reference, agreed in November 2012, the Trust's Incident Policy, September 2011 (including Management and Reporting Processes for Incidents and Near Misses), the Policy for Investigation of Incidents, Complaints and Claims, September 2011, and other relevant policies listed in the appendices to this report.

2. Executive Summary

On the night of the 1st October 2012, two days after Norbury Ward had moved to Spring Ward, two separate but patient-related disturbances occurred on Spring Ward, where Norbury patients had been temporarily relocated as part of a phased programmed of planned ward moves, to facilitate essential health and safety works being carried out in River House (RH).

In the first incident, four patients besieged the nursing station where staff had retreated, causing damage to property, whilst at the same time making threats to kill and rape staff. This necessitated intervention from the RH Rapid Response team, The Bethlem Royal Hospital (BRH) Emergency Team, various on-call managers from the Behavioural and Developmental Psychiatry (BDP) Clinical Academic Group (CAG), an On-Call Executive Director, three divisions of the Metropolitan Police, the London Ambulance Service, and the presence of the London Fire Brigade.

The first incident began at approximately 2200, when one patient, as part of his recurrent delusional state, accused the designated ward-based security nurse on the night shift of stealing designer wear and trainers which he believed his mother had brought to RH for him.

Attempts to deescalate this incident were unsuccessful. Although a decision was taken to offer the patient prn medication, a second patient destabilised the intervention and two other patients subsequently became involved. Staff considered the situation to be unsafe and retreated to the nursing station.

Assistance from the Metropolitan Police was first requested at 2244 and the first police officer from Bromley Police Station arrived promptly at 2247.

The police contend that on arrival they were unable to access key information about the patients involved in the first disturbance which frustrated their ability to risk assess the situation.

[redacted]

[redacted]

In the course of approximately three and a half hours, somewhere in the region of forty police officers were on-site, [redacted] The Territorial Support Group (TSS) – Commissioner's reserve, three police dog units and Trojan (specially trained armed officers).

With the assistance of the Metropolitan Police and the first on-call CAG manager, three of the four patients were, after several hours, placed in supervised confinement (SC) on other wards. The clinical environment was restored at approximately 0230.

In the second incident which occurred at approximately 0250, one patient challenged staff with regard to decisions which had been taken about the management of the four patients involved in the first incident. He accused them of discrimination, believing that there had been a racist motive and that staff had assisted the police to pursue this line of action. He threatened to kill staff and one of the white perpetrators, who he declared had been treated differently to the black perpetrators. This resulted in nursing staff losing control of the ward for a second time when they retreated to the nursing station.

This incident also required intervention from on-call managers and the Metropolitan Police. The clinical environment was finally restored at 0500.

Staff that had been [redacted] [involved in the incident] were emotionally and physically shaken by the first incident, however, they returned to duty following time spent in RH Reception, where they were seen by paramedics from the London Ambulance Service.

One patient sustained injury to his hand during the second incident. No physical injuries were sustained by staff.

The care and treatment of ten patients, five of whom were identified as perpetrators and five who were referred to during examination of events was examined specifically for the month of September 2012, leading up to incident 1 and incident 2 on the night of 1st October 2012. The time frame was extended either side when it was considered to be relevant to do so.

The Independent team found that for all ten patients there was a completed ePJS risk assessment in place that ranged from satisfactory to excellent, completed by a range of disciplines. As at 1 October 2012, the average age of those ten patients' risk assessments was 40 days exactly.

In contrast, it is of note that no 'risk event' entry was made for the night of 1 October for any of the ten patients identified as being involved.

Of the ten patients, seven had HCR20 risk assessments. The three patients that did not have HCR20 risk assessments had been admitted to hospital for less than three months.

The Independent team was very impressed with the scope and depth of the HCR20s and with the risk scenarios. They went well beyond the standard and rather categorical approach.

There was quite a range of ages of HCR20s, with the oldest (on 1 October 2012) being 435 days old. The average age of the seven completed HCR20 risk assessments was 244 days, or eight months and one day.

