



INDEPENDENT INVESTIGATION INTO THE CARE AND TREATMENT OF MS

NOVEMBER 2018

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1 INTRODUCTION:

- 1.1 MS had a history of depression. Following a significant period between 2003 and 2015 during which he had remained well, he was admitted to hospital on 31 January 2015. This episode was characterised as being “manic” at a number of subsequent points in MS’s records. He was discharged on 16 March 2015. A diagnosis of ‘Bipolar Affective Disorder’¹ was made.
- 1.2 On 7 April 2015, members of MS’s family called an ambulance to his home following an incident whereby MS had stabbed himself using a kitchen knife. MS had sustained injuries to his wrist, neck and chest.
- 1.3 Admission to Leeds Teaching Hospitals NHS Trust:
- 1.4 MS was initially taken to Leeds General Hospital but was subsequently transferred to St James’s Hospital in Leeds so that his wounds could be managed more appropriately. Both hospitals are part of Leeds Teaching Hospitals NHS Trust (LTHT).
- 1.5 To ensure that his physical injuries received appropriate treatment, MS remained in St James’s Hospital until 10 April 2015. During this period, he underwent two assessments of his mental health by trainee psychiatrists but did not receive care from nurses trained in mental health.
- 1.6 The transfer to Leeds and York Partnership NHS Foundation Trust and the incident:
- 1.7 On 10 April 2015, a decision was taken to transfer MS from St James’s Hospital in Leeds to Bootham Park hospital in York (part of the Leeds and York Partnership NHS Foundation Trust – ‘LYPFT’) to undergo further mental health assessment and, if indicated, receive care and treatment. MS had previously received care at Bootham Park Hospital.
- 1.8 The ambulance was operated by a company called ERS Medical (any references to “ERS Medical” relate to ERS Medical owned and operated by SRCL Ltd). The arrangements for the ambulance transfer were made between LTHT and ERS Medical.
- 1.9 During his transfer from St James’s Hospital to Bootham Park, MS gained control of the ambulance which had been allocated for his transfer. MS drove the ambulance in bare feet. Video footage confirmed that the ambulance driven by MS passed through a red light. A number of witnesses described the ambulance as being driven erratically in terms of the variation in its speed.
- 1.10 MS drove the ambulance for approximately 15 miles, speeding up and slowing down. The vehicle swerved into the path of a bus, which caused a collision at around 8.30pm. MS died at the scene of the collision. The bus

¹ Bipolar disorder, which in the ICD-10 is classified as Bipolar affective disorder, or manic-depressive illness (MDI), is a common, severe, and persistent mental illness. Bipolar affective disorder is characterized by periods of deep, prolonged, and profound depression that alternate with periods of an excessively elevated or irritable mood known as mania. (<https://emedicine.medscape.com/article/286342-overview>)

driver suffered serious leg injuries. Five other people were also injured.

2 THE IMPACT OF THE DEATH OF MS:

- 2.1 The death of MS lies at the heart of this Independent Investigation. Whilst the purpose of this Report is to ensure that learning is maximised from the events leading up to the death of MS, it is important to highlight that the death of MS has had a far-reaching impact upon his family.
- 2.2 The following statement was given by LS, MS's wife, at the MS Inquest, which provides an insight into the loss which she, his son, and members of their family have suffered:

'MS had been my best friend and husband, my son's father and hero until his illness changed him to the point that I felt it was unsafe for us to stay with him. I had tried to give him the support and help he needed but it was beyond my capabilities, MS needed professionals. I miss the man I married and grieve for him and I grieve for my son who will grow up not knowing his daddy'.

3 AIMS OF THE INVESTIGATION:

- 3.1 Leeds Teaching Hospitals NHS Trust, Leeds and York Partnership NHS Foundation Trust and ERS Medical (SRCL Group Company), (the three organisations involved in the care of MS) undertook investigations in order to unlock any learning which their organisations could take from the care which was provided by them to MS.
- 3.2 The Terms of Reference of this Independent Investigation are set out in Appendix 1.
- 3.3 The main aims of this Independent Investigation are as follows:
- Review the adequacy of each internal investigation into the incident having regard to their terms of reference, the methodology employed, the timeliness of the investigation, liaison with MS's family and the findings, recommendations and action plans produced;
 - Review MS's history and the historic care, support and treatment provided to him from his presentation on 7 April 2015 onwards (including his assessments, care plans, treatment and support with reference to the care provided by each service provider);
 - Review each service provider's arrangements for risk assessment and risk management of MS in effect on 10 April 2015;
 - Review the admission and discharge arrangements for MS, and in particular the discharge from LTHT on 10 April 2015 and the planned admission with LYPFT on 10 April 2015, including the process of booking the MS's transport with ERS Medical (SRCL Group Company) on that date; and,
 - Determine the extent to which this incident was either 'predictable' or 'preventable', providing detailed rationale for the judgement.
- 3.4 The methodology employed by members of the Independent Investigation Team is set out at Appendix 2.
- 3.5 A chronology setting out key dates relating to MS and his care and treatment is set out at Appendix 3.
- 3.6 The identities of the Investigation Team members are set out at Appendix 4.
- 3.7 A Glossary of the Terms and abbreviations used in this Report are set out in Appendix 5.
- 3.8 A detailed analysis of the three Internal Reports has been conducted and is attached at Appendix 6.

4 EXECUTIVE SUMMARY

4.1 Introduction:

4.2 MS was able to gain control of the ambulance being used to transport him between separate NHS services pursuant to his treatment plan on 10 April 2015. Having taken the vehicle mid-transfer, owing to the fact that the keys were left in the ignition of the vehicle by the ambulance personnel. MS left the two ambulance technicians by the side of the road, and then drove approximately 15 miles before colliding with a bus. MS died at the scene of the collision.

4.3 Effectively, the relapse in MS's illness remained largely untreated and unobserved by trained mental health practitioners until 10 April 2015. As a result, MS's safety and the safety of those with whom he had contact was not ensured.

4.4 Had MS been reviewed on each day of his stay in hospital by psychiatrically trained nursing staff, then his mental state and risk could have been more effectively monitored. The information gathered could have been used to better inform the review of MS's mental state performed by Trainee Psychiatrist 2 at the point he was transferred to a psychiatric hospital.

4.5 It is the view of the Independent Investigation Team that the events of 10 April 2015 occurred as a result of several concurrently occurring and overlapping factors, each compounding the others.

4.6 Lack of understanding of the risk which MS presented:

4.7 Key historic risk information contained within MS's paper records was not available to clinicians responsible for MS's care during his admission to hospital between 7 and 10 April 2015. This information was not included in risk assessments prepared in relation to that admission to hospital which were available in an electronic format. It was however contained within a discharge summary which was dictated but not typed prior to MS's death. This information included the fact that MS had previously attempted to gain control of a vehicle when he was ill and was reluctant to attend hospital.

4.8 Transportation used:

4.9 The Independent Investigation Team is of the opinion that the death of MS could have been avoided if MS had been transported in a vehicle which accommodated the risk which he presented.

4.10 This is a conclusion reflected in all three internal reports. In addition, the Coroner at the Inquest into MS's death stated;

'It is clear that the transport and personnel allocated were not appropriate with MS's condition'.

4.11 The Independent Investigation Team considers that transport options were available and could have been provided by ERS Medical (SRCL Group Company) which could have accommodated the level of risk which MS posed, but these were not utilised due to a number of factors set out in this report.

4.12 The Coroner at MS's inquest stated that:

'there had been inadequate and insufficient assessment made of the type of transport in which he (MS) should be conveyed and the personnel that was accompanying him'.

4.13 Organisational understanding of Transport Arrangements:

4.14 The Independent Investigation Team considers that the failure to utilise the correct type of ambulance in MS's transport was further compounded by the fact that the organisations involved in MS's transfer had insufficient grasp of their respective organisations' requirements and operational procedures relevant to the transfer process.

4.15 This concern was also conveyed in the internal investigation reports of all three organisations. The result was that in the lead-up to the allocation of the ambulance service used to transport MS on 10 April 2015, information relevant to the risk which MS posed to himself and others was not properly conveyed, recognised or managed.

4.16 Practical Transfer Arrangements:

4.17 There were two contractual options for transferring patients using ERS Medical's (SRCL Group Company) ambulances. The first was for Patient Transfer Service ambulances ('PTS'). The second option was for secure mental health related transfers.

4.18 Evidence given at MS's inquest confirmed that none of the clinical or nursing team involved in MS's care on 10 April 2015 had any experience of the practicalities of arranging patient transfers. Consequently, they would have struggled to have understood the different options which were available.

4.19 However, nurses from LTHT booked MS's transfer through the PTS option and had selected the 'T1' option (patient requires a tail-lift to get in and out of the vehicle and assistance of one person). However, the mode of transport which was later selected by the LTHT nurses was a 'T2' booking (patient requires a tail-lift to get in and out of the vehicle and assistance of two people). This was appropriate for a 'self-mobilising patient' who required the support of two ambulance care assistants one of whom would drive the vehicle, the other would provide support.

- 4.20 However, there was significant confusion surrounding the booking which was made to transfer MS to hospital. Information relevant to the risk which MS posed with regard to self-harm and absconson identified by Trainee Psychiatrist 2 was not accurately transferred to ERS Medical (SRCL Group Company), despite attempts made by ERS Medical (SRCL Group Company) to clarify the situation. However, it is also clear that some members of ERS Medical's (SRCL Group Company) team were also unclear as to completion of their own processes, once again due to a lack of familiarity. The result was that a transfer took place without key information which ERS Medical (SRCL Group Company) required as a result of its own internal processes being absent.
- 4.21 Lack of leadership in the transfer process:
- 4.22 Whilst one dispatcher from ERS Medical (SRCL Group Company) made 'valiant' attempts to question the mode of transport allocated to MS at an early stage, notwithstanding ERS Medical's (SRCL Group Company) own processes which were not adhered to by ERS Medical's (SRCL Group Company) staff, no one from any of the three organisations involved seemed willing or able to step forward and take overall charge of the transfer.
- 4.23 It is the view of the Independent Investigation Team that a significant factor contributing to the events of 10 April 2015 was a notable lack of any substantive leadership or 'ownership' of overall responsibility for overseeing the transfer of MS.
- 4.24 As a result, the possibility of there being a problem with the transfer itself increased.
- 4.25 Failure to meet MS's mental health care needs:
- 4.26 Throughout the course of MS's interaction with services in the lead-up to the incident, MS's physical healthcare requirements were met. However, whilst his presentation was reviewed on two separate occasions by two trainee psychiatrists, his mental health requirements were largely unaddressed during his admission to hospital. The Independent Investigation Team acknowledges that MS did have two psychiatric assessments within the space of a few days, as a result of which a management plan was drawn up and a mental health bed was sourced.
- 4.27 However, it is the view of the Independent Investigation Team that the problem in this regard was the 'uni-disciplinary nature' of the mental health input; although there were two medical (psychiatric) assessments, there were no psychiatric nursing assessments.
- 4.28 In terms of the service commissioned by the CCG at the time of MS's care, psychiatric nursing provision was confined to a 0.8 WTE (whole time equivalent).
- 4.29 As a result, the mental health nursing needs of MS, a very mentally ill

individual, were left to general nurses who were running a busy surgical ward and had no psychiatric training. Whilst these nurses could have requested input from the Psychiatric Liaison Service during this admission, the nurses would have had to have had the knowledge and skills to recognise the need to do so. Evidence given at MS's inquest was that the acute nurses who were responsible for MS's physical healthcare had no psychiatric training.

- 4.30 The provision of effective mental health care is not a uni-disciplinary activity. The psychiatric assessment documented a severe depressive episode with psychosis, the presence of a serious risk of suicide, and the possibility that MS would act impulsively. The plan developed included an acknowledgement that it was difficult to predict short-term risk, but suggested 15-30-minute observations, and minimising access to items that might be used for self-harm, such as cutlery.
- 4.31 It is the view of the Independent Investigation Team that the concept of staff from the surgical ward being able to seek help from the ALPS team, assumes that nursing staff in the surgical ward had a degree of training and expertise in mental health which would allow them to recognise the clinical significance of any changes in behaviours or presentation and seek help from the ALPS Team accordingly. Without this degree of knowledge, it would be difficult for those nurses to monitor the mental health of a psychotic patient who was at serious risk of suicide and capable of acting impulsively.
- 4.32 A nursing assessment which was carried out refers to MS having 'bipolar'. It is the view of the Independent Investigation Team that the assessment tool used is clearly designed to reflect and identify patients' physical care needs and not their mental health needs.
- 4.33 The Independent Investigation Team considers that regular input from trained mental health nurses whilst on the surgical ward could have contributed to considerably more robust risk assessments of MS's mental state based upon informed clinical observations, allowing for the development of a care plan which could have met both MS's physical and mental health needs. This could also have better informed the decisions made about the risks posed during his in patient stay in the acute hospital and transfer to the psychiatric hospital, and how those risks could be addressed.
- 4.34 Psychiatric nursing input would have worked in conjunction with the psychiatric medical assessment to allow for a more comprehensive assessment of MS's mental health needs, and the development of a nursing care plan (in conjunction with the general nurses) that would have addressed these at the same time as his physical needs were being addressed, reflecting an 'integrated' approach to the care of the patient. However, the evidence given to the Independent Investigation Team during the Independent Investigation was that the ALPS Team did not have the resources to provide this type of support during the time of MS's admission to hospital.
- 4.35 The antipsychotic effects of Olanzapine take some time to be effective, and

a patient's psychotic symptoms would not abate within 2-3 days of starting treatment. In this case, MS's ongoing impulsivity was recognised by Trainee Psychiatrist 1 carrying out the medical assessment; further there is a history of MS acting impulsively when psychotic.

- 4.36 As a result, it is therefore the view of the Independent Investigation Team that a psychiatric nursing assessment should have been completed. This would have enabled a more detailed and regular assessment of MS's mental state (which is beyond the expertise of general nurses) given that MS had been admitted to hospital following a significant uncompleted suicide and whose history demonstrated a significant degree of risk when he was experiencing a relapse. For example, it may have suggested the need for special (continuous) observation.
- 4.37 The risk assessment carried out by Trainee Psychiatrist 2 would have been rendered more comprehensive had it been supported by a psychiatric nursing assessment and a resultant appropriate level of psychiatric nursing care, which could have better informed a more detailed appraisal of the risks at the time of MS's transfer to the psychiatric unit, rather than leaving the decision about mode of transport to be used to nursing staff who had little, if any, psychiatric training. A psychiatric nursing assessment would have allowed for a more comprehensive assessment of MS's mental illness. It would have informed the nursing care plan during the patient's time in the surgical ward. In particular, it would have enabled a more comprehensive assessment of the risks around his transfer from the acute to the psychiatric hospital.
- 4.38 It is clear that the Psychiatrist did not consider it within his role or expertise to advise on the best mode of transport. This decision was left to a discussion between a nurse on the surgical ward (who had no psychiatric training or expertise), and a member of staff from the ambulance service provider (who had no direct knowledge of the patient). A psychiatric nursing assessment would have addressed the risks secondary to MS's mental illness both during his time in the surgical ward, and at the time of his transfer, when he was fully mobile.
- 4.39 Multidisciplinary teams consist of staff from several different professional backgrounds who have different areas of expertise. These teams are able to respond to patients with complex mental health needs who require the help of more than one kind of professional.
- 4.40 The Internal Investigation Report prepared by LYPTF recognised that engagement with a mental health nurse would have been preferable in relation to MS's care.
- 4.41 Psychiatric nurses are an important part of the multidisciplinary team. In addition to their specialist knowledge of the symptomatology of mental health illness, their functions include promoting an open dialogue with patients, support for the patient due to an understanding of the complexities and implications of a psychiatric illness.
- 4.42 However, during the course of the Independent Investigation, the

Independent Investigation Team was advised that the nursing provision commissioned on behalf of the service was confined to a 0.8 WTE. i.e. one nurse for approximately 4 days per week spread across the service. Further LYPFT advised the Independent Investigation, *'even if engagement by a mental health nurse had been possible on say 9 April that engagement would have been limited'*.

- 4.43 It is the view of the Independent Investigation Team that physical health needs should not necessarily take priority over mental health needs. Instead, both should be addressed at the same time, in a parallel, rather than in a sequential fashion.
- 4.44 Guidance for commissioners of liaison mental health services to acute hospitals issued by the Joint Commissioning Panel for Mental Health in February 2013 stated:
- "The mental health needs of a patient in a physical health care setting often remain undiagnosed and therefore untreated. To optimise the physical health care of patients, it is essential that their mental health and wellbeing are addressed at the same time"*.
- 4.45 In MS's case, his physical injuries which resulted from a serious incident of self-harm were described as *'mostly superficial'*. However as one of his chest wounds had punctured a lung causing a pneumothorax, a chest drain was required. MS was transferred to St James Hospital for ongoing care in a thoracic surgery ward. MS's physical injuries did not prevent a psychiatric review taking place on 7 April 2015 by Trainee Psychiatrist 1.
- 4.46 On 7 April 2015, Trainee Psychiatrist 1 prescribed Olanzapine which was an appropriate choice of medication. However, the antipsychotic effects of Olanzapine would not have taken effect within the three days which MS spent in hospital. In addition, the prescription of medication alone does not constitute effective psychiatric care, the plan which was developed on this occasion was effectively to review the patient again when MS was 'medically fit'. It did not provide any advice or support which would allow a nursing plan to be developed which could be implemented by nurses who had psychiatric training, let alone those who had little or no psychiatric nursing experience. In addition, the plan did not address or give consideration to what should be done should MS experience a further crisis on the ward or in the hospital given his known impulsivity and 'high' risk of self-harm.
- 4.47 Notably, MS could have left the hospital at any point in his stay prior to 10 April 2015. His physical injuries, in the opinion of the Independent Investigation Team, were not so extensive as to preclude this. He could have left the hospital when he was taken to x-ray for example. Standard nursing practice in relation to patients with a chest drain in situ is to encourage mobility as mobility facilitates drainage and prevents stiffness of the shoulder joints. Deep breathing exercises and coughing are also encouraged so as to open the airways and increase intrathoracic pressure and promote re-expansion of the lungs.
- 4.48 Mental health care is multidisciplinary, and it is the view of the Independent

Investigation Team that a psychiatric nursing assessment should have taken place and an appropriate level of psychiatric nursing care been initiated at this time in addition to the ongoing physical care which MS was receiving. In this way, MS's health needs both physical and mental would have been more comprehensively addressed. It would have also meant that initial steps to build a rapport with MS were taken in an attempt to secure engagement with future treatment.

- 4.49 The Independent Investigation Team considers that were it not for his physical injuries, sustained as a result of a significant act of self harm on 7 April 2015, it is likely that MS would have been admitted to a psychiatric hospital. The fact that he was not, appears to have resulted in the treatment of his physical injuries, described as 'superficial' taking significant priority over addressing his mental health needs.
- 4.50 The Independent Investigation Team recognises the fact that if a patient is bed-bound for a period of time, then this would have a bearing on how their risk is managed. However, it does not negate their risks. The anti-psychotic effects of Olanzapine would not have taken effect in three days. The Independent Investigation Team notes that, at the time of the transfer request, a T1 journey was initially requested, meaning that MS had been assessed as being able to 'mobilise himself'. This was subsequently amended to a 'T2' option.
- 4.51 The Joint Commissioning Panel for Mental Health points to the importance of integration of mental health and physical health care, and states that a key component of a liaison service is the provision of comprehensive assessment and formulation, including risk assessment; the assessment provided in MS's case was uni-disciplinary, and did not comprehensively address his needs; the shared objective should be to address physical and mental health needs together.
- 4.52 There is clear evidence of impulsive behaviour when MS was ill; this is recognised in Trainee Psychiatrist 2's assessment but was not factored into the transfer plan in practical terms in relation to the time which MS would inevitably have spent between hospital settings. During this period, it would have been difficult to summon immediate assistance from hospital security or the police for example. The transfer time should have been recognised as a period of 'increased risk', especially given the previous incident during which MS grabbed the wheel whilst his wife was driving. The Independent Investigation Team considers that a psychiatric nursing care plan could have recognised this.
- 4.53 MS's care illustrates a divide between mental and physical health care which is a problem throughout the NHS and which requires action at a national level.
- 4.54 Had MS been reviewed each day of his stay in hospital by psychiatrically trained staff, then his mental state and risk could have been more effectively monitored. The information gathered could have been used to better inform the review of MS's mental state performed by Trainee Psychiatrist 2 at the point he was judged to be 'medically fit' for discharge.

- 4.55 Effectively, the relapse in MS's illness remained untreated and unobserved by mental health practitioners until 10 April 2015. As a result, his safety and the safety of those with whom he had contact was not ensured because this risk was not sufficiently recognised.
- 4.56 Transfer arrangements:
- 4.57 The issue of leadership arises in relation to the transfer process.
- 4.58 The nursing staff and clinicians involved in MS's transfer to Bootham Park Hospital lacked any practical knowledge of the modes of transport available to transfer an individual who was mentally ill to hospital. In addition, the Independent Investigation Team was advised during the course of the Investigation that mental health nursing staff working within the Liaison Psychiatry Service would also have lacked this knowledge.
- 4.59 From ERS Medical's (SRCL Group Company) perspective, the transfer process started at LHT. Information about MS was passed by those responsible for his care and treatment in hospital to those who made an electronic booking. There then followed an exchange of telephone conversations with ERS Medical (SRCL Group Company). However, it is also correct that MS's transfer was allowed to take place without ERS Medical (SRCL Group Company) having obtained all of the information required by its own processes.
- 4.60 There was no clarity about which organisation had the 'lead' role and how deficiencies in the processes would or could be addressed. Each organisation placed significant reliance upon the other organisations involved understanding without clarity what its role was.
- 4.61 Examples of this include the choice of vehicle used. ERS Medical (SRCL Group Company) understood what options were available and the contractual arrangements which were in place. However, the nurses booking the transport would not have had this knowledge. In addition, there is evidence that even within the organisations, key aspects of the existing process were not adhered to or were indeed omitted due to poor management decisions. A further example is the differences in opinion expressed throughout the course of the Independent Investigation as to where responsibility for risk assessment lay.

5 RECOMMENDATIONS

- 5.1 The Independent Investigation Team understands that a full review of the Psychiatric Liaison services provided by LYPFT was commissioned and completed in 2016.
- 5.2 The review of the Psychiatric Liaison service was commissioned by the CCG commissioners and, whilst led by LYPFT, was overseen by a multi-agency steering group. The Review has resulted in increased resources being made available to the ALPS service.
- 5.3 The review incorporated all LYPFT services that currently provide a liaison service to LTHT (including Older People's Services and Addiction services) and developed a new, coherent model of liaison provision which addressed a number of gaps and challenges. The planning of this review had happened with commissioners prior to the MS incident – not least, due to an acknowledgement that the commissioned service was not able to meet the significant need and core national standards at that time - and the outcomes were signed off at an Executive level within LYPFT and the CCGs.
- 5.4 The Independent Investigation Team has been informed that, as a result, a new model of care has been developed and a number of key work streams were established, which report jointly to both LYPFT and LTHT. For example, the Independent Investigation Team has been advised that one of these work streams relates specifically to recording of clinical information between the mental health and acute Trust services and is currently piloting the use of mobile technology to ensure clinical documentation is available to both the mental health professionals and the staff within the general hospital wards.
- 5.5 The Independent Investigation Team is of the view that, as a result of the introduction of the new model of care, an audit be undertaken by LYPFT to ensure that the following recommendations have been implemented as part of the review of services undertaken by LYPFT and LTHT in order to ensure that learning from MS's care is embedded.
- 5.6 Recommendation one – LTHT - training:
- 5.7 In accordance with the Recommendations made in Mental Health in General Hospitals: Treat as One (Date of publication: 26th January 2017) all hospital staff who have interaction with patients (including clerical and security staff), should receive training in mental health conditions in general hospitals. Training should be developed and offered across the entire career pathway, from undergraduate, to workplace-based continued professional development.
- 5.8 Recommendation two - LYPFT – Integration of physical and mental healthcare:
- 5.9 Following the care of MS, the Independent Investigation Team understands that a review has been undertaken by LYPFT and LTHT which has

addressed a number of the concerns highlighted in this report. The review has resulted in significant changes to the model of liaison services and has been supported by significant additional income from commissioners.

- 5.10 In order to establish the success of the review conducted by LYPFT referred to in paragraph 5.1 above and to confirm that the recommendations in the NCEPOD report 'Treat as One' report have become embedded in current practice, it is recommended that an audit is conducted by LYPFT.

The audit should seek to establish the nature and extent of multi-disciplinary working involving professionals and clinicians when caring for mental health patients being treated on general wards following the introduction of the new model of working.

As a minimum, the audit should cover the following areas;

- a. The nature of the problem (diagnosis or formulation);
- b. The legal status of the patient and their mental capacity in the event that a decision might need to be made, if relevant;
- c. A clear documentation of the mental health risk assessment – immediate and medium term;
- d. Whether the patient requires any additional risk management e.g. observation level;
- e. A management plan, including medication or therapeutic intervention;
- f. Advice regarding contingencies, e.g. 'if the patient wishes to self-discharge please do the following....'
- g. A clear discharge plan in terms of mental health follow-up;
- h. Mental health involvement in transfer process from acute setting;
- i. Risk assessment relating to discharge process including any transfer arrangements.
- j. Such an audit should seek to establish the involvement of organisations or individuals without specialist knowledge such as transport providers in the MDT process.

Having completed the audit any deficiencies identified should be rectified and the audit repeated to confirm effectiveness thus completing the audit cycle.

- 5.11 Recommendation three – integrating liaison psychiatry services:

- 5.12 In order to overcome the divide between mental and physical healthcare, liaison psychiatry services should be fully integrated into general hospitals. The structure and staffing of the liaison psychiatry service should be based on the clinical demand, both within working hours, and out-of-hours, so that they can participate as part of the multidisciplinary team.

- 5.13 Recommendation four – Information sharing:
- 5.14 A discharge summary dated 15 April 2015 was dictated but not typed until after the death of MS.
- 5.15 LYPFT is required to undertake an audit to establish whether the delay in issuing a comprehensive discharge summary is a Trust wide issue and if so, to formulate a strategy in order to address any issues which are identified.
- 5.16 Recommendation five – consolidating/fully reviewing medical records:
- 5.17 LYPFT is required to adopt a strategic response in relation to its consolidation of patient records, i.e. the migration of the paper and digital notes system into one system. The Independent Investigation Team is of the view that ideally, this should be the unification of records within an electronic system, capable of allowing a care professional at any given stage of treatment to retrieve information relating to the patient and in particular, the status of their risk assessments, at a glance, in order to ensure that they have all requisite and relevant clinical information necessary to make an informed decision on the appropriate next step.
- 5.18 For instance, in relation to the facts of MS's case specifically, a significant issue identified by the Independent Investigation Team related to the fact that key information, of considerable clinical significance to Trainee Psychiatrist 2's decision to discharge MS from LYPFT, was 'lost' in the paper notes and therefore not readily available. A successfully 'consolidated' patient record or comprehensive risk assessment, (preferably electronic) could, in this instance, have provided the relevant clinician with information that could have resulted in a significantly different direction in MS's care, at the time that clinician needed it.
- 5.19 A strategic response at LYPFT Board level is therefore required in order to address the practical difficulties faced by their clinicians when presented with the challenge of accessing a service user's historical records over multiple systems. The loss of information when migrating to electronic service user records is also a risk which must be addressed.
- 5.20 New database packages allow a Care Professional to retrieve from their (consolidated) electronic patient record to show the service users under a team member's care, and the update status of risk assessments for the last 6 months. This does not address the needs of a patient who has had previous admissions over a period of time. Consequently, a protocol should be developed to ensure a review of paper and electronic records held for service users who have experienced a number of episodes of care, such as MS.

6 PREDICTABLE AND/OR PREVENTABLE:

- 6.1 The Terms of Reference of this Independent Investigation require the Independent Investigation Team to consider whether MS's death was 'predictable' and/or 'preventable'.
- 6.2 'Hindsight bias' is a paradigm that promotes the belief that adverse events were more foreseeable and more avoidable than they actually were. Moreover 'errors' in the chain of events can assume greater importance with the knowledge of the outcome. To a retrospective observer, all the lines of inquiry can point to the end result, but those individuals who were involved at the time did not have the benefit of foresight.
- 6.3 In order to ensure that proportionate and meaningful learning is achieved, the Independent Investigation Team has taken into account the notion that knowledge of the outcome can colour ideas of how and why an adverse incident occurred when making its judgements.
- 6.4 MS's death was the subject of an Inquest which was held over four days and which concluded on 22 January 2016. The Coroner heard evidence from a number of witnesses about the fatal collision involving MS. In relation to the verdict, the Coroner stated:
- 'there was insufficient evidence to conclude it was a deliberate act, or equally that it was a tragic accident and therefore the conclusion must remain open.'*
- 6.5 During the course of the Inquest into MS's death the coroner made the following comments:
- 'In order for me to be satisfied so as to reach a conclusion that MS intended to kill himself I must be satisfied beyond a reasonable doubt on the criminal standard of proof.'*
- 6.6 A coroner is required to make specific findings in relation to the following:
- who the deceased was;
 - how, when and where the deceased came by his or her death;
 - the particulars (if any) required to be registered concerning the death.
- 6.7 By contrast the task of an Independent Investigation is to examine events and identify lessons which in its opinion can be drawn from those events.
- 6.8 There is much legal authority upon what is the appropriate standard of proof in civil and criminal proceedings, but this is of limited relevance to an Independent Investigation because of the differences between the public inquiry process and court proceedings (including those applicable in the Coroners Court).
- 6.9 The context of the task which was set for this Independent Investigation is relevant in this respect as the Terms of Reference require the Independent Investigation to identify learning. As a result, the Independent Investigation

Team is not required to apply the test of 'beyond reasonable doubt to the motivation behind MS's actions which led to his attempt to gain control of the ambulance.

6.10 Many Independent Investigations identify failings, missed opportunities, or gaps in the care which was provided to an individual. However, this does not mean that a death could have been either predicted or prevented. The following tests are commonly applied to determine whether a suicide could have been predicted or prevented;

6.11 **Predictability:**

6.12 The Terms of Reference of this Independent Investigation require the Independent Investigation Team to consider whether the 'incident' which resulted in the death of MS, was predictable by the clinicians and professionals involved in MS's care.

6.13 The incident which caused the death of MS:

6.14 MS died as a result of a crash involving an ambulance which he was driving and a bus. In recording the verdict into the death of MS, the Coroner stated:

'there was insufficient evidence to conclude it was a deliberate act, or equally that it was a tragic accident.'

6.15 Notwithstanding this finding, what is clear is that MS was able to gain control of a vehicle in which he was subsequently killed. He was not authorised to drive the vehicle and accordingly may not have been familiar with its type, layout and controls. MS had no shoes on at the time of the collision which in itself would have added an element of difficulty to controlling the vehicle.

6.16 The act of taking control of the ambulance in these circumstances was in the opinion of the Independent Investigation Team a behaviour was risky and involved an element of risk to harm to self and indeed others. MS appears to have taken control of the vehicle in what appears to have been an 'impulsive' act.

6.17 MS had previously exhibited impulsive behaviour during the course of a journey to hospital when he was experiencing a relapse of his illness at a time when he described himself as being reluctant to go to hospital. This incident was referred to in MS's paper medical records, but not any electronic risk assessments, as 'a 'significant risk ...in terms of unpredictably reckless behaviour.

6.18 There is no evidence from MS's words, actions, or behaviour that suggested that he had planned this action. Indeed, for the reasons set out later in this report, it would have been very difficult for MS to have formulated a detailed plan in relation to a number of the 'variables' involved in the fatal crash. In addition, the Independent Investigation Team consider it relevant that in relation to the uncompleted suicide which led to his admission to hospital on this occasion, MS had told clinicians that this event was not planned.

6.19 TEST OF PREDICTIBILITY

6.20 Notwithstanding the above distinction between the standards of proof in criminal proceedings and those applied to an inquiry such as this, the test of predictability which has been applied, with a focus upon the purpose of this Independent Investigation, which is learning, is as follows:

‘Predictability is “the quality of being regarded as likely to happen, as behaviour or an event”. An essential characteristic of risk assessments is that they involve estimating a probability’.

6.21 A number of variables exist in relation to the fatal collision. MS was able to gain control and drive the ambulance, the crew who were in the ambulance left the vehicles keys in the ignition, the bus passing by were not events which could have been controlled or indeed wholly anticipated by MS.

6.22 At each of these junctures, MS was required to react as and when he was faced with a different set of circumstances or indeed ‘opportunities’ and he was required to make a number of decisions on an ad hoc, “impulsive” basis.

Whilst the Independent Investigation Team recognises that when applying the definition of ‘predictability’ to the facts of MS’ case, the means of absconsion and ultimately death, i.e. an accident in an ambulance he had opportunistically commandeered, were not “predictable”, it is nonetheless the opinion of the Panel that the engagement of MS in “high lethality acts of impulsivity” whilst in the throes of a psychotic episode was ‘predictable’.

In this instance, the means chosen to execute that act of impulsivity was the taking of the ambulance and the driving of it in a fashion, whether by default, or design, that resulted in an act of significant self-harm, i.e. the death of MS. Death by stealing and crashing an ambulance was not predictable; serious harm that could have resulted in death as a resultant of impulsive and dangerous behaviour was.

6.23 As a result, the Independent Investigation team has concentrated upon MS and his behaviours in its assessment of whether, given this series of unfortunate events, and MS’s recognised ‘impulsivity’, an incident such as the fatal crash was predictable because it was MS’s behaviours and choices which ‘drove’ the chain of events leading to the collision from a risk assessment perspective.

6.24 UNCOMPLETED SUICIDE: 7 APRIL 2015:

6.25 MS was admitted to hospital as a result of ‘*multiple stab wounds to chest-self inflicted; 8 inch knife*’. He was being transported to a psychiatric hospital when the incident occurred.

6.26 An assessment carried out by Trainee Psychiatrist 1 on 7 April 2015 records that MS’s intention was to kill himself, he had low mood and he couldn’t see a way forward. It records clearly biological signs and symptoms of

depression (decreased appetite, weight loss, loss of pleasure in life (anhedonia), poor concentration and decreased energy levels). It goes on to record that *'even though he denied any self-harm or active suicidal thoughts, he wasn't sure about anything'*.

6.27 The mental state examination conducted by Trainee Psychiatrist 1, records objective evidence of depression (no eye contact, speech low in volume and tone, slouched shoulders, a flat affect.

6.28 No diagnosis is given at that time, but the risk of self-harm and suicide is recorded as 'high'- because of the act of significant self-harm and because MS had stated that he had no regrets about doing it. The assessment indicated high risk.

6.29 Trainee Psychiatrist 1's diagnosis was of a severe mental illness and the assessment was that MS was at high risk of suicide. The response of a prescription of Olanzapine was appropriate, but not adequate in view of the presence of severe mental illness and high risk. A psychiatric nursing assessment could have explored in more detail the symptoms and signs of depression that had been elicited by the Psychiatrist; MS's attitude to the suicide intent (e.g. although he stated that he had no active suicidal thoughts, he had no regrets about the act, and he was not sure about anything); the statement that he couldn't see a way forward.

6.30 ASSESSMENT: 10 APRIL 2015:

6.31 On 10 April 2015, MS was reviewed by Trainee Psychiatrist 2. There are a number of entries made by Trainee Psychiatrist 2 relevant to the issue of predictability as they relate to the issue of risky and unpredictable behaviour.

6.32 Trainee Psychiatrist 2 notes record the following in relation to that uncompleted suicide:

'At the time he stabbed himself he wanted to die. He thinks he had been feeling suicidal for 2-3 days and considering various methods. He had not planned the act however-he had felt agitation and 'panic' building up inside him and 'grabbed whatever was to hand' to hurt himself... Again timings are unclear but he seemed to indicate that after stabbing himself he attempted further harm by lighting a barbeque indoors to inhale the fumes which didn't work'.

6.33 It is further recorded that MS was *'Regretful he didn't die can't find answers to anything'. He denied current plans for suicide' don't know what I want to do – scared to die but can't find answers' He had previously considered overdose but didn't think this (or hanging) would work due to past experience.'.... He has been hearing a voice in the second person telling him to kill himself'.*

6.34 Trainee Psychiatrist 2 also reported:

'Very indecisive, looked distracted. Limited rapport or eye contact. Appeared troubled and depressed – subjectively depressed and hopeless.

At one point paused in responses and spoke of 'knotted sensation' and 'panic' rising in him. Slow, quiet hesitant speech. No formal thought disorder. Repeatedly spoke of pessimism and hopelessness and uncertainty about the options open to him. Regretful he was not dead though denied current active suicidal ideation'.

6.35 During this assessment, a psychotic symptom was elicited- a command hallucination (hearing a voice telling him to kill himself). Command hallucinations are concerning and indicate high risk. The other signs and symptoms of depression are, if anything, more concerning than those elicited during the first assessment by Psychiatric Trainee 1 and Trainee Psychiatrist 2 also elicited a history of impulsive behaviour in the past as well.

6.36 Trainee Psychiatrist 2 described the consultation in the following terms:

'We discussed many things, we discussed the incident where he had attempted to end his life ... We discussed his thoughts and motivations around those actions and he described to me how he had been feeling very low in mood, how he had been hearing a voice telling him to kill himself and how he had been feeling panicky...'

...He denied having suicidal thoughts but he was ambiguous. He would frequently say 'I don't know how I'm feeling'. He indicated he didn't have any suicidal thoughts at the time but he appeared distressed, he appeared tormented when you asked him these questions so it was ambiguous but concerning...

...my conclusions were that he was severely depressed with psychotic symptoms, that he was an extremely unwell distressed man and that he presented certainly out of the hospital context high risks of another unpredictable attempted suicide because of his mental state at that time'.

6.37 It is clear that Trainee Psychiatrist 2 was very concerned about MS and the possibility that he could act impulsively with regard to any implements which came to hand in order to potentially commit an act of self-harm. This concern developed despite MS's denials of suicidal ideation and the ambiguities in his presentation. In his plan with regard to the care of MS which included advice about intermittent observations, Trainee Psychiatrist 2 has specifically highlighted the following *'Be alert to access to potential implements to harm self e.g. cutlery'*.

6.38 Although Trainee Psychiatrist 2 had given some practical advice about minimising access to means of suicide (cutlery and intermittent observations) no precautions or advice about minimising risk during the transfer was given. A psychiatric nursing assessment could have addressed this issue. However, it was identified that MS presented a serious risk of suicide if discharged from hospital and that his risk of self-harm as an inpatient was unpredictable but possibly high (given his impulsivity and previous attempt at hanging in prison).

6.39 Trainee Psychiatrist 2 recorded that constant observation should be

considered on admission to the psychiatric hospital. There is an obvious discrepancy about the observation levels recommended between the two settings without any explanation or rationale recorded in MS' medical records. The concern held by the Independent Investigation Team in this regard is that there is no consideration of the observation levels which were to be applied during the period of the journey and the purpose that the imposition of observations was intended to address.

6.40 TRANSPORTATION PLAN:

- 6.41 The historical data on MS's risk level is relevant insofar as it documents MS's risk of acting impulsively when undergoing a psychotic episode.
- 6.42 The risks documented by Trainee Psychiatrist 2, together with his documented plan (15-30 min observations, control access to means to self-harm) appears, to the Independent Investigation Team, to be at odds with the decision made to book either a T1 or T2 means of transfer between hospitals.
- 6.43 The decision to book this form of transport was made by staff who did not have mental health risk assessment and management training; accepting that they had guidance from Trainee Psychiatrist 2, who, when asked for advice, said that staff involved in the transfer should be aware of the risks.
- 6.44 The key risk which was known about MS was that when ill, he presented a significant risk of acting *impulsively*. Whilst the nursing staff at LTHT and ERS Medical (SRCL Group Company), were satisfied that they had sufficient information upon which to make decisions regarding the mode of transport to address the risks posed by MS, this decision that they had the requisite knowledge was made without the benefit of specialist knowledge of mental health or indeed training in mental health. In addition, these decisions were made without the direct input of Trainee Psychiatrist 2 who was unfamiliar with the processes of the other organisations involved in the practicalities of the transfer process in terms of the type of vehicles which were available to accommodate the needs of individual patients.
- 6.45 Each of the three organisations involved in the transfer process had different roles, and as a result, different expertise. ERS Medical (SRCL Group Company) did not have the clinical knowledge or the key information to enable them to make a safe decision about the best mode of transport in order that MS's risk of impulsive behaviour could be addressed. LYPFT had completed a diagnostic formulation and risk assessment that addressed to some (albeit incomplete) extent the management of MS in LTHT and his anticipated admission to LYPFT, but not the actual process of transfer between the hospitals. LTHT were responsible for booking the transport with ERS Medical (SRCL Group Company) but did not have the mental health training or knowledge to convey accurately the risk posed by MS because of his mental illness. No one person took a leadership role that would have led to an overview of the complete process, ideally as part of an MDT process.