The Forensic Inpatient Emergency Transfer protocol recommends the inclusion of a current and complete HCR20 at the time of patients transferring between wards. The Independent team found that transfers went ahead more often than not without transfer forms (i.e. clinical summaries) in place. It found also that HCR20s are not updated for this purpose and did not accompany transferring patients.

The Independent team was impressed with the good intention behind the running of the HCR group and the principle that lay behind it - the involvement of the patient in risk management.

Of the clinical notes examined, the Independent team was impressed with the quality of the OT entries in particular, by the thorough and regular CT-grade doctor entries for secluded patients, and by the contribution made to the record by gym instructors.

One of the features that really stood out, however, was the reduced amount of senior medical entries on ePJS and the reliance instead on Ward Round minutes to record clinical changes and decisions that had been made. The Independent team is clear in its finding that during the timeframe when care and treatment was reviewed there were fewer entries made by senior doctors setting out clinical information relevant to treatment than would be expected.

The Mental Health Act Code of Practice states that If the patient is secluded for more than 8 hours consecutively or for 12 hours or over a period of 48 hours, then a multi-disciplinary review should be completed by a senior doctor or suitably qualified approved clinician, and nurses and other professionals who were not involved in the incident which led to the seclusion. In a number of cases there was significant deviation from the Mental Health Act Code of Practice.

Care planning practice was variable. The Independent team was impressed by the OT care plans in particular but found that there was an inconsistent overall picture.

The prescribing practice on Norbury Ward is up-to-date and is evidence-based. However, the Independent team did not find good evidence of mediation changes always being discussed with patients and recorded and that is of note.

The Independent team was impressed with the reliable pattern of consent always being obtained at the three-month point for newly admitted patients as Section 58 of the Mental Health Act requires it to be. However, the situation concerning valid Consent to Treatment procedures for patients who were already in River House but had moved on to Norbury Ward needs attention.

One hugely impressive feature of Norbury Ward is the Family Surgery which the RC operates (and which is a feature of a very busy Monday, alongside the Management Round). The Independent team was very impressed that the Management Round was used as an opportunity to ensure that invitations were made to others to attend this.

While substance misuse groups are available in the central therapies department in RH, in practice Norbury Ward patients have restricted access. However, the ward-based assistant psychologist runs

a substance misuse group. There is no dual diagnosis practitioner as part of the RH establishment. Given the prevalence of substance misuse, support to clinical teams with regard to dual diagnosis and access to substance misuse groups should be reviewed.

As part of the security review a range of policies were reviewed to examine quality, with reference to their contribution to the overall security envelope of River House, and the translation of these policies into practice.

The operational policies for both RH and Norbury Ward offer a clear vision and structure for the service. They are aspirational in nature, realistic and achievable. They are presented clearly and concisely, and provide a logical progression; setting out appropriate objectives for the care and management of patients within a Medium Secure Service. The policies offer a baseline for service audit through which organisational assurance can be tested.

Despite the comments above, there is serious disconnection between excellence in policy and translation of policy into practice and serious concern on the part of the Independent team that assurance testing of agreed polices is not rigorously and consistently applied.

Relational security is poorly understood by some staff. The attitude and behaviour on the part of some of the nursing staff, observed during this Independent investigation is counterproductive to safe clinical practice.

[redacted]

[redacted] The Lock Down policy stipulates that for a major incident the Bronze, Silver and Gold command structure should be established.

[redacted]

Staff entering clinical areas are expected to collect and return [redacted] [communication devices] from RH Reception, although in the case of the Rapid Response [redacted] [communication devices] these are kept on the wards, for which charging units are available. [redacted] [These devices] are tested by reception staff on every occasion prior to allocation.

[redacted]

Some staff told the Independent team that they had little confidence in the [redacted] [communication device] system and that it was not uncommon for there to be systems failure, as opposed to incorrect usage by staff. However, when the Independent team met with the Security Team Leader and Risk Management Portfolio Lead, the Clinical Service Leader – Service Line One, the RH

Customer Services Manager and representatives from [redacted] [communication device] suppliers it became clear that the main problem lay with staff, as opposed to systems failure (soft or hardware).