- 6.46 Knowledge of the necessary elements of a safe transfer process was therefore 'held' in 'silos'. Each element was equally as important as the other. LYPFT were aware of MS's clinical presentation, ERS Medical (SRCL Group Company) understood the transport options and LTHT were at the time responsible for the care of MS on the acute ward including observing his presentation. However, the necessary elements did not come together.
- 6.47 The lack of a comprehensive multidisciplinary psychiatric assessment, and management plan, meant that, in the view of the Independent Investigation Team, the risks posed by MS in the transfer process were not addressed in relation to his transfer.
- 6.48 LYPFT have submitted the following representations to the Independent Investigation Team concerning this issue:
- 'LYPFT reject the contention that MS's death was predictable. The report fails to acknowledge that when the circumstances of the events that occurred on the evening of 10 April 2015 were notified to the staff at LYPFT and LTH they were shocked and surprised.*
- ...Put simply, there is insufficient evidence to indicate whether MS intended to kill himself or even harm himself. Essentially the Coroner concluded an open conclusion".*
- 6.49 Notwithstanding that the Independent Investigation Team does not accept this assertion for the reasons set out above, there remains, in the opinion of the Independent Investigation Team, sufficient evidence to indicate the very real potential for an impulsive, potentially fatal action; a "high lethality act of impulsivity".

Comment one

At the point that MS left the hospital by ambulance, the following was known or was a matter of concern for clinicians because of MS's overall clinical presentation, noted in the paragraphs above, including specifically the specific risk of impulsive risky behaviour:

It was identified that MS risk of self-harm as an inpatient was also unpredictable but possibly high (given his impulsivity and previous attempt at hanging in prison).

MS had a history of using several different methods of significant self harm.

Trainee Psychiatrist 2 has specifically highlighted the following 'Be alert to access to potential implements to harm self e.g. cutlery'.

MS had in the past acted impulsively and in a risky manner in a moving car

Command hallucinations instructing him to self-harm

Trainee Psychiatrist 2 identified that MS 'presented certainly out of the hospital context high risks of another unpredictable attempted suicide because of his mental state at that time'.

Observations were recommended in both hospitals because of clinician's concerns about the risk which MS posed.

One of the most effective ways to prevent suicide is to reduce access to high-lethality means of suicide. A significant proportion of suicides are believed to occur through impulsive acts using the first means to hand and without time for reflection.²

By its very nature impulsivity is difficult to predict. However, MS's case, clinicians highlighted this very specific risk which was addressed in in-patient terms but not in relation to MS's transportation to hospital.

The Independent Investigation Team recognises that MS did not discuss any specific plans about suicide with clinicians. However, as noted above clinicians recognised that he presented a high risk of unpredictable risky behaviour because of his mental state at that time. The act of risky behaviour resulting in self-harm was therefore predicted, the method was not. However, the risk that MS might grab something to hand was highlighted in relation to his recent stabbing.

The Inquest into MS's death recognised a lack of evidence regarding planning or intent in respect of the crash which led to MS's death. However, what was not considered at inquest in this respect was the issue of a risk of an impulsive act by MS. This was recognised by clinicians as being both high and indeed predictable.

As a result, the Independent Investigation Team is of the view that the series of decisions which MS took regarding his taking control of and subsequent driving of the ambulance which subsequently crashed were impulsive acts of risky behaviour of the nature which could have been predicted in relation to his illness and presentation at the time.

- 6.50 The Independent Investigation Team has amended the definition of 'predictable' used in relation to Independent Investigations in accordance with the serious incident framework relating to mental health homicides.
- 6.51 Consequently, the 'test' which has been applied is *'the incident was 'predictable' if there was evidence from the individual's words, actions, or behaviour that should have alerted professionals that there was a real risk of significant self-harm, even if this evidence had been un-noticed or misunderstood at the time it occurred'*.
- 6.52 **Preventability**
- 6.53 MS died in an incident involving an ambulance in which he was being transferred to hospital for care and treatment following a significant suicide attempt three days earlier.
- 6.54 MS was able to gain control of the vehicle in which he was being driven. The planned journey to York took the ambulance along the A64 dual carriageway near York.
- 6.55 As the ambulance neared Askham Bryan, MS stood up in the ambulance, stated that he heard voices, then moved forward and grabbed the steering wheel trying to drag the vehicle to the nearside. The ambulance driver managed to maintain sufficient control to bring the vehicle to a stop. The ambulance driver and the ambulance care assistant, who was travelling in the rear of the ambulance, left the ambulance immediately fearing for their own safety, leaving the keys in the ignition. MS immediately took control of the ambulance and drove off.
- 6.56 MS's history of absconsion and self-harm:
- 6.57 MS had a history of incidents of significant and unpredictable self-harm when he was experiencing an episode of ill health. He had attempted suicide on a number of occasions, using a variety of means (largely using implements which were to hand, such as using shoe laces as a ligature, the use of a kitchen knife to stab himself, and the use of a hose to connect to his car).

² Florentine JB and Crane C (2010) Suicide prevention by limiting access to methods: a review of theory and practice. *Social Science & Medicine* 70(10): 1626–1632.
42 Mann JJ, Apter A, Bertolote J et al. (2005) Suicide prevention strategies: a systematic review. *JAMA: The Journal of the American Medical Association* 294(16):2064–2074 Department of Health *Preventing Suicide in England Strategy (DoH 2012)*

6.58 MS also demonstrated a history of absconding when experiencing a manic episode and had, in the past, run towards a road. In addition, he had attempted to gain control of a vehicle which was driving him to hospital during an earlier admission a few weeks previously. This attempt had included an attempt to grab the handbrake while the vehicle was moving. This information was contained within MS's medical records, but the information was not easily accessible to health professionals involved in MS's care on or around 10 April 2015. MS's medical records contain conflicting evidence about how fast the car was being driven at the time.

6.59 Preventing MS's death:

6.60 In order to have prevented MS's death, it would have been necessary to have prevented him having been able to gain control of the ambulance, or to have made alternative transport arrangements in advance that provided a greater degree of safety for all individuals involved in MS's transfer.

6.61 There were two options for transporting MS to Bootham Park Hospital by ambulance; One for Patient Transfer Service ('PTS') ambulances and crew, and the other for 'secure', i.e. mental health related transfers.

6.62 Trainee Psychiatrist 2 was not able to address himself as to the mode of transport necessary. Similarly, the nurses were also unfamiliar with the methods of transporting patients with mental health issues. The Independent Investigation Team notes that Trainee Psychiatrist 2³ was unable to offer any advice or guidance about how MS ought to be transferred. Representations made on behalf of Trainee Psychiatrist 2 state that;

'he spoke to a nurse during the afternoon of 10 March(sic) 2015. During that conversation he told the nurse that he did not know what the different transport options would be (and there is no evidence from anyone that would suggest that at the time, this information would be within the knowledge, experience or understanding of a trainee psychiatrist) but that the choice of transport should take into account the risks of absconsion and possible suicide as detailed in his written note'

'..... Trainee Psychiatrist 2 was not aware that there were ambulances other than the type seen at A&E – large "blue light" ambulances with the patient partitioned in the rear of the vehicle. He was unaware that mental health patients were ever transported in vehicles where he would have access to the driver, and had not come across this before. It therefore never crossed his mind to discuss the specifics of this with the nurse'.

6.63 The ambulance which transported MS was not specially equipped or staffed to manage patients who become violent (or threaten violence) nor those who attempt to assume control of the vehicle through an impulsive act. MS

³ In section 4.18.

had a history of acting impulsively when experiencing a relapse which was recognised by Trainee Psychiatrist 2. Such an option was however available. No contingency plans had been made to manage this situation should it have arisen. As a result, the Independent Investigation Team has concluded that this manner of transport was not appropriate for MS's needs and risk profile.

Conclusion – MS's death was preventable:

A death can be 'prevented' if *'there were actions that healthcare professionals should have taken, which they did not take, that could in all probability have made a difference to the outcome'*.

In the opinion of the Independent Investigation Team, a vehicle should have been sought with a driver and two mental health trained support staff sitting either side of MS which would, in all probability, have made a significant difference to the outcome. This could only have been achieved if the risks which MS presented had been properly recognised with an appropriate management plan being put in place and implemented.

In order for such a vehicle to be assigned to MS, clinicians would have required full access to MS's documented history of serious harm to himself and others when ill as a result of his 'potential for unpredictably reckless behaviour'. That knowledge would then have to be used to inform a travel plan which involved recognising and accommodating those risks.

In this case, Trainee Psychiatrist 2 had completed a diagnostic formulation and risk assessment that addressed to some (albeit incomplete) extent the management of MS in LTHT and his anticipated admission to LYPFT, but not the actual process of transfer between the hospitals.

LTHT were responsible for booking the transport with ERS Medical (SRCL Group Company) but did not have the mental health training or knowledge to convey accurately the risk posed by MS because of his mental illness.

ERS Medical (SRCL Group Company) did not have the clinical knowledge or the key information to enable them to make a safe decision about the best mode of transport.

No one person or organisation took a leadership role that would have led to an overview of the complete process. Had such an action been taken, then the Independent Investigation Team is of the view that MS's death would have been preventable because MS's known potential for 'unpredictably reckless behaviour' would have been accommodated in appropriate transportation.

7 PROFILE OF MS:

7.1 MS was born on 1 June 1974. He was raised by his parents in York and had two siblings.

7.2 MS obtained 2 A-Levels but as it was never his intention to go to University; he regretted staying on at school until the sixth form. MS commenced work upon leaving school. He married his wife in 2008. The couple had one child who was born in 2010. MS worked as a builder and landscaper.

7.3 MS's history of low mood/depression:

7.4 The following table summarises the significant episodes of low mood/depression which MS experienced between 2001 and 2015. As demonstrated by the table, MS was not in contact with Mental Health Services as a result of episodes of self-harm between 2003 and 2015.

Date	Problem	Risk to self	Risk to others
1994	Depressive episode, suicidal ideation.	MS took an overdose of paracetamol. MS was treated by his GP with Fluoxetine. MS was seen by a consultant psychiatrist who confirmed that MS was suffering from a depressive illness. No follow-up care was required.	
19 September 2001	Depressive episode, suicidal ideation.	MS drove to an isolated park, attached pipe to the car exhaust, and left the engine running for 45 minutes. Later that same evening, MS returned home. MS attempted to end his life and that of his partner by turning on an unlit gas fire. MS thought of his next-door neighbour and turned the gas off.	MS did not act on these thoughts.

		MS also admitted to thoughts of killing his partner using a cricket bat. At one point, MS removed a cricket bat from his bag. MS planned to kill himself afterwards by taking an overdose.	
20 September 2001	Thoughts of hopelessness and despair reported. It is reported that MS believed the only way to 'get out of the mess that he believed himself to be in' was to go to prison, and as a result he carried out an unprovoked attack on a work colleague with a hammer.	Following the attack on his colleague, MS travelled to his parents' house, where he cut his wrists and was admitted to hospital.	MS attacked a colleague with a hammer, hitting him over the head several times. MS was initially charged with attempted murder. However, MS was instead convicted of Grievous Bodily Harm.
2001 -2003	Severe depressive illness.	MS attempted hanging using shoe laces whilst in prison. MS was transferred to a medium secure hospital under Section 48/49 of the Mental Health Act 1983. MS remained in the medium secure unit for a period of 8 months prior to returning to custody.	

7.5 In November 2001, a forensic psychiatrist gave the following assessment of MS's personality:

'an anxious type, always a worrier and easily frightened. He tells me he has always felt intimidated by others and frequently felt 'not good enough' and self-conscious in others company. He was keen to tell me that in the past

he has always shied away from violence. This is corroborated by the history from MS's parents and suggests that the index offence is out of character'.

- 7.6 MS responded well to the treatment which he received in the secure unit. MS remained well following his release from prison in 2003.
- 7.7 MS set up his own landscaping and construction business in 2005.
- 7.8 MS's wife reported that MS experienced a number of financial difficulties during the period between 2003 and 2015. This resulted in complex financial arrangements and significant debts (many of which were not known to MS's wife until MS's admission to hospital in 2015). MS had developed a serious problem with gambling in or around 2009. He did not reveal the extent of this problem to his wife. In addition, the couple experienced the death and poor health of their close family members.
- 7.9 However, MS had no subsequent contact with mental health services until January 2015. MS's history indicates the episodic and relapsing/remitting nature of MS's condition, which is characteristic of bipolar affective disorder. In between episodes, MS appears to function well. However, his episodes of relapse, particularly depressive relapse, are severe and are characterised by significant risk to himself and, on one occasion, to others.

8 ORGANISATIONS PROVIDING CARE TO MS:

8.1 Leeds and York Partnership NHS Foundation Trust ('LYPFT'):

8.2 Leeds and York Partnership NHS Foundation Trust provides specialist mental health and learning disability services to the people of Leeds and across the Yorkshire and Humber region.

8.3 Leeds Partnerships NHS Foundation Trust was awarded NHS Foundation Trust status on 1 August 2007. On 1 February 2012 Leeds Partnerships NHS Foundation Trust merged with mental health and learning disability services from NHS North Yorkshire and York becoming Leeds and York Partnership NHS Foundation Trust. The Trust also provides specialist mental health services in York and North Yorkshire commissioned by NHS England.

8.4 On 6 May 2014, LYPFT confirmed that it would provide an Acute Liaison Psychiatry Service in the Emergency Department at York Hospital.

8.5 CQC inspection of Leeds and York Partnership NHS Foundation Trust:

8.6 The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. They routinely inspect health and social care services to make sure they provide people with safe, effective, compassionate, high-quality care. They also encourage care services to improve.

8.7 The CQC carried out a comprehensive inspection of the Leeds and York Partnership NHS Foundation Trust from September to October 2014. Leeds and York Partnership NHS Foundation Trust was given an overall rating of 'requires improvement'. Whilst LYPFT accept the CQC's ratings of "requires improvement", LYPFT have requested that this report reflect their view that this rating applies to the vast majority of NHS Trusts in England. However, inspectors noted that staff at the Leeds and York Partnership NHS Foundation Trust treat service users with 'kindness, dignity and respect'.

8.8 The inspection in 2014 covered services in both Leeds and York. The majority of services in York have now been transferred to Tees, Esk and Wear Valleys NHS Trust, including services ran out of Bootham Park Hospital.

8.9 Leeds Teaching Hospitals NHS Trust ('LTHT'):

8.10 Leeds Teaching Hospitals NHS Trust is one of the largest Trusts in the United Kingdom and serves a population of about 752,000 in Leeds and surrounding areas, treating around 2 million patients a year. In total, the Trust employs around 15,000 staff and provides 1,785 inpatient beds across its hospitals, which include Leeds General Infirmary and St James's University Hospital.

- 8.11 Both Leeds General Infirmary and St James's University Hospital provide medical services.
- 8.12 CQC inspection of Leeds Teaching Hospitals NHS Trust:
- 8.13 The CQC undertook an announced inspection of the Trust in March 2014. It also inspected Leeds General Infirmary and St James's University Hospital unannounced on 30 March 2014.
- 8.14 The CQC noted that care was provided in line with national best practice guidelines and the Trust performed well in comparison to other hospitals providing the same type of treatment. However, the Trust was given an overall rating of *"requires improvement"*.
- 8.15 However, the CQC noted that *"Not all staff had completed their mandatory training"*.
- 8.16 **ERS Medical (SRCL Group Company):**
- 8.17 ERS Medical (SRCL Group Company) provides a range of specialist patient transport and courier services to the NHS and the wider healthcare sector. ERS Medical (SRCL Group Company) is a trading name of SRCL Limited.
- 8.18 ERS Medical (SRCL Group Company) is registered with and regulated by the CQC in the provision of private ambulance services. It is also licenced by Monitor.
- 8.19 ERS Medical (SRCL Group Company) is specifically contracted to provide ambulance services for NHS Trusts routinely serving approximately 30 hospitals in England. In addition, ERS Medical (SRCL Group Company) provides *ad hoc* ambulance services more widely. In a typical year, the company will carry out around 1.2 million ambulance journeys.
- 8.20 ERS Medical (SRCL Group Company) is contracted to provide Patient Transfer Service ambulance services to LTHT. That contract runs from 9 July 2014 for a period of 3 years.
- 8.21 In addition, ERS Medical (SRCL Group Company) is contracted in areas of the North of England to provide ambulances and crews specifically to support those with mental health needs. These services are called on an *ad hoc* basis according to a framework agreement, one for Patient Transfer Service ('PTS') ambulances and crew, and the other for, 'secure' i.e. mental health related transfers.
- 8.22 The CQC has not published any inspections of ERS Medical (SRCL Group Company).

9 ADMISSION TO YORK HOSPITAL: 31 JANUARY 2015:

- 9.1 MS presented in an increasingly bizarre and erratic fashion during the course of January 2015. He was also noted to act impulsively.
- 9.2 MS's first known attempt to obtain control of a moving vehicle:
- 9.3 On 31 January 2015, MS's wife had become very worried about her husband. She reported that he was '*becoming manic and losing touch with reality, MS was pale, his pupils were dilated and I (sic) had to dress him, he was confused and unable to function*'. She telephoned NHS 111 and was advised to take MS to the Out of Hours Unit which is based in the A&E Department at York Hospital, which is part of York Teaching Hospitals NHS Foundation Trust.
- 9.4 MS's wife drove herself, MS and their young son to the A&E Department at York Hospital. The conditions at the time were snowy. During the course of this journey, MS grabbed the steering wheel and the handbrake of the car at the same time. This caused the car to veer off the road, travel up the kerb and onto the pavement. There are conflicting accounts in MS's medical records as to what speed the car was travelling at the time. MS's son was very distressed by this experience. He was crying and shouting and was asking his father to stop.
- 9.5 MS's running towards a road upon arrival at York Hospital:
- 9.6 When MS arrived at the hospital, he ran towards the road outside the hospital. MS's wife went into the hospital with her son. A GP who worked in the Out of Hours Unit managed to call MS on his mobile and he agreed to meet them at the hospital entrance. He was then shown to a cubicle.
- 9.7 On arrival in A&E he behaved in a very agitated and disturbed manner, repeatedly shouting bizarre statements and refusing to accept medication.
- 9.8 The intervening s136 assessment:
- 9.9 The account provided to the Independent Investigation Team by MS's wife was that two security officers were then called. MS was very confused; he left the cubicle and started to crawl along the floor. MS was placed in a wheelchair which the security staff then pushed to the entrance of the hospital. At the entrance of the hospital, they were met by a Police Officer who invoked his powers under section 136 of the Mental Health Act 1983 to detain MS.
- 9.10 There are occasions when the Police may act if they believe that someone is suffering from a mental illness and is in need of immediate treatment or care. Their powers for such occasions are set out in Section 136 of the Mental Health Act 1983. This gives the Police the authority to take a person from a public place to a 'Place of Safety', either for their own protection or for the protection of others, so that their immediate needs can be properly

assessed.

- 9.11 MS was subsequently taken by the Police to the Cotford Centre at Bootham Park Hospital, York which is a Health-Based 'Place of Safety' (Section 136 suite) which cares for those service users who are detained by the Police under Section 136 of the Mental Health Act. A section 136 referral was made at 11.45 and an assessment was carried out by a Consultant psychiatrist at 16.30.
- 9.12 Upon arrival at the 136 Suite in Bootham Park Hospital, MS was considered to be *'elated, unpredictable and labile in mood, with clear evidence of hypomania'*. It was established at a very early stage that MS had undergone a forensic assessment following an attack on a colleague with a hammer in 2002. It is recorded that MS stated he had no thoughts of harming himself at that time (although it is noted that he had a slightly threatening manner), but he was not violent.
- 9.13 As part of the recommendations and comments made upon admission, it was noted that Torquay Services would be contacted to establish MS's history with them. MS's parents had lived in Torquay and it was thought that MS had travelled to Torquay following his release from prison in or around 2002/3. This is an element of good practice. MS had not had contact with mental health services since this time. However, MS's records do not contain any indication of whether any action was taken with regard to this instruction, nor whether any information was obtained from services in Torquay or indeed any confirmation that MS received care there.
- 9.14 The section 136 assessment which was carried out highlighted the 'significant risk of unpredictable behaviour and assault' which MS presented at this time. The plan following the section 136 assessment was for admission in accordance with Section 2 of the Mental Health Act 1983.
- 9.15 The resulting Section 2 Mental Health Act (1983) admission:
- 9.16 MS was subsequently admitted to an acute ward in Cross Lane Hospital Scarborough due to a lack of beds being available locally.
- 9.17 Section 2 of the Mental Health Act 1983 allows people to be detained in hospital primarily in order to have their mental condition assessed or indeed assessed followed by treatment.
- 9.18 The criteria for detention in accordance with Section 2 of the Mental Health Act 1983 is that the person is *'potentially suffering from a mental disorder of a nature or degree which warrants their detention in hospital and that it is in the interests of the person's own health, their safety or for the protection of other people'*.
- 9.19 The information surrounding MS's detention on this occasion is limited. There is a handwritten record within MS's notes which outlines the fact that MS was brought by Police under section 136 of the Mental Health Act for

assessment on the 30 January 2015. MS is recorded as seen at 16:30 the same day. The conclusion was that MS had hypomania, and a significant history of violence associated with mental illness in the past, and a recommendation for Section 2 of the MHA was accordingly made.

- 9.20 It is unclear from the medical records which have been provided to the Independent Investigation Team, and indeed which would have been available to those caring for MS at the time, the process through which a bed was found for MS in Cross Lane Hospital, and how MS's transfer to that hospital was undertaken.