At interview and during visits to Norbury Ward, there was a surprising number of staff who gave incorrect information, when asked to explain how [redacted] [the communication device] units worked, especially with regard to the means by which they could summon help in an emergency. This is something which has been identified previously in a number of internal investigations, but not addressed sufficiently to secure a high level of compliance and confidence in the system.

There were examples of user failure on the night of 1st October 2012. Some of this may have been the result of human error arising from 'panic- scramble' on the part of individuals. However, even allowing for this as a factor, the evidence presented to the Independent team indicates serious failings across RH as well as Norbury Ward. The root cause appears to be a culture of no confidence in the [redacted] [communication device] system, with ineffective controls assurance.

There is evidence of very good and consistent training for staff on security and particularly the use of [redacted] [communication device].

See Think Act – Your guide to relational security, published by the Department of Health 2010, was used as marker, with specific reference to team functioning, boundary setting, therapy, patient mix, patient Dynamic and physical environment.

The Chair of the Independent Investigation spent most of one day in RH Reception, shadowing different members of the team in the execution of their duties and responsibilities. This demonstrated a high level of policy being delivered in practice.

The Independent team visited Norbury Ward on three occasions and Spring Ward twice. During the first visit to Norbury Ward (a planned visit), the SC rooms, in the opinion of the Independent team, were unfit for clinical purpose. The Trust took immediate steps to decommission the two SC room on Norbury Ward, whilst remedial works took place before the SC rooms were put back into clinical use. In addition, new measures with regard to monitoring the safety of SC rooms were immediately implemented.

[redacted]

[redacted]

The Independent Team understand that the Trust is planning a further review and reprovision of supervised confinement facilities in RH.

[redacted]

Two impromptu visits to Spring Ward were made on 10/12/12 and 28/01/13. The first visit examined the exact location where the incidents on the night of the 1st October 2012 had taken place.

The second visit examined the lay-out [redacted]

[redacted]

[redacted]

The importance of shared understanding and mutual respect between patients and staff is vital in the maintenance of relational security, as advocated in See Think Act.

Some of the evidence associated with this Independent Investigation demonstrates that there are times when control of the shift passes from the nursing team to some of the most challenging patients on Norbury ward [redacted] .

It is important to recognise the impact of change in circumstances which effect how people feel. Although the Independent team found one example of a one-to-one session with one patient with reference to their move from Norbury to Spring Ward, this was not consistently the case across the cohort of patients considered as part of this investigation.

Norbury Ward requires their patient mix to be fully appreciated at all levels in the service and subjected to continual impact and risk assessment. The very nature of Norbury ward means that patient mix is a continual challenge and something which requires robust clinical and managerial leadership to secure, as far as is possible, a clinical environment which is within the competency of staff allocated to work on this ward across all shifts, including nights and at weekends.

There is no documentary evidence to demonstrate that in the period leading up to Norbury patients moving to Spring Ward that patient mix was adequately assessed, either at ward level, Pathways or by the Senior Management Team.

Although there is a weekly Pathways meeting, usually chaired by the Clinical Service Leader - Line One Forensic Services, the record of such meetings is produced in such a way that concerns with regard to patient mix are not identifiable. For this reason, and from what some staff have said about Pathways meetings, the Independent team is concerned that the clinical implications of decision making, both admissions and internal transfers, is not given a consistent level of priority.

See Think Act captures the very essence of why patient dynamics are a critical feature in safe and effective service provision: 'The mix of patients and the dynamic that exists between them has a fundamental effect on our ability to provide safe and effective services – the whole group can be affected by the arrival or departure of just one patient'.

During September 2012, three patients arrived on Norbury Ward, two of whom played a part in the incidents on the night of 1st October 2012, namely: Patient C, who transferred on 07/09/12, and

Patient A, who transferred on 24/09/12; having perpetrated a serious assault on a member of staff. It is also worth noting that Norbury Ward received three other patients during late August 2012, whilst the RC was on annual leave.

There were known dynamics between named patients, for example, between patient B and patient D. However, there is no documentary evidence that patient dynamics were fully assessed in preparation for Norbury patients moving to Spring Ward on 29/09/12.

[redacted]

Very considerable resources were consumed both on the part of the Trust and the emergency services, especially the Metropolitan Police.