Comment two:

An issue which is not recorded in MS's mental health assessment that was conducted at this time is the details of the incident which occurred during MS's journey to hospital on the morning of 31 January 2015.

It is recorded that MS's wife was concerned about her safety and that of MS's son who was present in the car and who was very upset by his father's actions. However, MS's attempts to grab the steering wheel have been omitted.

This incident had clinical relevance being subsequently described in MS's notes as being a significant risk in terms of '*unpredictably reckless behaviour*'.

10 ADMISSION TO BOOTHAM PARK HOSPITAL: 10 FEBRUARY 2015 UNTIL 16 MARCH 2015:

- 10.1 MS was re-admitted to Bootham Park Hospital on 10 February 2015 when a bed became available for him.
- 10.2 Upon re-admission to Bootham Park Hospital, MS was initially noted to be elated and overly talkative. He was pre-occupied with his gambling ideas and it was noted to be difficult to divert him onto other topics.
- 10.3 MS's detention in a secure forensic unit following an attack in 2001:
- 10.4 MS had been placed in a secure forensic unit following an unprovoked attack on a colleague in 2001.
- 10.5 MS had spent approximately eight months in the Centre under the terms of a 'hospital' order in accordance with sections 48/49 of the Mental Health Act 1983. Whilst information was known about the circumstances surrounding his admission, little information was available concerning his progress in the Unit and what his presentation was like when he moved from crisis to recovery.
- 10.6 Potentially, this could have had a significant impact upon assessing MS and understanding whether MS's problems, and the risks he presented, were more than those related to bipolar affective disorder.
- 10.7 The relevance to MS's admission to Bootham Park on 10 February 2015:
- 10.8 By the time MS had transferred to Bootham Park Hospital on 10 February 2015, he was no longer elated or exhibiting any psychotic symptoms. MS appealed against his detention and the Section 2 was lifted by a Mental Health Review Tribunal on 23 February 2015 following which he remained in the hospital as an informal patient. During this period of time he was given unlimited unescorted leave and essentially was using the hospital as a place to sleep and eat and during the day was free to work or undertake such activities as he chose to. There were no recorded episodes of attempted self-harm, attempted suicide or harm to others referred to in his medical records during this period.
- 10.9 Whilst MS was felt to have limited insight into his illness and into the risks associated with the recent acute episode, he was compliant with medication. This suggests that the risk which MS posed reduced with active treatment. Notwithstanding this, the Independent Investigation Team is of the view that the risk posed by MS when in acute relapse was high. The Independent Investigation Team recognise that MS was low risk when in remission but high risk when in relapse. MS was in relapse when he presented in April 2015.
- 10.10 At an early stage in his re admission to hospital, MS received notification of his wife's intention to obtain a 'non-molestation order' preventing him

contacting his wife and child. As part of the documentation supporting the legal proceedings brought by MS's wife was an affidavit. A copy of this document was placed in MS's paper records and was reviewed by his clinicians. MS's records state in relation to the affidavit that;

'it gives an excellent collateral history which very much gives a picture of a man who has become unwell with mania and psychosis. Wife's worries are very understandable – significant history of violence years ago when unwell. Significant risk recently in terms of unpredictably reckless behaviour when his wife was driving'.

10.11 As stated above at paragraph 6.15, the historical 'risk' data reflected the impulsivity and risks presented by MS when he was suffering from a relapse of his mental illness. This data was therefore relevant when assessing the risks posed during relapse. The data also pointed to the fact that MS appeared to recover well in between episodes. MS's history indicates the episodic and relapsing/remitting nature of MS's condition, which is characteristic of bipolar affective disorder.

10.12 LYPFT has provided the following statement of opinion in this regard:

'whilst LYPFT acknowledge the relevance of the historical "risk" data, equally one has to have regard for the overall history. This demonstrated an absence of mental health illness since 2003 until January 2015. As such whilst this is of relevance caution would have to be exercised when assessing the degree of reliance one should place upon historical risk data'.

10.13 The Independent Investigation Team is of the view that this statement of opinion fails to recognise that MS's history indicates the episodic and relapsing/remitting nature of MS's condition, which is characteristic of bipolar affective disorder.

10.14 During his admission to Bootham Park, clinicians met with MS's wife and other members of MS's family including his brother. This is a further example of good practice.

10.15 The Independent Investigation Team's concerns about the format of MS's records:

10.16 A concern which the Independent Investigation Team has about the substantial body of clinically relevant information which was gathered about MS was that a significant amount of it is contained within the handwritten section of the records. Some information has been summarised and can be found in the electronic records. LYPFT has submitted that this is not an unusual experience within the NHS albeit that over time there is a move towards electronic records.

10.17 In addition, meetings held whilst MS was at Bootham Park Hospital in the period between 10 and 16 March 2015 involved representatives from the local Community Mental Health Team which would have afforded those staff

members an opportunity to acquire some knowledge of MS's history not contained within his electronic records.

10.18 LYPFT has made the following submission upon this point:

'(this) demonstrates that the Community Mental Health Team, i.e. the organisation that is more likely to have had contact with MS in the event of any incidents following his discharge from hospital on 16 March 2015 had knowledge of events. This demonstrates good practice'.

10.19 However, a significant amount of information, including the information contained within the affidavit of MS's wife and which is relevant to the assessment of risk, would not have been easily 'available' to individuals subsequently accessing MS's electronic records, such as Trainee Psychiatrist 1 or 2 who saw MS in a crisis situation on an acute ward, or indeed other 'crisis' services, such as psychiatric liaison teams even within the same Trust including potentially, the Acute Liaison Psychiatry service operated by LYPFT in York Hospital A&E Department.

10.20 The failing of the electronic records in relation to the incident in which MS attempted to obtain control of a moving vehicle:

10.21 A significant amount of time appears to have been spent by clinicians exploring the incident during which MS tried to take control of the car from MS's wife as she drove to the hospital on 31 January 2015. This is recorded at length in the handwritten records as the incident was discussed in a number of multidisciplinary team meetings and at other points during MS's admission. However, this information which was clearly and appropriately the subject of detailed consideration by those caring for MS during his admission to Bootham Park Hospital is not fully included in MS's risk assessments to which other services provided by LYPFT involved in MS's care would have had access, such as the Trainee Psychiatrists, his local Community Mental Health Team and psychiatric liaison services in St James Hospital and Leeds General Infirmary because they were in not contained in a comprehensive risk assessment which was available electronically.

10.22 This is a concern because the historical information clearly indicated the high degree of risk as a result of impulsivity presented by MS when experiencing a relapse. Had a systematic review taken place which pulled together all of the information in MS's paper records and placed it in a comprehensive risk assessment such as a SAMP Risk assessment which was available electronically, then that information would have had a greater chance of coming to the attention of those who saw MS in the future should he experience a relapse of his illness.

10.23 The absence of 'risk' information from the risk assessments:

10.24 In addition, this information, which is clearly relevant to the issue of 'risk', was not included in any of the Risk Assessments which were provided to the Independent Investigation Team. In particular, a SAMP Risk assessment which was conducted on 16 March 2015 (the day that MS left hospital) states:

'KNOWN SIGNIFICANT RISK HISTORY Give dates and context where known.

Include: 1) a summary of the risk type events (type and number) 2) the most serious event(s) 3) the most recent

10.02.15 MS received papers detailing wife instigating a non-molestation order against him as she feels he poses a current threat. No history of harm to wife or son reported'.

10.25 In relation to details relating to 'Harm to children' it is stated:

'No current or historical thoughts/plans/intent of harm to children.

'LS is concerned about risksbecause of recent manic state and risks from past when unwell'.

10.26 The deficiencies of the PARIS system used by LYPFT:

10.27 The PARIS electronic records system used by LYPFT and a number of other NHS Trusts does not have a facility which allows users to 'scan in' clinically relevant documents. Consequently, if information from 'paper' documents is to be entered into the electronic system, it must be done manually. This has significant resource implications for individual Trusts such as LYPFT.

10.28 The relevance of this to MS's case:

10.29 Evidence given to the Independent Investigation Team by Trainee Psychiatrist 2 stated;

'Trainee Psychiatrist 2 had spent approximately 45 minutes before seeing MS, reviewing the detailed paperwork involved in his case and despite that 45 minutes, had not come across any reference to the "steering wheel incident" a few weeks earlier.'

10.30 In addition, evidence submitted on behalf of Trainee Psychiatrist 2 stated;

'It is not in the section labelled "in patient admission" dated 12 February 2015 giving information about his in patient admission'.

'It was not in the "crucial information" section of the PARIS notes, used to alert staff to significant risks'.

10.31 The issue of access to information contained within patient records is a significant problem across the NHS. However, the failure to ensure that this information was available for 'future' clinicians was not symptomatic of the difficulties in migrating information to an electronic records system, but rather a failure to incorporate key information into a comprehensive risk assessment.

Comment Three - The capture of information relating to risk:

A key predictor of patient risk is knowledge of their previous history. Accurate patient records are crucial to deliver an appropriate standard of patient care and facilitate assessment of risk. The SAMP Risk assessment dated 16 March 2015 is inaccurate and incomplete in relation to the risk which MS posed to others when ill.

The deficiencies in MS's SAMP risk assessment:

In particular, the SAMP Risk assessment states that 'No history of harm to wife or son reported'. As is recorded at paragraph 7.4, MS had previously reported thoughts of harming his wife with a cricket bat, and there had been a recent incident described by those responsible for MS's care during this admission as 'unpredictably reckless behaviour' whilst MS and his son were in a car being driven by his wife. Both incidents are explored at length in MS's paper records but are not recorded in the SAMP risk assessment.

LYPFT have responded to this point in the following terms:

'the SAMP risk assessment identifies MS's impulsive behaviour when hypomanic and it is that, that LYPFT submit is the more important statement of risk than necessarily identifying particular examples'.

The Independent Investigation Team would disagree with this statement of opinion as it fails to recognise the 'violent' element to MS's behaviour when ill.

The lack of content recorded in relation to the non-molestation order:

A further concern for the Independent Investigation Team is the use of the term 'non-molestation order' without any description of the conduct which gave rise to the order. Applications for non-molestation orders need not be restricted solely to acts of violence and are extended to all acts of 'molestation'.

There is no statutory definition of what constitutes 'molestation', and Courts look at all the circumstances that go toward securing the health, safety and well-being of the applicant, relevant child or any other person that the order is being sought to protect. Consequently, the term cannot be used as a 'shorthand' because the types of behaviour covered by such an order are wide, and as a result, have differing clinical relevance.

The unavailability of MS's paper records:

MS's paper records would not have been available to clinicians treating MS outside Bootham Park hospital including the Psychiatric Trainees and Social Worker. This caused important information to become lost or difficult to find without significant effort.

In turn, this had a significant impact upon the quality of information for those charged with assessing the risk which MS presented when in a crisis situation such as that on 7 and 10 April 2015.

Reducing the risk of oversight of crucial information:

There were steps that could have been taken by clinicians to reduce the risk of key information relevant to the assessment of risk not being recognised. This could have involved completing a full review of MS's paper notes prior to the completion of the SAMP Risk Assessment in order to ensure its accuracy. This potentially would have had significant resource implications.

During the course of the Independent Investigation, evidence submitted on behalf of Trainee Psychiatrist 2 referred to the 'complete impracticality of one clinician reading and digesting an enormous amount of case notes. In MS's case this would have taken probably at least 2 hours'.

However, the Independent Investigation Team is concerned by a failure to 'think ahead' by placing information which was relevant to 'risk' into a properly formulated crisis and/or risk assessment where it would be in an easily accessible electronic format for clinicians who could subsequently become responsible for MS's care in a crisis situation.

This had a significant impact upon the remainder of MS's care.

11. CRISIS PLAN

- 11.1 A crisis plan sets out the things that the individual wants others to do for them should they begin experiencing a crisis. The purpose of a crisis plan is to set out what an individual wants to happen to them should they experience a crisis and require others to take care of them and keep them safe.
- 11.2 The Independent Investigation Team was concerned by the lack of crisis planning undertaken in relation to MS's discharge from hospital on 16 March 2015. NICE (2011) Quality Standard for adult mental health states that a crisis plan should contain;
- *'Possible early warning signs of a crisis and coping strategies*
 - *Support available to help prevent hospitalisation*
 - *Where the person would like to be admitted in the event of hospitalisation*
 - *The practical needs of the person if they are admitted to hospital (e.g. childcare, care of other dependants, including pets)*
 - *Details of advance statements and advance decisions*
 - *Whether and the degree to which families or carers are involved*
 - *Information about 24-hour access to services*
 - *Named contacts'*
- 11.3 There is evidence that at the time of MS's discharge from hospital, a SAMP assessment (Safety Assessment Management Plan) was conducted which has a section called *'crisis/contingency plan'*. However, this contains limited information as it only refers to MS's care coordinator; no other action is specified in the event of a crisis. In particular, given the difficulties which MS was experiencing with his marriage for example, no detail has been provided as to the individuals which MS wanted to be contacted in a crisis situation.
- 11.4 The Independent Investigation Team recognises that MS had a number of interactions with social workers following his discharge from hospital on 16 March 2015. Notably MS was seen in the community by a Social Worker on 20 March 2015, 25 March 2015 and 2 April 2015. During these interactions, MS's Social Worker described that MS engaged well, and would spend a long time in their appointment discussing issues. He was noted as being sad/tearful at times in relation to his relationship with his wife and access to his son. He was asked about, and denied, suicidal ideas. The sessions focused on coping skills, access to his son, and discussions relating to gambling which the Social Worker felt was a significant ongoing issue and one into which MS lacked insight. The Social Worker was aware of the past history in relation to risk and actively sought further information from the local Community Forensic Nurse.
- 11.5 MS's Social Worker was aware of the previous incident involving the steering of the car off the road prior to the admission to hospital on 31 January 2015, and sought to discuss this with MS. MS confirmed that the incident had taken place, but had described the car as travelling very slowly

and said that he had simply attempted to stop the car so that he could talk to his wife and persuade her not to take him to hospital. As at 25 March 2015 MS reported that he was still taking medication, but at the appointment on 2 April, told the Social Worker that he had now stopped taking his medication and therefore the Social Worker agreed to bring forward his appointment with the Community Psychiatrist MS was also advised to re-start the medication. As the forthcoming weekend was a long weekend, the Social Worker took care to ensure MS was aware of the options available to him should he need support including GP, A&E and the Crisis Team and explored early warning signs with him again.

- 11.6 During the course of LYPFT's Internal Investigation, it appears that MS's Social Worker was interviewed by the Internal Investigation Team. In interview, MS's Social Worker indicated that he did not consider MS's mental state to have deteriorated since discharge, and that MS had exhibited no signs/symptoms to suggest this. MS had not expressed any suicidal ideation, denied this when asked, and had clear plans for the next few days and for the future in general. In addition, MS's Social Worker recognised the stressful and difficult situation that MS's wife was in and referred her for carer's support to the Carers' Support Worker in the team.
- 11.7 MS was known to be experiencing difficulties in his family life. However, there does not appear to have been any discussion about which family members or carers MS wanted to be contacted in a crisis situation, and importantly the way in which they should be involved. The difficulties which this can cause are illustrated by the following entry in MS's records on 8 April 2015 outlining the content of a telephone call which MS's wife had with MS's social worker.

'Mrs MS said that she had spoken with the ward this morning- He is now on ward 84 at St James'. They would not give her further details but she understood that his injuries were not life threatening. She said she had understood from MS's brother that MS had stabbed himself at home. The police had been called. She was unclear why or how he had gone to Leeds. She said she had emailed MS this morning to say she was sad about what had happened and wishing him well for his recovery but she was not intending to go to see him as she did not want to give the impression that they might get back together. She said they were due in court on 13th April to agree a way forward about the arrangements for their son...

Mrs MS said that she feels MS is very vulnerable at present and not being honest about how unwell he is and that he needs a "serious amount of support'.

- 11.8 The Independent Investigation Team accepts that MS was made aware of the organisations which he could contact if experiencing a crisis. However, the Independent Investigation Team recognises that the organisations to which he was sign-posted, including MS's GP, A&E at York Hospital and the Crisis Team, did not have access to the information concerning recent developments which were available to MS's Social Worker. In particular,

MS's GP would not have received a discharge summary dated 15 April 2015 relating to MS's recent admission to hospital as this was not typed until after his death. This discharge summary contained details of MS's care coordinator. No other documentation addressed to MS's GP contained this information.

11.9 Accordingly, this clinically relevant information was not available to all of those individuals who it was suggested that MS could approach for support in a crisis situation. Whilst MS's social worker was aware of past history in relation to risk, (including the incident with the car on 31 January 2015), it is not clear that the two clinicians were aware of this incident when they assessed MS during his admission in April 2015. Equally, MS's social worker was on sick leave at the time of MS's admission to hospital on 7 April 2015 and would not have been available to provide information about MS. A crisis plan prepared following his discharge from hospital in March 2015 could have accommodated this eventuality.

11.10 Reluctance to Accept Hospital Admission

11.11 It was known that MS had previously been reluctant to be admitted to hospital. This issue could have been dealt with in an appropriate advance statement which formed part of a crisis plan. This information could have been useful to individuals who were subsequently involved in MS's care in the event that he experienced a crisis.

11.12 Relapse Indicators

11.13 In addition, whilst it is recorded that MS '*is aware of warning signs re mania*', no information is given as to the way in which to identify MS's relapse signatures, or indeed the signs that he was or indeed might be experiencing a crisis. Had information concerning MS's individual relapse indicators been set out in a properly formulated crisis plan, then this could have provided assistance to those who were responsible for observing his behaviour when he experienced a crisis such as the trainee psychiatrists. On 2 April 2015, an entry in MS's records states;

'He is aware of warning signs re mania and has none. He knows how to access support via GP or attend A & E if in a crisis can contact support line too'.

11.14 Evidence given during the course of the Inquest by the nurses responsible for MS's care on the acute ward was that MS '*had kept quiet, believed to be agitated*'. However, with the benefit of hindsight, it is possible to infer that this behaviour could have been viewed differently. A properly formulated crisis plan could have removed any uncertainties in this respect as it could have included information about MS's behaviours when experiencing a relapse to allow those observing his behaviour to reach a more informed opinion had they had appropriate training.

11.15 Representations by LYPFT

11.16 LYPFT made a representation to the Independent Investigation Team based on the observations set out in this chapter in the following terms:

'LYPFT submit that there was adequate and sufficient information in that those services that MS was likely to have come into contact with would have been aware of recent developments and as importantly MS had been given details of points of contact in the event he was in crisis. As such LYPFT do not accept that there was an inadequate crisis plan.'

'What LYPFT cannot factor in is whether despite plans being in place a service user such as MS accesses those services when in crisis'

'Furthermore, the steps that the Social Worker took to ensure MS was aware of the options available to him essentially amounted to a modified crisis plan. LYPFT would submit that the steps taken by the Social Worker were appropriate to reflect a dynamic and evolving situation which is what a crisis plan was intended to do'.

11.17 The Independent Investigation Team has considered this representation. Considering the information contained in Paragraph 11.7 above and in recognising that the service provided by Community Mental Health Teams does not extend to 'out of hours' cover, the Independent Investigation Team remain concerned about the nature and content of the crisis plan which was developed. In addition, the Independent Investigation Team note in this regard that at the time of MS's admission to hospital on 7 April 2015, Social Worker was on sick leave.

Comment Four – Crisis Plan

The purpose of a crisis plan is to set out what an individual wants to happen to them should they experience a crisis and require others to take care of them and keep them safe.

The Independent Investigation Team is concerned by the lack of a structured review of the arrangements which were put in place to support MS should he experience a crisis.

12 LYPFT DISCHARGE SUMMARY DATED 15 APRIL 2015:

12.1 'Good practice' by services:

12.2 MS was discharged from hospital on 16 March 2015. Much of the care which MS received during his admission could be described as 'good practice'.

12.3 Regular multidisciplinary reviews took place throughout the course of this admission. Although MS was described as being '*low in mood and tearful at times*', this was seen as being appropriate to his circumstances. His mood and mental state were frequently described as '*stable*'.

12.4 The approach which was taken was holistic. It was established that MS was suffering from a manic episode. However, clinicians explored in some detail psychosocial stressors, including his relationship with gambling and financial difficulties. It is important to address these problems as they could have precipitated a further relapse.

12.5 A significant focus for the delivery of MS's care was the difficulties which he was experiencing in his marriage, his gambling addiction etc. However, there appeared to be little diagnostic curiosity in establishing what MS's premorbid presentation was as a means of understanding his current illness.

12.6 MS's discharge from Bootham Park Hospital:

12.7 MS returned to work whilst still an inpatient. MS was discharged from Bootham Park Hospital on 16 March 2015.

12.8 A 'Preliminary Discharge Letter' was sent to his GP that day. It does not contain any clinical information about his stay in hospital other than to provide the following diagnosis:

'Bipolar Affective Disorder – Current Episode Manic F31.1'.