Whilst the management on-call arrangements were successfully and appropriately initiated, the on-call arrangements, with regard to the on-call RC were not.

There was significant service disruption from 02/10/12. Norbury Ward, in particular, faced difficulty in covering shifts. This was exacerbated further by other bank staff cancelling shifts.

There was a constellation of factors which, to a greater or lesser extent, played their part in some of the patients gaining control of the ward on two separate but linked occasions on the night of 1st October 2012, namely:

- Patient mix.
- Patient acuity.
- Disengaged staff from the process of management
- Sub-optimal senior clinical involvement in the planning process with reference to Norbury patients moving to Spring Ward, despite there being provision for this.
- Insufficient management oversight.
- Imperceptible clinical leadership.

Linked together, these factors represent systemic failure, which on the night of 1st October 2012, resulted in the destabilisation of the care environment which could have had catastrophic consequences.

Systems and safety culture are the root cause of the majority of incidents and no less so in relation to what took place on the night in question.

There was a departure from risk management protocols in fully assessing the risks of Norbury patients moving to Spring Ward and this too had a direct bearing on the night of the 1st October 2012.

Once the incidents took hold, there was impulsive and deliberate intention to harm on the part of the perpetrators, three of whom (Patients B, C and D), were very unwell. There is no evidence that either incident was premeditated.

The Independent team considered whether substance misuse, at least in the form of cannabis, may have played its part with some of the perpetrators. However, the RC is of the view that the patients did not require cannabis to be disinhibited. Patient B at the time, according to the RC, had been very unwell, but was improving mentally. His significant mood disorder would account for his disinhibition. Moreover, when urine samples from the perpetrators were tested for cannabis they proved to be negative. Nevertheless, Patient B is known to be a dealer. His nursing management plan written by patient B's Primary Nurse to manage his physical aggression and his drug taking/dealing activities dated 11/08/12, does not contain any specific therapeutic intervention, distraction techniques or focused work around drug issues. It does, however, insist that he must not have any access to private calls, other than his solicitor and benefit agency.

The RH management and service culture appears to place less than optimal emphasis on standards of professional practice, practice development, clinical leadership, risk management and impact assessment, which creates anxiety and stress amongst some staff. Some of the nursing staff have adopted 'distancing' as a means of coping.

Seven out of the twelve factors cited in the Contributory Factor Taxonomy (National Patient Safety Agency, Root cause analysis – 2004) feature generally in this investigation, namely: patient factors, individual factors, task factors, communication factors, team and social factors, working condition factors and organisational and management factors.

Recurrent factors, previously identified as areas of concern by internal investigations carried out by the Trust and cited in an Organisation with a Memory (Department of Health, June 2000), are also relevant to this investigation, namely: institutional context, organisational and management factors, work environment, team factors, individual (staff) factors, task factors, patient characteristics.

This Independent investigation raises a number factors highlighted in the Francis Inquiry (Final Report February 2013) with specific reference to:

- A lack of impact assessment.
- Staff disengagement from the process of management.
- Leadership.

The appointment of a new BDP CAG Service Director creates a fresh opportunity for transformational leadership of forensic services. The Independent team suggest there are three priorities:

I. A review of management costs and arrangements, including medical and other professional engagement in the management process, and investment in supporting and developing clinical practice.

II. A forensic service review which examines patient flow through RH, including: case-mix, triage, assessment and the management of patients who require forensic intensive care.

III. Development of an agreed protocol which specifies the core competencies and behaviours necessary for effective clinical leadership and multidisciplinary working at ward level, for which the RC and Team Leader have accountability to deliver.

It is evident that the BDP CAG commits itself to thoughtful initiatives, as can be evidenced in the examples provided by the BDP CAG in section 17 of this Independent report. Furthermore, comprehensive action plans are generated as and when required.

Successful implementation of action plans aimed at securing maxim impact with regard to relational security, pathways, risk reduction, improving patients and staff safety, the physical environment and service delivery in its broadest sense, is crucially dependent on transformational leadership which engages all staff in the process of leadership and management, and in particular a collective medical responsibility from within the forensic service for the service as a whole system.