12.9 In relation to the 'Level of CPA/MHA Status information' to which the pro forma letter refers, no information has been entered. Consequently, MS's GP would have been unaware that MS's admission to hospital was initially on a formal basis for example. In addition, no information was provided concerning MS's management in hospital, nor did it include detail of plans or arrangements concerning his discharge. However, MS's medication upon discharge was included, as was his care coordinator's telephone number.

12.10 LYPFT has made the following submission in this regard:

'following MS's discharge from hospital on 16 March 2015 he was under the care of the Community Mental Health Services. Even if further clinical information had been provided in the preliminary discharge letter, the reality of the situation was that MS's GP did not become involved in his care, MS did not consult his GP and further clinical information would not have led to MS's GP making a proactive step to become involved in MS's care bearing

in mind that MS remained under the Community Mental Health Team. Furthermore even if MS had approached the GP, the overwhelming likelihood is that MS's GP would simply have signposted him to the Community Mental Health Services...'

12.11 GMC guidance makes it clear that communication with other doctors is an integral part of essential medical care. Notwithstanding the fact that MS did not approach his GP following discharge from hospital, the Independent Investigation Team are of the view that the information which was provided about MS's admission was not sufficient to have ensured continuity of MS's care in the event that he had or had his GP been contacted for advice about MS mental health history by another Trust for example.

12.12 The discharge letter from Bootham Park Hospital:

12.13 The discharge letter in relation to this admission to hospital dated 15 April 2015 states;

'SINCE THIS DISCHARGE LETTER HAS BEEN DICTATED THE PATIENT IS NOW DECEASED.'

12.14 The letter includes the following references:

'By his account he also remembers having thoughts to end the life of himself as well as his wife and putting on the gas at home. He then switched this off and thought about ending his wife's life first by killing her with a baseball or a cricket bat however he could not carry this through'.

12.15 The letter goes on to include the following reference:

He admitted that on the day that he was sectioned he had grabbed the steering wheel on the way to the hospital because he did not want to go there. He said his wife was driving and they were going about 10 miles an hour. At this point he acknowledged that maybe he was manic as all he wanted to do was get to a friends (sic) birthday party and relax and chill out and his wife was forcing him to go to hospital. He denied that he was trying to harm her in any way. He acknowledged that it was silly but he did not want to hurt anyone. The patient appeared to have limited insight'.

12.16 In relation to 'Risk' the discharge letter stated:

'It does appear that when unwell, particularly depressed MS is at risk of harming himself as well as others'.

12.17 LYPFT has made the following representation to the Independent Investigation Team in relation to the discharge letter.

'Whilst the Trust accepts that a timely discharge letter would have provided information to the GP, LYPFT would submit that the overwhelming likelihood is that had MS presented to his GP in crisis, the GP would simply have

referred MS back to mental health services knowing that he had a history of contact with them and would have had sight of the "preliminary discharge letter" sent to the GP on 16 March 2015'.

- 12.18 The Independent Investigation Team is of the view that this assertion whilst potentially being correct in relation to MS's GP's response, fails to recognise that as an electronic document, had the Discharge Letter been completed prior to MS's death, it would potentially have been available to Trainee Psychiatrist 1 and 2, thereby providing a potentially valuable summary of information which was not easily accessible elsewhere within MS's medical records.

Comment Five – Delayed discharge letter:

The potential benefits of a correctly actioned discharge letter:

A discharge summary is intended to contain important information about an individual's hospital visit: it is an important letter because it informs a GP about what happened during a hospital visit.

MS's records make it clear that MS was aware how to access support through his GP if he felt himself to be in crisis. This support could have been problematic for MS's GP to implement given the limited information which was made available to the GP by the hospital.

In addition, a discharge letter can provide a useful starting point for clinicians who see the patient at a later stage. In this case, the discharge letter contained information which was not easily accessible in MS's records. This is a matter for concern.

Concerns regarding the dispatch of MS's discharge letter:

It is a matter of significant concern for the Independent Investigation Team that a detailed Discharge Letter concerning this admission to hospital was not sent to MS's GP until after his death, despite having been dictated prior to 10 March 2015.

The contributory effect this had on essential capture of crucial information relation to the 'risk' MS posed:

The Independent Investigation Team has outlined, a number of issues relating to the risk which MS posed which were omitted from a SAMP Risk assessment, and which were not easily accessible elsewhere in MS's notes.

It is the opinion of the Independent Investigation Team that the information which was omitted from the SAMP Risk assessment was regarded as being of sufficient clinical importance for it to be included in a discharge letter written prior to MS's death.

However, because the discharge letter had not been available to clinicians prior to MS's death and the SAMP risk assessment lacked relevant clinical detail, crucial information which it could have provided those responsible for MS's care following his discharge from hospital was lost.

13 MS'S POST-DISCHARGE TRANSFER TO COMMUNITY MENTAL HEALTH TEAM:

13.1 Following his discharge from Bootham Park Hospital, MS's care was transferred to the care of a local Community Mental Health Team (York NE locality). The management plan which was to apply following his discharge was as follows:

'7 day follow up provided by care co-ordinator – Friday 20-03-15 @08.45 at BPH

'28 day supply of medication

'Refer to relapse signature work

'Contact CMHT regularly

'Refer to 24hr support line

'Work on contact with his son via the court system (hearing in April).'

13.2 MS's care coordinator:

13.3 The process through which MS was allocated a care coordinator is unclear from the records. It is also unclear as to whether a CPA meeting was held which involved Care Coordinator 1 prior to his discharge.

13.4 However, MS did attend his 7 day follow up appointment on 20 March 2015. The duration of the appointment was 105 minutes. The record of this appointment describes MS as:

'very tearful at times but denied thoughts of any suicidal ideation and when asked to compare himself now with how he had presented in 2001 when he had been actively suicidal stated he was not near that way of feeling.....MS stated he had not been sleeping well and would like an antidepressant rather than Olanzapine although stated he would continue with this.....He presented as reactively depressed but still had enthusiasm for his gambling and spent some time justifying his reasons for continuing...'

13.5 MS attended a further appointment with Care Coordinator 1 on 25 March 2015.

13.6 An entry in his records relating to this attendance states;

'MS was quite down at times and tearful but he stated he has continued to take his medication and work.....Discussed the EMAILS forwarded by [MS's wife] to services re MS and discussed Aspergers (sic) and Autism Spectrum in terms of the concerns. It appeared that although MS is a bit of a perfectionist and can be quite rigid in his thinking regarding his own viewpoint (sic) his socialisation and numerous social activities and functioning would suggest this would be a mild condition if any'

13.7 During the course of this consultation, MS asked Care Coordinator 1 to accompany him to Court in relation to family proceedings brought by MS's wife in relation to their son. The Care Coordinator agreed to this request.

13.8 LYPFT has submitted that this constitutes evidence that *'MS was prepared to engage with Mental Health Services such that this would be further evidence as to why Trainee Psychiatrist 2 was right to proceed on the basis of MS being admitted informally to Bootham Park Hospital on 10 April 2015'*. The Independent Investigation Team notes that this statement of opinion fails to take the deterioration in MS's mental state and increased risk of impulsivity resulting in his uncompleted suicide on 7 April 2015 into account.

Comment Six - Elements of good practice:

Following MS's departure from hospital, a number of steps were taken which could be considered to be good practice from the point of view of suicide prevention.

Timely reviews:

A significant factor was that timely reviews were arranged in order to engage with MS which potentially performed two purposes. Firstly, engagement with a patient such as MS is a means of instilling hope. Further, such engagement provides an opportunity to discuss problems and condense them to make them more manageable. It also allows an explanation of symptoms in the context of those problems which, of themselves, might have a beneficial effect, particularly if it is put in the context of a treatable condition.

MS's involvement in his treatment:

Secondly, it appears that MS's views about his possible treatment were taken into account and adjustments were considered in that it appears to have been agreed to seek an early appointment with MS's Consultant regarding MS's views about his medication.

MS's care coordinator:

There is also evidence that MS's care coordinator helped MS with some specific challenges which he was facing and in particular, the Family Court Proceedings involving access to his son. They also provided MS with details of organisations which could be contacted in a crisis.

In summary:

Consequently, there was a variety of different layers to the package of care being used to build a relationship with MS with the hope of reducing the risk of suicide. It very much presented a message 'that there are things which can be done'.

It is important to remember that during these interactions, clinicians would have been able to read the signals produced by MS about his feelings and in particular, his level of hopelessness. This should have put clinicians in a better position to read the signals given by MS as to his feelings and also to plan his care, rather than react to unforeseen difficulties.

In summary, the Community Mental Health Team was undertaking action for MS in order to help him, assess him and plan for his future care which is an element of good practice.

14 ATTEMPTS TO OBTAIN ADDITIONAL INFORMATION ABOUT MS RELATING TO RISK:

14.1 On 25 March 2015, during the course of a consultation with Care Coordinator 1, MS asked Care Coordinator 1 to advocate on his behalf in relation to a forthcoming Court Hearing in relation to MS's family. Care Coordinator 1 appears to have determined that in order to do this, he would require access to historical information regarding the potential risks to MS's family in the event that the Court ordered that MS should have contact with his family as he appears to have been of the view that he had insufficient information. Care Coordinator 1 therefore requested historical information regarding any risks which MS might pose to his family. The entry in MS's records relating to this request made by Care Coordinator 1 states:

'there was no official background information re history of risk to base any reports on for the court if needed or safeguarding for the family or the public. In particular as the patient had been in the Humber Centre and prison following depressed mood and an impulsive offence of GBH involving a hammer to assault a third party. In addition, there were several other attempts to harm self or threaten to harm the family so presumably there would be relevant psychiatric assessments from that time to help assess any reoccurring risks or warning signs now. Also of concern is the possible lack of empathy expressed by the patient regarding the incident and to how much this related to a reoccurrence of behaviours now ant the extent this is manageable by the client'.

14.2 Deficiencies in MS's electronic records:

14.3 It is not clear from the records whether this request was followed up in writing. Equally, it is not clear when information from the Humber Centre was received. It is clear however, that a detailed Forensic Report dated 23 November 2001 was contained within MS's records. The key findings of this report were not summarised into an electronic format within MS's records or included in a document such as a SAMP risk assessment conducted during the course of MS's admission to hospital in earlier in 2015 which would have allowed other clinicians working within the same Trust such as Care Coordinator 1 to easily access potentially relevant information without the necessity of them having to access MS's paper records. In addition, the Report refers to the period prior to MS's conviction for GBH. It is understood that MS remained in the Humber Centre for a period of approximately 8 months.

14.4 LYPFT have made the following submission:

'the suggestion that the findings of a detailed forensic report should be summarised into electronic records is made with the benefit of hindsight. The reality of the situation was that this report would have been available to those who were most likely to have had contact with MS, namely his Local Community Mental Health Team. It was simply not foreseeable over the latter part of March 2016 or early April 2017 that MS would come into contact

with Liaison Psychiatric Services in Leeds. Furthermore, it is clear that when one analyses the entries made following the consultations by the Liaison Psychiatry Services on 7 and 10 April 2015 that they were aware of MS's forensic history...

...LYPFT would submit that it would have played no part in revising the management / plan of care'.

- 14.5 As highlighted by Care Coordinator 1 on 25 March 2015 and referred to in paragraph 14.1 above, the relevance of the Forensic Report dated 23 November 2001 is that it *'would help assess any reoccurring risks or warning signs now'* notwithstanding knowledge of MS's offence of GBH.
- 14.6 The historical information clearly indicated the high degree of risk presented by MS when experiencing a relapse. In the absence of a systematic review of this data including the warning signs which MS may have exhibited when experiencing a relapse, the treatment plans and risk assessments were incomplete notwithstanding the knowledge of MS's previous prior offences.
- 14.7 This failure may have had an impact not only upon MS's care whilst at Bootham Park Hospital, but it meant that the results of such reviews would not have been included in his notes creating a difficulty for clinicians who were responsible for his care subsequently such as that highlighted by Care Coordinator 1. Had a review taken place which pulled together all of the information in the paper and electronic records, that information would have had a greater chance of coming to the attention of those who saw MS between 7 – 10 April 2015 and being considered as part of their assessment of the risk which MS presented at a time of relapse.
- 14.8 MS again attended a consultation with his care coordinator on 2 April 2015. The record of this consultation includes the following references:

'Very tearful on occasion and feeling down...He stated he was not taking Olanzapine now and wanted an antidepressant also requested an outpatient appointment earlier than that available with... On 27 April 2015...He did not present in any way psychotic in my opinion and the depression seemed relevant and measured to the situation... Agreed to request earlier appointment and made crisis plans in terms of relapse with MS. He is aware of early warning signs re mania and has none he knows how to access support via GP or attend A&E if in a crisis can also contact support line too'.

Comment Seven:

The Independent Investigation Team could find no evidence that an earlier appointment was arranged for MS to be reviewed.

The Independent Investigation Team recognises that the attempts made by MS's Community Mental Health Team demonstrate an element of good practice. The information which was gained by the Community Mental Health Team was gathered to update MS's risk information which had noted to have been absent.

15 ACUTE LIAISON PSYCHIATRY SERVICES ('ALPS'):

15.1 'ALPS' Practitioners are employees of LYPFT (Leeds and York Partnership NHS Trust). The team is commissioned by Leeds CCG's.

15.2 The 'ALPS' Annual Review 2014/15:

15.3 The 'ALPS' - Annual Review 2014/15 published by LYPFT states:

'The Acute Liaison Psychiatric Service (ALPS) delivers self harm assessments to both Emergency Departments and medical wards at St James' Hospital and Leeds General Infirmary. The service model expands to providing non self harm mental health assessments in both respective Emergency Department's (sic).

The drive to provide the ALPS service model is to reduce admissions to the CDU's within LTHT and to conduct more timely assessments to those admitted to medical inpatient areas of LTHT.

15.4 Key aims of the service were stated to include:

1. *'To provide rapid bio-psychosocial and risk assessment of individuals who present to the ED (Emergency Department)(sic) with deliberate self-harm and acute mental health problems.
[...]*
6. *To facilitate prompt access to mental health intervention for those individuals who have an identified mental illness working closely with the acute care pathway to access in-patient psychiatric admission and intensive community services.
[...]*
8. *To liaise with other services in Leeds including GP's and primary care workers, community mental health teams, specialist mental health teams, addiction services, crisis services and voluntary organisations.*
9. *To provide a resource to general hospital colleagues for information and advice on mental health issues.'*

15.5 Psychiatric Liaison:

15.6 MS was assessed on 7 April 2015 by Trainee Psychiatrist 1.

15.7 Trainee Psychiatrist 1 provided the Independent Investigation Team with the following account of MS's care:

'I reviewed MS since I was doing an oncall (sic) shift with the Liaison psychiatry team. Prior to reviewing MS, I was told by Liaison psychiatry team that he wasn't medically fit for discharge and only needed a review to check his mental state which can be monitored in the future visits when medically

fit for discharge. It also told the nursing team in the surgical ward that psychiatry inpatient wards are not suitable for someone with a chest drain since the nurses aren't trained to take care of the same.

When I reviewed MS, he had a chest drain in place and as per the information given by duty nurse, MS was immobile due to the same. He needed assistance to do basic things like going to the toilet and even get up for a meal.

During the assessment although this hasn't been mentioned in my notes, I noticed that in terms of safety there were no sharps, ropes or anything in his room that posed any risk to self in terms of suicide or self-harm. Also to note that his room was right next to the nursing station and they were able to observe him all the time. This arrangement was particularly because of his physical health and his needs.

Halfway during the assessment he needed a glass of water and couldn't even take it himself due to the pain and chest drain. I had to help him with the same. This indicated that there was (sic) minimal chances of him absconding from surgical ward with the drain'.

15.8 The capture of this information in MS's records:

15.9 Notes of the consultation undertaken by Trainee Psychiatrist 1 were entered onto PARIS at 12:44 that day. It was recognised in the PARIS entry that MS had experienced a 'serious adverse episode'.

15.10 Brief details regarding MS's social and forensic history are recorded. The assessment noted that MS was separated from his wife and that he had a son who lived with MS's wife.

15.11 MS was noted to be low in mood with no eye contact and reported that he was 'depressed'. No thought or perceptual abnormality was detected. He stated he had intended to kill himself and said that he did not regret doing this act, as he could see 'no way forward'. MS also stated he had not been compliant with Olanzapine for 3 weeks. In addition, it is recorded that 'according to paris notes (sic) he currently has a court order protection (sic) from his wife. MS wasn't aware of this'.

15.12 Trainee Psychiatrist 1 recorded the following points in relation to risk:

'Risk of selfharm (sic) and suicide – high due to current act and historical risks

Risk to others – moderate – due to historical risk of assaulting his colleague with a hammer

Risk of non-compliance – high, since hasn't been compliant with his medications'.

15.13 The plan of action generated as a result:

15.14 The following plan was formulated:

*'Needs to be reviewed again by ALPS team once medically fit for discharge
'Continue Olanzapine and rest of the medications'.*

15.15 Trainee Psychiatrist 1 made some effort to access MS's past notes. This is an element of good practice. However, in accessing MS's past records, it appears that Trainee Psychiatrist 1 was not aware of the incident involving MS and his family which took place on the way to hospital on 31 January 2015, or of MS's subsequent attempt to leave the hospital. However, Trainee Psychiatrist 1 did have the benefit of information concerning MS's admission to the secure forensic centre.

15.16 In addition, in conducting the assessment, it does not appear that Trainee Psychiatrist 1 contacted the Community Mental Health Team which was involved in his care, nor any members of MS's family.

15.17 The Independent Investigation Team's views on this treatment:

15.18 The assessment which was carried out by Trainee Psychiatrist 1 was of an acceptable standard. It was established that MS was suffering from a relapse of his mental illness with associated risks.

15.19 However, the Independent Investigation Team has significant concerns with the care plan which was generated as a result of MS's assessment. It is the opinion of the Independent Investigation Team that MS's mental health needs should have been managed in parallel with his physical health needs.

15.20 It is clear from the assessment which was undertaken that MS would have been in a psychiatric hospital (either under section or as a voluntary patient), were it not for his physical health needs.

15.21 Mental health is not a uni-disciplinary activity, the psychiatric assessment documented a severe depressive episode with psychosis, that there was a serious risk of suicide and that it was possible MS would act impulsively. A degree of hopelessness had been identified and MS had expressed the view that he did not regret his uncompleted suicide. The antipsychotic effects of Olanzapine take some time to be effective and the patient's psychotic symptoms would not abate within 2-3 days of starting treatment. The Independent Investigation Team recognises that evidence given at the inquest of MS was that nurses on the ward stated that during this period MS appeared quiet and anxious. He did not present any management problems as a result of his behaviour.

15.22 Surgical nurses would not be expected to have the training or expertise to detect concerning signs of mental illness- especially in psychotic patients. A psychotic patient who is 'quiet and anxious' may be at high risk. A psychiatric nursing assessment could have explored the patient's mental state and provided a more comprehensive assessment of the risk

particularly in relation to the practicalities of patient transfer.

- 15.23 Without a detailed examination of MS's mental state at this point by mental health practitioners trained to recognise the symptoms and behaviours related to a psychotic illness, it was not possible to determine the significance of this behaviour and therefore the risk which MS presented. It is the opinion of the Independent Investigation Team that an individual whose presentation is apparently quiet and compliant can still be at risk of acting impulsively. Accordingly, a psychiatric nursing assessment should have been completed. It may have suggested the need for continuous observations or observations every 15-30 minutes such as those recommended by Trainee Psychiatrist 2 in relation to MS care following transfer to Bootham Park Hospital. It may also have provided advice about MS's access to implements such as cutlery which could have been used in an act of self-harm such as that given by Trainee Psychiatrist 2.
- 15.24 Despite this, the plan generated by Trainee Psychiatrist 1 did not seek to address MS's problems and needs in the setting in which he was receiving care, such as his highlighted non-compliance with medication, his risk of impulsivity and the risk which he posed to himself and indeed others should he attempt to abscond, notwithstanding his physical injuries.
- 15.25 The Independent Investigation Team accept that MS did not seek to abscond from the Ward during his admission and that therefore this action did not have a direct causal impact upon the death of MS. However, the purpose of an Independent Investigation is to identify learning, and this is an area of clinical practice highlighted in MS's care where appropriate steps were not taken to reduce the level of risk which MS presented to himself and others.
- 15.26 Whilst the Independent Investigation Team accepts that as a result of his injuries MS had reduced mobility during his admission and that the risk that he would be able to abscond from the ward was reduced as a result, the risks which he posed were not completely eliminated. In addition, the risk that he was known to act impulsively when unwell was not addressed.
- 15.27 Risk can never be completely eliminated (suicides occur even in psychiatric inpatient units), MS may have been at reduced risk of absconding because of his reduced mobility, but MS was fully mobile at the time of transfer. This is the time when the risk of his absconding was at its highest - he was mobile, he had the opportunity and he was only reluctantly agreeing to go into the psychiatric unit.

Comment Eight:

Liaison psychiatry is the subspecialty of psychiatry that provides specialist mental health assessment and treatment for patients attending general hospitals. Liaison psychiatrists work at the interface between physical and psychological health.

Deficiencies in the plan adopted:

However, the plan which was developed on this occasion was effectively to review the patient again when MS was '*medically fit*'. It did not provide any advice or support which would allow a nursing plan to be developed which could be implemented by nurses who had psychiatric training, let alone those who had little or no psychiatric nursing experience.

The Independent Investigation Team is of the view that it was unreasonable to expect general nurses to have the expertise to assume responsibility for assessing and monitoring MS's mental state. MS was clearly experiencing a depressive relapse despite being administered a course of Olanzapine. The historic information which was available to clinicians was that he was '*risky and unpredictable*' when experiencing a relapse.

Notably, MS could have left the hospital at any point in his stay prior to 10 April 2015. He could have left the hospital when he was taken to x-ray for example. Indeed, the physical injuries sustained by MS would not have precluded him from doing so. The plan devised by Trainee Psychiatrist 1 did not address this eventuality, nor did it offer any assistance should MS experience a further crisis.

In addition, it is a matter of concern that there was a difference in 'understanding' between services when MS was to be reviewed by the ALPS team. The plan states that review was to take place when MS was physically fit. However, in a note made of a conversation between the community health team and a nurse on MS's ward dated 8 April 2015 it was stated:

'He has been visited by the psychiatric liaison service who have stated that he is not currently esectionable(sic) -presenting as very loww (sic) in mood. They are due to review each day'.

Had MS been reviewed each day of his stay in hospital by psychiatrically trained staff, then his mental state and risk could have been more effectively monitored. The information gathered could have been used to better inform the review of MS's mental state at the point he was judged to be 'medically fit' for discharge.

Effectively, the relapse in MS's illness remained effectively unaddressed (despite the recommencement of the Olanzapine) and unobserved by mental health practitioners until 10 April 2015. As a result, his safety and the safety of those with whom he had contact was not ensured because this risk was not sufficiently recognised.

LYPFT have submitted the following representation in relation to this point:

'As the nursing staff on that ward would have been aware, if there were any concerns regarding MS's mental state it would have been open to them to have sought advice from ALPS'.

It is the view of the Independent Investigation Team that the notion of staff from the surgical ward being able to seek help from ALPS staff if they thought it necessary is impractical in that it assumes that nursing staff in the surgical ward have a degree of training and expertise in mental health sufficient to allow them to accurately monitor the mental health of a psychotic patient who was at serious risk of suicide and capable of acting impulsively. Without training in mental health, there is a risk that aspects of a patient's presentation which have clinical relevance from a mental health perspective are missed. It also relies on the availability of trained mental health professionals having the capacity to assess and provide advice on management appropriately. It is the opinion of the Independent Investigation Team that surgical nurses would not have the training to detect risk in psychotic patients.

Psychiatric nursing input would have worked with the psychiatric medical assessment to allow for a more comprehensive assessment of MS's mental health needs and the development of a nursing care plan (in conjunction with the general nurses) that would have addressed these at the same time as his physical needs were being addressed, reflecting an integrated approach to the care of the patient.

LYPFT have also stated;

'The suggestion that MS could have left the hospital at any point in his stay prior to 10 April with respect, fails to reflect the reality of the situation in that MS's physical health precluded this. The plan devised was quite clear that as and when MS was medically fit for discharge contact should be made with the ALPS team again for a further review. It was not unreasonable to expect and indeed the case for the ALPS team were contacted and indeed attended promptly on 10 April'.

In response, the Independent Investigation Team considers that the fact that a patient is bed-bound for a period of time would have a bearing on how that risk is managed but does not negate those risks. The Independent Investigation Team notes that, at the time of the transfer request, either a T1 or a T2 journey was requested, meaning that MS had been assessed as being able to 'mobilise himself'.

16 DECISION MAKING PROCESS AROUND MS'S ADMISSION TO BOOTHAM PARK HOSPITAL AS A VOLUNTARY PATIENT:

16.1 MS's assessment at St James's Hospital:

16.2 On 10 April 2015, MS was seen by Trainee Psychiatrist 2. Trainee Psychiatrist 2 was based within the Liaison In-Reach Service at the Becklin Centre but offered supervision and second opinions to the ALPS team based in A&E at St James's Hospital at the time of MS's care. Trainee Psychiatrist 2 had been in post as an 'acting' Consultant for 4 days when he met MS.

16.3 Trainee Psychiatrist 2 was able to obtain background information about MS concerning his admission to hospital in January 2015 prior to meeting MS on the ward. Trainee Psychiatrist 2 spent a significant period of time in undertaking a review of MS's medical records to obtain his previous medical history. This was an example of good practice on the part of Trainee Psychiatrist 2.

16.4 The information relating to MS that was available:

16.5 Evidence given by Trainee Psychiatrist 2 to the Inquest into MS's death made it clear that Trainee Psychiatrist 2 had access to a substantial amount of material concerning MS and his previous history. The information which Trainee Psychiatrist 2 was able to access was that which was available in electronic format.

16.6 However, Trainee Psychiatrist 2 did not have access to MS's paper records or the additional information which they contained. Evidence provided on behalf of Trainee Psychiatrist 2 to the Independent Investigation Team stated:

'There was a wealth of background information and Trainee Psychiatrist 2 spent approximately 45 minutes reviewing it before he saw MS and continued to review it whilst he was in consultation with MS for 30 minutes. For the avoidance of doubt however, the large amount of information he reviewed however did not enable him to pick up any reference to the "steering wheel incident" a few weeks earlier where MS had attempted to stop a car that was driving him to hospital.'

16.7 In addition, Trainee Psychiatrist 2 provided a description of how difficult it would have been for him to have obtained that information:

'In particular:-

- The only place that this information is mentioned is within old case notes which were approximately 15 pages in length, where this piece of information was mentioned one time and buried in the middle of that information;*

- *It was not mentioned anywhere in the current risk assessment documents, which were reviewed by Trainee Psychiatrist 2; it was not mentioned anywhere in the recent case notes which were reviewed by Trainee Psychiatrist 2;*
- *It is not in the section labelled “in patient admission” dated 12 February 2015 giving information about his in patient admission, which was reviewed by Trainee Psychiatrist 2;*
- *It was not in the “crucial information” section of the PARIS notes, used to alert staff to significant risks, which was reviewed by Trainee Psychiatrist 2;*
- *Evidence given to the Coroner by a... Clinical Lead ... (who Trainee Psychiatrist 2 had telephoned to discuss and find out any further background, before seeing MS) was that when she had spoken to Trainee Psychiatrist 2, she had not mentioned this incident to him (although she had been aware of it);*
- *Evidence given to the Coroner by MS’s Social Worker, was that when he had spoken to MS about the incident a few weeks earlier, the view he had taken was that it was not an attempt to endanger the deceased or others, and that the deceased had simply tried to stop the car, which was driving at 10mph at that point, because he did not want to go to hospital;*
- *Trainee Psychiatrist 2 had spent approximately 45 minutes before seeing MS, reviewing the detailed paperwork involved in his case and despite that 45 minutes, had not come across any reference to the “steering wheel incident” a few weeks earlier.’*

16.8 The electronic records can be broken into two parts. First there is the ‘Case Notes’ section; secondly there is a section called ‘Assessments’. Trainee Psychiatrist 2 examined the most recent case note entries which concentrated upon MS’s care following discharge from hospital in January 2015.

16.9 Notably, in evidence, Trainee Psychiatrist 2 confirmed that he had read a document entitled ‘In Patient Admission’ which described MS as being ‘manic’. This document made reference to the incident which occurred on the way to hospital when MS attempted to grab the steering wheel of the car being driven by MS’s wife. He also confirmed that he had been able to access an updated Risk Assessment for MS which did not make reference to the incident on the way to hospital.

16.10 In evidence provided to the Independent Investigation Team on behalf of Trainee Psychiatrist 2, the difficulties which a clinician faced in this situation are explored:

‘The document referred to, entitled “In Patient Admission” was a 9 page long document with just one single line referring to MS having grabbed the wheel of a car a few weeks earlier. Trainee Psychiatrist 2 did not read that line and had no particular prompt to do so given the fact that this had not been mentioned in any of the other many documents that Trainee Psychiatrist 2 had reviewed.’

16.11 Trainee Psychiatrist 2 also provided the following information about how MS came to their attention:

'Trainee Psychiatrist 2 had initially been informed by MS at about 9 am that morning and yet did not see him until 10.30am. The majority of the time in-between was involved in preparing for that consultation.'

16.12 It was also explained on Trainee Psychiatrist 2's behalf that MS's records were ('rather disordered') which '*hindered Trainee Psychiatrist 2's ability to find out the most relevant parts of information both by the way it was arranged and by its volume*'.

16.13 Trainee Psychiatrist 2 attempted to speak to Care Coordinator 1 who was not at work because of illness. Instead he was able to contact staff from the Community Mental Health Team who had had contact with MS. He was advised about MS's decision to stop taking his medication. Details were also provided about the incident involving MS's colleague in 2001 when MS had become depressed and psychotic, which had led to his incarceration to prison and subsequently the Humber Unit. In addition, information was passed on regarding the forthcoming Family Court proceedings involving MS.

16.14 Trainee Psychiatrist 2's consultation with MS:

16.15 Trainee Psychiatrist 2 met with MS at 10:30am. This meeting took place in the privacy of a side room. Immediately prior to this meeting, Trainee Psychiatrist 2 spoke with the nurses on the ward who described MS as having been 'flapping and threatening' upon first admission. However, they stated that he settled and became quiet and accepting of his treatment.

16.16 Trainee Psychiatrist 2 described the consultation in the following terms:

'We discussed many things, we discussed the incident where he had attempted to end his life ... We discussed his thoughts and motivations around those actions and he described to me how he had been feeling very low in mood, how he had been hearing a voice telling him to kill himself and how he had been feeling panicky...

...He denied having suicidal thoughts but he was ambiguous. He would frequently say 'I don't know how I'm feeling'. He indicated he didn't have any suicidal thoughts at the time but he appeared distressed, he appeared tormented when you asked him these questions so it was ambiguous but concerning...

...my conclusions were that he was severely depressed with psychotic symptoms, that he was an extremely unwell distressed man and that he presented certainly out of the hospital context high risks of another unpredictable attempted suicide because of his mental state at that time'.

16.17 Trainee Psychiatrist 2 also noted that MS appeared to not understand the

use of Olanzapine, and was asking to be prescribed an alternative, anti-depressant drug which Trainee Psychiatrist 2 thought was not indicated (and potentially would lead to a risk of him becoming manic).

16.18 Trainee Psychiatrist 2 encouraged MS to telephone his brother. Trainee Psychiatrist 2 was present during this conversation. Trainee Psychiatrist 2 then spoke to MS's brother. Trainee Psychiatrist 2 explained to MS's brother his view that MS was very unwell. There was a discussion about the options which were available if MS was to return home. Trainee Psychiatrist 2 sought MS's brother's views upon admission to hospital. MS's brother agreed with this course of action.

16.19 Following this conversation, Trainee Psychiatrist 2 spoke again with MS. His account of this conversation given at Inquest was as follows:

'He asked me then if he would be detained if he did not agree to go into hospital and I said 'I would have to consider that if that is your decision' and then he said I agree to go into hospital and there was some other discussion about the fact that he had nowhere to go home and him agreeing that a hospital was an option in that sense'.

16.20 Ostensibly, MS had agreed to admission to hospital, and therefore, the least restrictive option would be informal admission.

16.21 Independent Investigation Team analysis of this consultation:

16.22 Following this conversation, Trainee Psychiatrist 2 spoke again with MS.

16.23 Trainee Psychiatrist 2's record of this conversation includes the following:

'I asked what he wished to do - he repeatedly said he did not know. I recommended hospital admission to him due to concern about his mental health and suicide risk – he did not seem willing to consider this but could not explain why or offer alternative suggestion. I suggested he discuss it with his brother...He allowed me to speak to his brother who expressed that the family were highly concerned about his health and safety and felt he ought to be admitted to a psychiatric hospital even if that required detention.

After the call MS said he had little choice but to accept admission, but also indicated one reason to do so was that he could not think of alternative accommodation at the moment – I asked him to honestly indicate his opinion about this and he said 'if I don't will you section me? To which I replied I would have to consider recommending it due to my concerns – he reiterated he was willing to come into hospital voluntarily.'

16.24 His account of this conversation given at Inquest was as follows:

'He asked me then if he would be detained if he did not agree to go into hospital and I said 'I would have to consider that if that is your decision' and then he said I agree to go into hospital and there was some other discussion

about the fact that he had nowhere to go home and him agreeing that a hospital was an option in that sense’.

16.25 Independent Investigation Team analysis of this MS’s consent to admission:

16.26 The Mental Health Code of Practice provides the following guidance for clinicians:

‘The threat of detention must not be used to coerce a patient to consent to admission to hospital or to treatment (and is likely to invalidate any apparent consent)’.

16.27 Clinicians regularly and appropriately employ a number of different strategies in order to encourage patients to accept treatment. These range from ‘persuasion’ at the lowest level of encouragement to ‘compulsion’ which is the most coercive option. It is the opinion of the Independent Investigation Team that coercion includes the use of threats whether actual or indeed perceived.

16.28 Ostensibly, MS had agreed to admission to hospital, and therefore, the least restrictive option would have been informal admission. However, the Independent Investigation Team note that MS described himself as having ‘little choice’ and are cognisant of his unwillingness to consider admission to hospital or to offer an alternative suggestion when discussing this issue with Trainee Psychiatrist 2. Consequently, in mentioning that detention would have to be considered if MS did not agree to go into hospital, the Independent Investigation Team is concerned that the possibility existed that MS may have perceived this as a ‘threat’ even if this was not intended by Trainee Psychiatrist 2.

16.29 The Independent Investigation Team accepts that this is a question which some patients ask. However, the Independent Investigation Team is concerned about the nature of the question raised by MS in light of the description of some of the responses which he gave to Trainee Psychiatrist 2 which were described as being ‘ambiguous’ particularly in relation to whether he was experiencing thoughts of suicide with MS stating that *‘I don’t know how I am feeling’*.

16.30 In the opinion of the Independent Investigation Team, Trainee Psychiatrist 2’s note of 10 April 2015 which states that MS *‘must not be discharged’* and includes a reference to section 5(2) of the Mental Health Act 1983 in this regard together with his note that MS agreed to admission with some reluctance, indicates that MS was given a limited choice with regards to admission. In these circumstances a significant question exists about whether MS did in fact provide a valid consent to voluntary admission to Trainee Psychiatrist 2. This concern is further exacerbated as there is no evidence in MS’s records to suggest that a review of MS’s capacity was undertaken at this time.

16.31 Trainee Psychiatrist 2 has responded to this concern in the following terms:

‘Trainee Psychiatrist 2’s clinical judgment at the time, on a very careful

assessment, was that the consent was valid and that his obligation in line with the MHA, and the appropriate action, was to take the least restrictive course of action. A psychiatrist would be criticised for moving to compulsory detention of a patient where there is a less restrictive course of action.

Clearly, this can be a difficult balancing act and Trainee Psychiatrist 2's plan acknowledged some uncertainty by making it clear that regardless of his consent to informal admission, if there were evidence of a change in his stance such as attempted absconion, he should then be placed on MHA Section 5(2) and that Trainee Psychiatrist 2 would then consider a different management plan. This information was given to the nurses on the ward. A psychiatrist cannot predict the future with certainty, and must reach the best clinical judgment that they can in the circumstances. Trainee Psychiatrist 2 did so and had a contingency plan in place'.

16.33 For the reasons set out above, the Independent Investigation Team are of the view that MS's consent to admission to hospital was not valid. Further, the Code of Conduct provided an alternative framework to support patients and clinicians in these difficult circumstances. The least restrictive option in this event is not an absolute rule. The use of the least restrictive option must be seen in the context of the guidance in the Code of Practice and when MS clearly expressed reluctance to a voluntary admission. The Independent Investigation Team recognise that there is a presumption of capacity as a general rule, but there is an obligation to assess capacity if there is a doubt as to whether the patient has capacity to consent to a particular intervention.

16.34 There is no evidence recorded in MS's medical records that records any assessment of MS's capacity or indeed that this issue was considered. In terms of MS's clear ambivalence about admission to hospital together with the psychotic symptoms which he was exhibiting at this time, the Independent Investigation Team believes capacity should have been assessed and the results of this assessment recorded in MS's notes.

16.35 Independent Investigation Team's Analysis of plan to utilise section 5(2):

16.36 There is no indication contained in MS's records that there was an assessment of MS's capacity conducted at this time.

16.37 The Mental Health Code of Practice provides the following guidance for clinicians:

'Patients with capacity to give or to refuse consent to admission

14.14 When a patient needs to be in hospital, informal admission is usually appropriate when a patient who has the capacity to give or to refuse consent is consenting to admission.

14.15 This should not be regarded as an absolute rule, especially if the reason for considering admission is that the patient presents a clear risk to themselves or others because of their mental disorder.

14.16 Compulsory admission should, in particular, be considered where a

patient's current mental state, together with reliable evidence of past experience, indicates a strong likelihood that they will have a change of mind about informal admission, either before or after they are admitted, with a resulting risk to their health or safety or to the safety of other people'.

16.38 As demonstrated above, the Code provides options for clinicians to consider if a change of mind is anticipated on the part of the patient. The Independent Investigation Team recognises that this presents a dilemma for clinicians. Clearly, clinicians should not detain patients if they agree to voluntary admission. However, detention can be considered where there are doubts about valid consent or indeed where there are significant concerns that a patient might change their mind.

16.39 It is the view of the Independent Investigation Team that, Trainee Psychiatrist 2's notes suggest that MS did meet criteria for Mental Health Act admission in terms of presence of mental disorder and risk;

'if changes his mind about admission, will need mental health act... Must not be discharged or allowed to leave the ward unaccompanied... if absconds, consider use of section 5(2), police, security'.

16.40 Trainee Psychiatrist 2 has stated that MS was not detainable unless and until he attempted to abscond. However, MS could have changed his mind about admission to a psychiatric hospital and decided to go home for example. He could have reached this decision at any point following his departure from the ward when a section 5 detention of any nature would not have been possible in practical terms. This would not be defined as absconding but, in this case, Trainee Psychiatrist 2 appears to indicate that he would have invoked the Mental Health Act.

16.41 Trainee Psychiatrist 2's notes record the following plan in the eventuality that MS changed his mind:

'if he changes his mind about voluntary admission I have asked the ward to contact me- I would consider instigating a mental health act assessment'.

16.42 It is the view of the Independent Investigation Team that the statement '*must not be discharged*' suggests that MS would not have been allowed to withdraw his consent to a voluntary admission and simply go home. It appears to the Independent Investigation Team that Trainee Psychiatrist 2 had therefore concluded that MS met grounds for detention in terms of risk. However, the reason that he was not detained was that he had agreed to admission. As is stated, in the Mental Health Act Code of Practice at Paragraph 4.17 '*the threat of detention must not be used to coerce a patient to consent to admission to hospital or to treatment (and is likely to invalidate any apparent consent)*'.

16.43 Whilst the Independent Investigation Team acknowledges this explanation provided on behalf of Trainee Psychiatrist 2, it has noted that in order to inform Trainee Psychiatrist 2's surgical colleagues and support MS' continuity of care, this caveat should have been fully recorded in MS' records.

- 16.44 The Mental Health Code of Practice (section 14.16) states that compulsory admission should be considered if *'there is a strong likelihood that the patient will change his mind about informal admission'*. Factors to be considered will include current mental state together with reliable evidence of past experience.
- 16.45 Whilst the Independent Investigation Team recognises that MS remained in hospital for a long period as a voluntary patient in the past, that was during a manic episode; on this occasion, he was suffering from a depressive episode. He had also during this period applied to have his section lifted. In addition, there is information in clinical entries made by individuals working with MS in the community that suggested information given by MS during interactions with clinical staff, in relation to the Court proceedings involving his wife, was potentially inaccurate in that this information was available to Trainee Psychiatrist 2.
- 16.46 Given the ambiguity recognised by Trainee Psychiatrist 2, other sections of the code of practice should have been considered as a better way of ensuring the safety of MS and others in the event that he changed his mind given that in practical issues in terms of utilising section 5(2) or indeed any form of Mental Health Act assessment, while MS was in transit to Bootham Park Hospital or indeed securing a police presence when MS's journey had commenced.
- 16.47 The relevance of the discharge summary:
- 16.48 A key guiding principle in the Mental Health Code of Practice is that care and treatment should be provided in the least restrictive way possible – this means that if possible, someone should be admitted to hospital without the constraints of the Mental Health Act applying to them.
- 16.49 During the course of the Inquest, Trainee Psychiatrist 2 was asked whether there were circumstances when, despite a patient agreeing to an informal admission, formal admission would still be appropriate. Trainee Psychiatrist 2 correctly pointed to the fact that where there was strong peripheral evidence or indeed historical evidence that what the patient was telling clinicians may not be true, then formal admission might be appropriate. A further reason for compulsory admission was the risk of absconding.
- 16.50 The Independent Investigation Team had the benefit of access to MS's paper and electronic records. It is clear that in relation to his inpatient stay in January 2015, MS was initially considered to be at risk of absconding when he was manic, and accordingly at greater risk of acting impulsively. Initially, all periods of his leave were escorted. These periods of leave appeared to pass without incident and latterly, when MS was permitted unescorted leave, he did return to the hospital.
- 16.51 In addition, following his discharge from his Section 2 by the Mental Health Review Tribunal on 23 February 2015, MS remained an informal patient at the hospital, had unescorted leave and essentially went out during the day to work.