Arguably, if clinical leadership and managerial oversight at every level had been stronger in the preceding months, this would have reduced the likelihood of occurrence of the incidents which have been subjected to examination by the Independent Team.

3. Recommendations

3.1 The appointment of a new BDP CAG Service Director creates a fresh opportunity for transformational leadership in forensic services. The Independent team suggests there are three priorities:

3.1.1 A review of management costs, culture, and arrangements and of the medical and other professional input into the management and leadership processes. Consideration should be given to the potential for an increased amount of clinical input. To be completed by September 2013.

3.1.2 A forensic service review which examines patient flow through RH, including: case-mix, triage, assessment, recovery, and the management of patients who require forensic intensive care. This should be underpinned by clear and consistent clinical leadership in the decision-making process. To be completed by October 2013.

3.1.3 Development of an agreed protocol which specifies the core competencies and behaviours necessary for effective clinical leadership and multidisciplinary working at ward level for which RCs and Team Leaders have clear leadership accountabilities. To be completed by October 2013 (The NHS Leadership Academy provides a Clinical Leadership Competency Framework).

3.2 Comprehensive relational security competency testing for all current and new employees (including NHSP staff). All employees to be tested by March 2014.

3.3 [Review design of the ward] [redacted]

3.5 Designation of a critical incident room. Immediate action.

3.6 Restrict access to pornographic TV channels. Immediate action.

3.7 Consideration should be given to [communication tools, alarm systems and effective flows of information] [redacted]

3.10 The RC and Team Leader should be informed of riot or hostage taking situations which require police assistance, the on-site presence of an on-call manager and when the Bronze, Silver and Gold command structure is invoked, regardless of whether they are on-call or not. To be done with immediate effect.

3.11 The [redacted] [communication device] Protocol/Guidance dated 31/03/13, due for consideration by the BDP CAG Policy Committee, has the full support of the Independent team. Once approved, compliance should be reviewed within three months and subjected to further review at six monthly intervals.

3.12 Current access to substance misuse services at RH, regardless of which ward patients may be on, should be reviewed to ensure ease of access, when this is considered to be clinically appropriate by the RC. To be completed by October 2013.

3.13 Clinical teams at RH should have ease of access to a dual diagnosis practitioner, to ensure that they receive timely specialist advice, when patients with mental illness have present with substance misuse. To be completed by December 2013.

3.14 The Mental Health Act Office to develop a robust mechanism to ensure that RCs always and without fail maintain adequate Consent to Treatment practice. For immediate action and completion by October 2013.

3.15 There is a need to improve contemporaneous clinical record keeping by senior medical staff in particular. Consideration could be given to the design and implementation of an electronic system to monitor the frequency of multidisciplinary patient contact.

3.16 The practice of supervised confinement reviews by senior doctors requires attention. An audit designed to monitor compliance with the Supervised Confinement Policy should be commenced without delay and the results (and an appropriate action plan) shared with the Care Quality Commission.

3.17 The process for inpatient transfers to forensic services should be reviewed. A clearly agreed protocol for this purpose needs to be agreed and regularly monitored to assure:

20.17.1 Assessment of internally-referred patients by the intended receiving team takes place as a standard operating procedure

20.17.2 HCR20 risk assessments are conducted by the referring team as a standard operating procedure

20.17.3 A transfer form is completed as a standard operating procedure.

The current Forensic Inpatient Emergency Transfer protocol recommends the inclusion of a current and complete HCR20 at the time of patients transferring between wards. The Independent team found that transfers went ahead more often than not without transfer forms (i.e. clinical summaries) in place. It found also that HCR20s are not updated for this purpose and did not accompany transferring patients. For immediate action and completion by July 2013.

3.18 Although the Independent Team has been advised of the 'priority status' enjoyed by Norbury Ward in terms of SpR allocation, the RC for the ward gave a different account. If gaps in the allocation of an SpR (or SpRs) occur, when all reasonable steps have been taken to provide an SpR, an immediate impact assessment should be undertaken and documented by the Co-Clinical Director (Forensic Service), in conjunction with the Norbury Ward RC on each occasion. In addition suitable alternative medical cover arrangements should be put in place, and or reasonable adjustments to the clinical workload, to ameliorate the risks. For immediate action.