16.52 It is clear that Trainee Psychiatrist 2 regarded MS's admission on 31 January 2015 as being a manic episode where MS was experiencing elevated mood. He appears to have placed some reliance on the fact that MS had remained in hospital as a voluntary patient. During this period MS was a voluntary patient. Essentially, he left the hospital in the morning went to work and returned in the evening. This information is relevant information to be taken account of when assessing risk.

16.53 Trainee Psychiatrist 2 has provided the following additional information in this regard:

'It is correct that MS staying on the ward had reduced the risk of absconion and this was part of Trainee Psychiatrist 2's reasoning not to detain, but not excessive reliance, and this grading of the risk of absconion remained high, as documented, hence Trainee Psychiatrist 2's documented contingency plans'.

16.54 However, MS did have a history of absconding from hospital when he was ill, albeit when experiencing a manic episode. On 31 January 2015, following the incident during which he grabbed the steering wheel from his wife, he ran away from hospital towards a busy road and had to be persuaded to return. This incident is recorded at various points in MS's paper records. However, Trainee Psychiatrist 2 had not read and was not aware of this information.

16.55 LYPFT made the following representation to the Independent Investigation Team in this regard

'LYPFT's understanding is that there was only one occasion when MS absconded from hospital being 31 January 2015. As such LYPFT reject the contention that MS had a history of absconding. Furthermore, as far as that episode is concerned, MS was persuaded to return to the hospital without difficulty'.

16.56 The Independent Investigation Team considers that this historical data is relevant insofar as it documents the risk of acting impulsively when MS is psychotic. Whether 'history' is defined as one instance or several, the salient point is that there was evidence of a *pre-existing propensity* for such behaviour, in the opinion of the Independent Investigation Team, this is highly relevant to the evaluation of risk.

16.57 A Discharge Summary of MS's admission on between 10 February 2015 and 16 March 2015 states:

'Initially he was referred by GP in Out of hours York. Had presented there with ... his wife. Stressed and appearing Hypermanic. Agitated and attempted to leave but GP persuaded him to return.

...started to walk as if to leave the cubicle but with encouragement remained inside'.

16.58 LYPFT have submitted the following opinion to the Independent Investigation Team:

'LYPFT reject the inference that the events of the 31 January 2015 acquire a greater significance than in fact is the case. It is a further example of hindsight bias. Furthermore, when one looks at the plan made following the ALPS assessment on 10 April 2015, it is clear that absconding was recognised and the plan to address this covering the frequency of observations and the possible use of Section 5(2) if MS did abscond'.

16.59 Trainee Psychiatrist 2 did not have access to this Discharge Summary (see Paragraph 16.6 above). Equally, this information is not included in any risk assessments which were undertaken in the period following his admission to hospital on 31 January 2015. The Independent Investigation Team's concerns about this are more fully presented in chapter 11.

Comment Nine:

The loss of clinically significant information:

With the benefit of hindsight, it is clear that the information concerning the immediate events leading up to MS's admission on 31 January 2015 were of clinical significance. However, this information became 'lost' in MS's paper records, both as a result of information being retained in paper format, but also because this information was not 'captured' in a comprehensive risk assessment maintained in an electronic format.

MS's attempt to leave the hospital on 31 January 2015 was potentially relevant to the issue of the 'least restrictive option' when considering whether MS should be detained in hospital using the Mental Health Act 1983. It was also directly relevant to the practical arrangements which were to be put in place concerning MS's transport to Bootham Park Hospital.

The question of MS's consent to admission to hospital:

The Independent Investigation Team believes that a significant question exists about whether MS did in fact provide a valid consent to admission to hospital. As a result, the decision not to initiate the assessment process which could potentially have led to a formal detention is a matter of concern. It also represents a missed opportunity to involve a team of professionals, including an Approved Mental Health Professional 'AMHP' in MS's care.

MS was admitted to hospital as an emergency patient following a significant suicide attempt and was assessed on 8 and 10 April 2015 as being at high risk to himself. MS's medical notes included instructions that should he try to leave the hospital, he should be detained under nurses' and/or doctors' holding powers for assessment under the Mental Health Act.

There is a legal difference between a voluntary patient and one who has been detained under the provisions of the Mental Health Act 1983. This difference should not be exaggerated in that the difference between MS and that of a detained psychiatric patient was one of form and not substance.

However, the difference in status in this case appears to have caused significant confusion for non-mental health trained staff. It also deprived MS of the structure and safeguards which are contained in the Mental Health Act 1983: Code of Practice.

17 PLAN TO TRANSFER MS TO BOOTHAM PARK HOSPITAL:

17.1 The plan to transfer MS:

17.2 Trainee Psychiatrist 2 had correctly identified that MS required admission to a psychiatric hospital.

17.3 A bed was found for MS at Bootham Park Hospital. In order to transfer MS from one clinical environment to another, a 'handover' of care would have to be affected.

17.4 The complexity of healthcare means that maintaining the continuity of patient care is a challenging process, particularly when patients are being transferred from one clinical environment to another.

17.5 Trainee Psychiatrist 2 produced the following plan in relation to MS's ongoing care, which included:

'2.Risk assessment discussed with ward staff at 84.

'a Not to be discharged...

'b Should not leave ward unaccompanied

'c Should be checked regularly by nursing staff e.g. 15-30 minutes

'd Be alert to access to potential implements to harm self e.g cutlery

'e If attempts to leave very high risk to self – consider section 5(2) security Police etc as required

'3 Offer lorazepam 1mg PRN for agitation'.

17.6 Clinical handovers:

17.7 The Independent Investigation Team has defined clinical handover as;

'the transfer of professional responsibility and accountability for some or all aspects of care for a patient to another person or professional group, whether on a temporary or permanent basis'.

17.8 Providing a good handover requires a number of elements to be in place. These include leadership and protected time. It also includes good communication.

17.9 The handover in MS's case:

17.10 Notwithstanding the fact that the plan set out at paragraph 17.5 does not address any issues which MS might have posed in relation to the period of time which MS would inevitably spend in a vehicle as part of his transfer to hospital, the plan does highlight a concern for the Independent Investigation Team.

17.11 The plan which has been written is one which would, to a mental health practitioner, be relatively clear. However, the plan was not to be implemented by mental health practitioners. It was to be actioned by nurses

and potentially clinicians without specific training in mental health. In addition, Trainee Psychiatrist 2 has provided the following information to the Independent Investigation Team:

'Trainee Psychiatrist 2 had no knowledge of the options of equipment or staffing in different types of ambulances and did not know there were different options. This lack of knowledge was in common with his more senior colleagues. He had made contingency plans for the risks that he had considered significant, which he documented and passed on to the nurses.'

- 17.12 Given that MS was being cared for on a surgical ward, he did not have the benefit of specialist psychiatric nursing. Trainee Psychiatrist 2 has put forward the following explanation of the plan which he had recommended be implemented;

'Clearly Trainee Psychiatrist 2 had no control over the fact that MS was on a medical ward and not a psychiatric ward. The handwritten plan that was available to the general nurses was as clear as Trainee Psychiatrist 2 could possibly make it. It stated that MS "must not be discharged or leave ward unaccompanied due to suicide risk – if absconds consider: Section 5(2), security, Police as appropriate". Whilst it is possible that the general nurses would not have understood the reference to Section 5(2) of the MHA, it was very clear that they should call security and/or Police if he was attempting to abscond the ward. He was not expecting them to continually assess and monitor MS's mental state.'

- 17.13 In addition, Trainee Psychiatrist 2 states that he spoke to the nurses as well as putting a clear management plan in the records. He explained to them that MS was a suicide risk. He explained to the staff that if MS tried to leave unaccompanied, then they should stop him due to the risk of suicide and that this could entail the use of security or police or Section 5(2) of the Mental Health Act.

- 17.14 Trainee Psychiatrist 2 has stated that the general nurses, would have been aware how to access mental health support if needed via ALPS by telephone. ALPS are geographically approximately 5 minutes from the ward where MS was being cared for.

- 17.15 In addition, LYPFT has made the following representation:

'LYPFT would submit that Trainee Psychiatrist 2 took all reasonable and necessary steps to convey his plan of care for MS. If there were any uncertainties on the part of staff within Ward J84 it would have been open to them to have sought clarification at the time of the discussion with the locum consultant psychiatrist or subsequently if on review of the notes matters were unclear contact could have been made with Trainee Psychiatrist 2 or the liaison psychiatry team generally.'

17.16 The Independent Investigation Team's evaluation of this plan:

17.17 In the opinion of the Independent Investigation Team, it was unreasonable to expect general nurses to have the expertise to assess and monitor MS's mental state. MS was an individual who was clearly in a depressive relapse and there is information about how risky and unpredictable he could be when relapsed.

17.18 Evidence provided on behalf of Trainee Psychiatrist 2 during the course of the Independent Investigation provided the following information concerning the rationale for the level of observations suggested by Trainee Psychiatrist 2:

'Trainee Psychiatrist 2 had judged the significant risk to be of absconsion and subsequent suicide and set the observations to 15-30 mins to ensure his presence on the ward – he would have needed to pass the nursing station to abscond and would have been seen. Trainee Psychiatrist 2 did not want to put him on constant observations at this time as he felt it would damage the therapeutic engagement with him and his dignity, given that he was agreeing to informal admission. As another factor, Trainee Psychiatrist 2 was aware that he had not attempted to abscond from the ward over the previous few days, despite having ample opportunity to do so. Finally, MS was moving slowly and painfully due to his chest injury, which again reduced the probability of a rapid absconsion'.

'The plan for constant observations once MS arrived at the receiving hospital was to reflect the lack of knowledge about the environment he was going to be admitted into. Trainee Psychiatrist 2 did not even know which hospital it was going to be at this stage'.

17.19 This position would seem to contradict the fact that the psychiatric assessment documented a severe depressive episode with psychosis, that there was a serious risk of suicide, and that it was possible MS would act impulsively. The plan developed included an acknowledgement that it was difficult to predict short-term risk but suggested 15-30-minute observations and minimising access to items that might be used for self-harm (e.g. cutlery).

17.20 The plan produced by Trainee Psychiatrist 2, whilst identifying risk, contained little in the way of formulating or supporting a care plan in the acute ward or indeed the ambulance to address that risk. The plan which was formulated could have been helpful for experienced mental health practitioners, but in terms of supporting colleagues without mental health training, it did not include sufficient practical assistance or support.

17.21 In addition, the plan makes no reference to the logistics of the transfer process itself. Representations made on behalf of Trainee Psychiatrist 2 state that:

'Whilst it is factually correct that Trainee Psychiatrist 2's written plan made

no reference to the transfer process, as mentioned above, Trainee Psychiatrist 2 did speak to a nurse about the transfer process in the afternoon and explained that he had never had any experience of this in the past and did not know the different options, but that whatever transfer option was chosen, it should take account of the risks that he had identified.

Even if a Mental Health Nurse had been present, they would not have been asking them to observe MS's mental health. The purpose of any "observations" was only to confirm his presence on the ward and to ensure that he did not go past the nurses' station without being observed'.

Comment Ten:

One of the key aims of the ALPS service in its Annual Review conducted in 2014/5 was stated to be:

'to provide a resource to general hospital colleagues for information and advice on mental health issues'.

The Independent Investigation Team is therefore concerned to note an apparent lack of recognition on the part of Trainee Psychiatrist 2 of the fact that those implementing their plan would not have the benefit of mental health training.

Deficiencies in the plan for MS's transfer:

This is best illustrated in three key respects.

Firstly, the plan refers to the need for observations to be carried out on MS every 15-30 minutes. However, the behaviours which were to be observed were not set out in the plan. This information could have provided a degree of guidance and support for the nurses on the acute ward who, in the absence of instructions, reached their own conclusions about the clinical significance of MS's behaviours. Crucially, they interpreted MS's 'quietness' as a positive feature which potentially reduced his level of risk. A similar plan implemented by a mental health nurse may have resulted in a different conclusion having been reached.

Secondly, it is important that staff know who, if anyone, could exercise section 5(2) powers of detention, so that there is neither uncertainty nor error in the event of an emergency or a crisis. It is not clear whether any doctors were available on the ward to exercise the power to hold MS in accordance with section 5(2) on 10 April 2015. This was not addressed in Trainee Psychiatrist 2's plan.

Section 5(2) is known as the doctor's holding power. A detention under section 5 (2) can only be authorised by the doctor in charge of a patient's treatment or the patient's approved clinician. The doctor in charge of the patient's care at the time (or a doctor nominated by the doctor in charge of the patient's care) must write a report explaining the need for detention and why informal treatment is inappropriate.

A section 5(4) is known as the nurse's holding power. Nurses must be of a 'prescribed class', which means that they should be registered in the area of mental health or learning disabilities nursing. The nurses responsible for MS on the acute ward upon which he was being cared for were not of the 'prescribed class' which would have allowed the exercise of section 5(4).

Thirdly, the Independent Investigation Team understands that when Trainee Psychiatrist 2 was contacted by nurses from the acute ward concerning travel arrangements, they were referred to the FACE risk assessment which had been carried out by Trainee Psychiatrist 2. The FACE risk assessment is a comprehensive document, but it is not one which acute nurses could be expected to be familiar with and to have the knowledge to implement or extract the information which was relevant to MS's transfer.

LYPFT has responded to this criticism in the following terms:

'whilst the LTHT staff were not trained in the management of mental health patients, Ward J84 is a ward that receives patients who in turn require the input of the Liaison Psychiatry Service. As such it would have been open to staff on Ward J84 to have requested further assessments from the Liaison Psychiatric Team'.

As has already been stated, the availability of nurses within the Liaison Psychiatry service was restricted at the time of MS's care which would have potentially impacted upon the service's response to any request made by LTHT staff.

LYPFT have also stated:

'Trainee Psychiatrist 2 was well aware that those implementing the plan would not have the benefit of mental health training but he took all reasonable and necessary steps to ensure his plan was understood and indeed it is of note that neither at the time of conveying that plan verbally was there any suggestion that the nursing staff to whom he conveyed that plan were unclear of the plan nor in terms of subsequent contact with the locum consultant psychiatrist'.

Equally, Trainee Psychiatrist 2 has put forward the following statement of opinion:

'Although the FACE risk assessment is a specialist document, it concludes with a paragraph summary of the risks in this case which are worded extremely unambiguously, with reference to the suicide risk and absconsion risk. A nurse would not need to be a specialist to understand that wording'.

The key skills of a registered mental health nurse differ from a registered general nurse, not that either one is more or less qualified, but the skill base and training of a registered mental health nurse is more focused on interpersonal and communication skills.

For example, listening skills are a key part of a registered mental health nurse's skillset and sometimes the ability to interpret what a patient is trying to say is equally as important as listening to what they are actually saying. Accordingly, subtle differences in MS's presentation which may have not been observed by a general nurse due to a lack of specialist mental health training and which could have triggered a review of Trainee Psychiatrist 2's plan or indeed a request for additional input from ALPS may have not have been recognised.

What is striking for the Independent Investigation Team is that both clinicians appear to have ascribed a significant level of knowledge to their colleagues.

A finding of the Internal Reviews has been the identification of a training need for acute staff in mental health issues. However, there is also a need for training in the ALPS service which highlights the importance of their role in providing knowledge and support for non-mental health trained colleagues such as general nurses working in an acute hospital setting.

It is a fact that the training for mental health nurses and nurses in a general setting is different.

Given that two doctors from Psychiatric Liaison have failed to provide this type of support, the Independent Investigation Team is concerned this could indicate a cultural issue which places emphasis on assessment rather than supporting the patient's overall care if viewed from a longitudinal perspective. However, LYPFT have provided a different perspective upon this concern which is related to *'the significant gap in resources within the team, which required them to prioritise their attention, and the way in which the model of the service had been developed. Following the review of the service and the move towards a new (and significantly better resourced) model, the team have capacity to provide more consistent and regular input to the wards within LTHT'*.

18 TRANSFER PROCESS:

18.1 Prior to MS's transfer:

18.2 Following Trainee Psychiatrist 2's assessment, MS got dressed and sat by his bed, awaiting transfer which occurred at around 19:45. There is no record of any interaction with MS during this time and he was not seen by any mental health professionals prior to his transfer to the care of the ambulance crew. LYPFT have submitted the following representation on this point:

'There was no expectation that transfer would be delayed until around 19.45 hours. Furthermore there was nothing in MS's presentation in the intervening period that would have given rise to need for a review by mental health professionals and lastly, if there had been any concern it would have been open to the LTH staff on the ward to have requested a further assessment by a mental health professional.'

18.3 The booking process which was applied to MS's transfer was complex. Evidence given to the Independent Investigation Team suggests that it was largely developed between ERS Medical (SRCL Group Company) and LTHT. LYPFT were not a party to the contractual arrangements between LTHT and ERS Medical (SRCL Group Company).

18.4 ERS Medical (SRCL Group Company) has provided the Independent Investigation Team with their description of the manner in which MS's transfer was arranged:

'At the time of the incident only PTS journeys were booked via the electronic Mediworks booking system.

It is key to understanding what occurred to note that had LTHT identified (as perhaps it should have done) that MS's needs and risks could not be managed in a PTS ambulance and with a care assistant crew that they should not have attempted to book his transport via the Mediworks system at all. Those booking the transport should have called the ERS Medical [SRCL Group Company] Secure contract booking line.

It is also then important to appreciate that LTHT populate (and populated) the PTS electronic booking system themselves. LTHT personnel first selected a T1 journey – meaning that the patient was able to mobilise himself and that the journey was suitable for a single ambulance care assistant to undertake the journey alone. In other words the patient could be taken in an ambulance, a car or a taxi with a lone driver.

LTHT then changed the booking to a T2 booking meaning that this was a self-mobilising patient requiring the support of 2 ambulance care assistants once(sic) of whom would drive – the other would be providing support.

Returning to the booking itself. LTHT did not populate the electronic booking with any risk related information.

It was and is unusual for a dispatcher to contact the hospital to enquire further about an electronic booking for a PTS ambulance and crew. In most cases the dispatcher would simply send the ambulance requested. Were it not for the case that the dispatcher first thought that the booked journey for MS could be run jointly in a taxi with another patient – and enquired accordingly – that anyone at ERS Medical [SRCL Group Company] had any awareness that MS may have had more complex needs.

In the final analysis the transport for MS was provided in the ambulance and with the ambulance crew that was booked for him by LTHT’.

- 18.5 The three Internal Investigation Reports have analysed the transcripts of the phone conversations involved in the transfer process. The Independent Investigation Team has reviewed the transcripts and the analysis produced. The purpose of this review was to gain an overall understanding of what went wrong rather than to ascribe individual ‘responsibility’.
- 18.6 It is clear that those making the electronic booking did not convey relevant risk management information in a manner which would have allowed ERS Medical (SRCL Group Company) a better opportunity to advise upon the options which were available regarding an appropriate vehicle for MS. It is also clear that an individual with knowledge of and expertise in mental health was not involved in the booking arrangements. This lack of understanding on the part of the LTHT staff is illustrated by the apparent confusion in relation to the choices which were made regarding MS’s transfer. However, what is also clear is that despite the clear confusion on the part of the LTHT staff and notwithstanding a lack of information required by ERS Medical’s (SRCL Group Company) own processes, the transfer was able to proceed.
- 18.7 Communication between the services involved in MS’s transfer:
- 18.8 Communication is essential if a safe transfer is to be effective in maintaining continuity of care. In order to ensure continuity of care, MS required a method of transportation which addressed his needs to ensure continuity of care.
- 18.9 Given MS’s historic risk profile, including the recognised risk of impulsivity, together with the possibility that the consent which he gave concerning admission may not have been valid, it is the opinion of the Independent Investigation Team that a vehicle should have been sought with a driver and two mental health trained support staff sitting either side of MS. This option was available through ERS Medical (SRCL Group Company). Instead, however, a less secure option was adopted involving non-mental health trained staff. Submissions made on behalf of LYPFT have provided the following observation in this respect:

‘As to the mode of transport that the (Independent Investigation Team) indicate should have been used, they overlook the fact that such a mode of transport was not immediately available within the locality, it would have

required significant logistical arrangements for that vehicle to be made available set against a background where staff at ERS Medical ERS [SRCL Group Company] were evidently content to use the mode of transport that they did.

... this would not have been possible, would have built in additional delays and ultimately the decision that was taken in terms of transfer to a psychiatric hospital being made at around 11am on the morning of 10 April 2015 delayed further.'

- 18.10 The practical problem identified by LYPFT is a further illustration of the need for the specialised knowledge of Trainee Psychiatrist 2, LTHT and ERS Medical (SRCL Group Company) to have acted in a multidisciplinary fashion to have considered this situation from an informed position regarding the risk of impulsivity which MS presented and the impact which a delay would have had on that risk.
- 18.11 In essence, information which should have ensured a safe transfer was not communicated in a manner which allowed a safe transfer to occur.
- 18.12 Analysis of the transcripts of the various calls between the staff in the acute hospital and ERS Medical (SRCL Group Company) shows a 'confused' picture, with information clearly being misunderstood by all concerned at different levels and at different points in the process.
- 18.13 Equally, an important factor is the fact that the participants in MS's transfer were unfamiliar with the process.
- 18.14 Causes for the breakdown in communication during MS's transfer:
- 18.15 The Independent Investigation Team has sought to understand the reasons for the causes of communication failure in this case. No matter how good communication systems are, unfortunately barriers can and do often arise. This may be caused by a number of factors.
- 18.16 In this case, it is clear that each of the three 'specialties' were using language which arose out of their individual understanding. Unfortunately, this set up a 'barrier' as, in effect, three different 'languages' were being spoken. The impact of this was that the meaning of the crucial information which had to be disseminated for safe transfer was lost.
- 18.17 Firstly, whilst similar terminology was being used by those involved in the process, it is clear that the understanding of that terminology, for example, 'risk assessment' and 'sectioned', differed.
- 18.18 Secondly, a significant amount of information concerning MS was sent, some of it contradictory, as it passed through different individuals. Consequently, the recipient lost key information at key points.
- 18.19 A further factor in this case may have been that MS's presentation was not

correctly interpreted by ward staff and therefore when they described his condition as they saw it, they misinterpreted what was actually going on which led to the concerns which Trainee Psychiatrist 2 had becoming 'lost' to some degree.

18.20 The lack of leadership in MS's transfer:

18.21 However, it is the Independent Investigation Team's view that what was lacking in the transfer was leadership. No one took charge of the process and the role and responsibility of each individual participant was not clearly set out or defined.

18.22 Evidence given to the Coroner at MS's Inquest for example, described how internal processes used by ERS Medical (SRCL Group Company) were the subject of 'amendment' by its own staff. In particular, evidence given at Inquest confirmed that ERS Medical (SRCL Group Company) staff had failed to adhere to its own risk assessment. In addition, it was identified that a former Operations Manager with ERS Medical (SRCL Group Company), instructed staff not to undertake the full risk assessment.

18.23 Whilst there were examples where individuals sought clarification, there was no attempt to bring all the information together. In addition, requests for assistance were either misunderstood or aimed at the wrong target. The information transferred to ERS Medical (SRCL Group Company) during the telephone calls was ambiguous at best on the issue of the level of risk presented by MS (*"I don't think so, but you never know"...*), and that ambiguous information was not further interrogated beyond this point to the point of satisfactory resolution. The essence of the matter, in the opinion of the Independent Investigation Team, was that the information which *needed* to change hands, as a result of the work of *both* organisations directly involved in the transfer, did not change hands – insufficient information was sought, and insufficient information was provided.

18.24 Equally, there was a lack of support for non-mental health trained professionals in effecting MS's transfer. This can be illustrated by comments submitted by Trainee Psychiatrist 2 to the Independent Investigation Team.

18.25 In relation to Trainee Psychiatrist 2's discussion with a nurse in the afternoon in relation to travel arrangements, Trainee Psychiatrist 2 states that his instruction to the nurses was that the transfer option should be in line with the risks that he had documented. Trainee Psychiatrist 2 stated that they felt it was therefore reasonable for him to assume that they would pass on that risk assessment to the Ambulance Service so that an adequate vehicle could be chosen.

18.26 Trainee Psychiatrist 2 confirmed that they did think the general nurses would understand what was meant by MS being a high suicide risk, would understand that Trainee Psychiatrist 2's instructions were that MS should not leave the ward, and would understand that they could access mental

health assistance from ALPS if need be, or assistance from security or the police. Trainee Psychiatrist 2 stated that as none of this is specialised instruction, it should have been understandable by those general nurses.

- 18.27 Trainee Psychiatrist 2 stated that their belief that the general nurses would have understood their instructions was based on the 15 months' experience that Trainee Psychiatrist 2 had at that time working in Leeds Hospital. During that time, Trainee Psychiatrist 2 had frequently had cause to ask general nurses to consider Section 5(2) of the Mental Health Act, and security issues. According to Trainee Psychiatrist 2, occasionally, nurses would seek clarification if they did not understand, but most would not.
- 18.28 Trainee Psychiatrist 2 stated that on this occasion, they did not seek any clarification. Trainee Psychiatrist 2 stated that they also have experience of general wards using MHA Section 5(2) on their own initiative before even contacting Liaison Psychiatry.
- 18.29 As an example of how leadership and clarity could have been improved, the Mental Health Act 1983: Code of Practice contains guidance that health professionals should follow when detaining and treating people under the Mental Health Act. A revised and updated Code of Practice came into force on 1 April 2015.
- 18.30 The Code of Practice lists 'guiding principles' that mental health professionals must consider when they take a decision to detain and treat someone under the Mental Health Act. It also contains guidance for clinicians and others about how patients should be transported. The Code is clear about who holds responsibility for what in relation to the transfer of detained patients. This clarity and clearly defined framework was lacking in the transfer of MS.
- 18.31 The Code of Practice did not apply to the transfer of MS because he was not under a formal section. The information provided to the Independent Investigation Team appears to suggest that the only written protocol or process relating to the transfer of psychiatric patients was the contract between ERS Medical (SRCL Group Company) and LTHT. ERS Medical (SRCL Group Company) has provided the following explanation of this contract.

'The PTS contract was drafted by or for LTHT. They specified its provisions including the type of ambulances and the level of training required by the crew. They were seeking (and secured) a general 'taxi style' commoditised service for PTS transfers.

LTHT exercised (and exercise) significant control over this PTS provision.

Uniquely in ERS Medical's [SRCL Group Company] experience for PTS provision LTHT made the bookings themselves electronically – without any contact or intervention from ERS Medical [SRCL Group Company]. LTHT took to themselves the responsibility of populating the electronic booking

system with all relevant information. This PTS contract did not (and does not) contain a provision entitling ERS Medical [SRCL Group Company] to evaluate, question or refuse to provide the requested transport.

As both the electronic booking audit and the chain of telephone communication demonstrate ERS Medical [SRCL Group Company] did not know what it did not know. All the relevant risk management information either was held by LTHT or should have been available to it. Under the PTS arrangement ERS Medical [SRCL Group Company] was wholly dependent on LTHT providing that information to it.

...it now came down solely to a matter of chance that ERS Medical [SRCL Group Company] would discover that the risk management arrangements for MS were insufficient.... But for the chance conversation between the ERS Medical [SRCL Group Company] dispatcher and the LTHT CSM as to whether two patients could travel together it is highly likely that the ordered PTS ambulance would have simply been provided.'

18.32 LYPFT have provided the following representation:

'it is unreasonable to have expected medical and nursing staff at the frontline to have practical knowledge of the modes of transport available. These matters rested with ERS Medical [SRCL Group Company] and the expectation is that ERS Medical [SRCL Group Company] should have conducted sufficient enquiries and undertaken sufficient risk assessments to satisfy itself.'

18.33 In fact, as ERS Medical (SRCL Group Company) has pointed out, there was an option available for the secure transport of mental health patients;

'The commoditised arrangements for PTS transport where risk identification and risk management arrangements were predominantly under the control of LTHT needs to be contrasted with the arrangements that would have been followed under the secure contract.

The secure contract is bespoke service where those booking the transport discuss with the secure mental health team at ERS Medical [SRCL Group Company] the needs of the patient and the relevant risk management arrangements. This bespoke service is necessarily much more costly and takes significantly more time to arrange'.

18.34 LYPFT have also submitted that;

'the reality of the situation was that ERS Medical [SRCL Group Company] failed to undertake the risk assessments that they should have, the reasons for its failures are a cause of concern in so far as their governance processes are concerned and that ERS Medical [SRCL Group Company] armed with the information that they did have coupled with undertaking the risk assessment that they should have undertaken, would have led to them being in a much better position to determine the most appropriate type of ambulance in which to convey MS.'

- 18.35 In turn, ERS Medical (SRCL Group Company) has accepted that *'recognising that a risk assessment was now required that its arrangements for ensuring an effective assessment of the risks posed regarding MS's transfer were inadequate'*. However, ERS Medical (SRCL Group Company) has also stated *'The point also needs to be made that the information provided to ERS Medical (SRCL Group Company) by LTHT was also seriously deficient in that process'*.
- 18.36 The Independent Investigation Team have included this divergence of views by way of illustration of how opaque the system which operated at the time of MS's care was and as a result was inherently unsafe due to the lack of clarity surrounding who was responsible for what and when.

Comment Eleven:

Essentially, what was missing in relation to MS's transfer was a degree of leadership and an understanding upon the part of all those concerned that they formed part of a chain of successive handovers.

Clearly, clinicians were very concerned about MS and had a good understanding of his presentation and the significant risk that he posed to himself, notwithstanding that clinically significant information was missing from risk assessments which were available to clinicians.

Equally, vehicles which could have transported MS safely were operated by ERS Medical (SRCL Group Company). However, ERS Medical (SRCL Group Company) did not receive the necessary information to ensure that an appropriate vehicle and staff were allocated.

All those involved in the transfer admitted to being unfamiliar with the process. The process lacked overall leadership as roles and responsibilities were unclear.

Shortly after the death of MS, LTHT and ERS Medical (SRCL Group Company) revised the arrangements for transporting mental health patients. Interim arrangements were introduced in July 2015. Those arrangements are the subject of regular review.

The revised arrangements include an obligation for LTHT and LYPFT to conduct a patient specific transport risk assessment. This obligation is supported by an operational procedure and checklist completed by the staff caring for the patient at ward level.

The procedure requires that the transport risk assessment be undertaken by the mental health professional who has assessed the patient.

The transport booking made with ERS Medical (SRCL Group Company) is now made by telephone. ERS Medical (SRCL Group Company) checks that the risk assessment is complete and books the journey with staffing as defined in the risk assessment. ERS Medical (SRCL Group Company) has an opportunity to challenge the risk assessment, as needs be.

The crew performing the transfer also have an opportunity to question the risk assessment and as needs be may decline the transfer if they identify risks which are not properly managed in their view.

Additionally, since the incident ERS Medical (SRCL Group Company) has revised their mental health transport risk assessment tool. Undue reliance upon whether a patient was 'sectioned' when determining risks and healthcare needs has also been addressed. Where a mental health patient is set to travel ERS Medical (SRCL Group Company) now checks whether the patient is 'sectioned' or could or would be sectioned had the patient not voluntarily consented to his or her treatment, assessment or transport.

A 'Standard Operating Procedure for the safe conveying of patients with mental health needs from Leeds Teaching Hospitals NHS Trust (LTHT) to a mental health in patient unit' has been introduced. The purpose of this document is to provide clear guidance to clinical staff within both organisations when making transport arrangements; taking into full consideration any risks factors evident in the individual's presentation. This represents a significant improvement in practice.

The improved procedure allows for a Transport Plan to be formulated. This is a significant improvement in practice. The LYPFT Clinician completing the Transport Plan must do so in consultation with the medical and nursing staff involved in the patient's care.

However, the Independent Investigation Team remains concerned that whilst there is an increased degree of multidisciplinary working between LYPFT and LTHT regarding patient transfer, there remains a 'gap' in that the specialist knowledge which ERS Medical (SRCL Group Company) has is not captured at the time of assessment. It is not clear how the 'gap' in the knowledge of the options for transport highlighted by the evidence given by Trainee Psychiatrist 2 have been addressed.

19. PATIENT EXPERIENCE

19.1 MS's physical treatment:

19.2 MS's injuries were sufficiently serious to require treatment on a surgical ward. Indeed, MS required a chest drain as part of his treatment for his physical injuries.

19.3 It is not clear how busy the ward was or indeed what its level of staffing during MS's admission was. Evidence given at the time of the Inquest into MS's death suggest that a maximum of 4 nurses were on duty on 10 April 2015 and that MS did have a named nurse assigned to his care. MS was being cared for in a bay with others and was relatively visible to staff from the nursing office.

19.4 On 10 April 2015, MS's chest drains were removed, and a chest x-ray was conducted after Trainee Psychiatrist 2 saw MS.

19.5 Nurses who gave evidence at MS's Inquest explained that largely they had received no mental health training. It has been reported that MS was quiet and subdued throughout his time on the ward. However, the amount of contact he had with staff, other than during necessary interventions in respect of his physical care, was not clear.

19.6 MS's experience as a patient:

19.7 What is missing from the report is detail concerning MS's experience as a patient.

19.8 As a result of this detail being missing, it is difficult to determine whether any learning could be obtained from this aspect of MS's care. Surgical wards may seem 'remote and clinical' to patients who may not have experience or knowledge of life on such a ward. Potentially therefore, there is scope for misinterpretation by someone suffering from mental health problems as disapproval or disinterest in them as individuals. Restrictions imposed by ward regimes may cause some to feel that they have had to hand control of aspects of their life to the ward staff.

19.9 A number of factors could potentially reinforce the negative feelings of patients with mental health problems on an acute ward such as Ward 84. Research suggests that a significant proportion of people who harm themselves have low self-esteem⁴, and conditions that ward staff view as normal, may exacerbate the problems of such patients⁵.

19.10 It is unclear what level of privacy MS had on the ward. This is important because lack of privacy may lead to individuals being reluctant to be candid

3. Favazza, A. (1989) *Why patients mutilate themselves*. *Hospital and Community Psychiatry*, **40**, 137–145.

4. Pembroke, L. (1991) *Surviving psychiatry*. *Nursing Times*, **87**(49), 30–32.

about their worries and problems due to fears about being overheard for example. This may have been a factor in relation to MS's acceptance of his medication.

Comment Twelve:

It is not clear how privacy was achieved for MS, nor indeed whether this need was in fact recognised.

The 'public' nature of a surgical ward round may be a source of concern for patients and make them feel that their problems are being aired for all to hear.

This issue was not explored in the Internal Investigation Reports.

It is clear from the evidence that MS was able to consult with Trainee Psychiatrist 2 in a side room which is an element of good practice.

However, MS's medical records refer to him spending at least some of his time in a four-bed bay, which may have impacted upon his willingness to discuss confidential matters.

20. ANALYSIS OF THE INTERNAL INVESTIGATION REPORTS:

- 20.1 The Independent Investigation Team is conscious of the ease with which 'hindsight bias' can enter into perceptions of events after the fact, and this has been borne in mind when reviewing the internal investigations.
- 20.2 Positive aspects of the three investigations:
- 20.3 The Independent Investigation Team acknowledges that there were positives to be taken from all three internal investigations;
- All three were comprehensive in their scope; and,
 - All three drew valid learning; and
 - Recommendations were made which could impact positively upon practice with a view to delivering a better level of service to an individual such as MS; and,
 - Learning from each of the internal investigations had been implemented prior to the conclusion of the internal investigations.
- 20.4 A detailed analysis of the three Internal Reports has been conducted and is attached at Appendix 6. This includes analysis of;
- i. the terms of reference;
 - ii. the methodology employed;
 - iii. the timeliness of the investigation;
 - iv. liaison with MS's family;
 - v. recommendations and action plan.
- 20.5 All three organisations adopted a structured approach towards investigation of MS's death.
- 20.6 ERS (SRCL Group Company) was able to share a very detailed draft of their report with LS at an earlier stage than the other organisations, which was an element of good practice, as was the detail and depth of the investigation performed by ERS (SRCL Group Company).
- 20.7 Omissions in the learning highlighted by the three investigations:
- 20.8 Whilst the Independent Investigation Team acknowledges that the schedule attached at Appendix 6 depicts elements of good, and indeed, 'best' investigative practice, there are some significant omissions in the learning highlighted by all three Internal Investigations in relation to MS's care.
- 20.9 In order to exploit the learning derived from these investigations, and implement appropriate action plans, the Independent Investigation Team is of the view that the three organisations would have had to come together and work across organisational boundaries to understand and identify that learning.

20.10 There is evidence that this did happen to some degree. For example, in the methodology section of LYPFT report it states:

'This investigation has occurred in parallel with (but separately from) two other investigations, which have been conducted by Leeds Teaching Hospitals NHS Trust and ERS Medical [SRCL Group Company], the patient transport service provider...

...I have also had the opportunity to share some information and receive specific advice on the physical healthcare aspects of MS's care at LTHT with ... the lead investigator for the LTHT review.'

20.11 LYPFT have informed the Independent Investigation Team that LYPFT and LTHT investigators interviewed key witnesses jointly and shared draft findings and recommendations.

20.12 In addition, the LTHT Investigation Report states;

'The investigation additionally called on the experience of the co-investigator, who had worked for many years as a Clinical Site Manager, and has received advice on mental health issues from the lead investigator for LYPFT.'

20.13 LYPFT has submitted the following representation to the Independent Investigation Team in this regard:

'LYPFT and LTH investigators did work together. For example, the respective investigators for those organisations, interviewed key witnesses jointly and shared draft findings and recommendations.'

20.14 However, representations received from parties during the course of the Independent Investigation reveal significant differences between the parties in their respective desires to work together, and instead appear to have concentrated upon apportioning 'blame', rather than being open to learning in relation to MS's care. For example, LYPFT have made the following representations during the course of the Independent Investigation;

'whilst the LTHT staff were not trained in the management of mental health patients, Ward J84 is a ward that receives patients who in turn require the input of the Liaison Psychiatry Service. As such it would have been open to staff on Ward J84 to have requested further assessments from the Liaison Psychiatric Team...

...LYPFT would submit that it is perhaps unsurprising that clinical or nursing staff would have had any experience of being involved in the practicalities of arranging patient transfers because these are matters that are within the sole province of ERS Medical [SRCL Group Company]. Put bluntly clinical and nursing staff would not be expected to have knowledge and involvement in such matters. It is for ERS Medical [SRCL Group Company] to have answered the appropriate questions, undertaken the appropriate

assessments and satisfied itself as to the appropriate mode of transport for MS...

...it is submitted that it is neither the role of clinical psychiatric staff or general nursing staff to provide ERS Medical [SRCL Group Company] who have the necessary knowledge and capabilities with advice to determining the appropriate method of transport'.

20.15 ERS Medical (SRCL Group Company) has stated:

'The PTS contract was drafted by or for LTHT. They specified its provisions including the type of ambulances and the level of training required by the crew. LTHT exercised (and exercise) significant control over this PTS provision.'

20.16 Independent Investigation Team evaluation of the internal reports:

20.17 It is the opinion of the Independent Investigation Team on the evidence made available to it that the three organisations throughout the course of the investigation appear to have been concerned about the legal risk posed to their organisations following the death of MS rather than facilitating learning. It is the view of the Independent Investigation Team that this may have adversely impacted upon collaborative working between the organisations, particularly in the period leading up to the Inquest in relation to MS's death.

20.18 It may also account for the defensive tone which is present within areas of the internal reports and the responses made by the parties to the Independent Investigation. For example, the ERS (SRCL Group Company) Internal Investigation Report deals at some length with the professional responsibilities of LYPFT and LTHT clinicians. The Independent Investigation Team would query the necessity for this unless it were to be used as a vehicle to construct a failsafe within its own policies to accommodate any deficiencies in professional practice. However, it is a finding of the Independent Investigation Team that this did not impact to such an extent that the duty of candour owed by all the organisations was impugned.

20.19 ERS (SRCL Group Company) has made the following representation to the Independent Investigation Team in this regard:

'So far as ERS Medical [SRCL Group Company] is concerned the comments regarding 'legal risk' and defensive tone are unfair and inappropriate ...

ERS Medical [SRCL Group Company] does not accept that its report was in any way defensive in tone – rather it was carefully, and perhaps formal. However, this was appropriate given the other investigations and the wider responsibilities ERS Medical's [SRCL Group Company] management have to the business and its stakeholders. There were significant legal and

business risks to ERS Medical [SRCL Group Company] (and the other parties) that ERS Medical [SRCL Group Company] had to traverse whilst seeking at all times to be candid and transparent.'

20.20 Disadvantages of collaborative working

- 20.21 Whilst the Independent Investigation Team wishes to encourage joint working amongst the organisations providing an individual with care in cases of this nature, the Independent Investigation Team was concerned that LYPFT provided LTHT with advice on mental health issues. In the opinion of the Independent Investigation Team, greater learning could potentially have been achieved for LTHT if advice had been sought from a mental health trust which was uninvolved in the day to day care of MS as this may have led to a more questioning approach.
- 20.22 This could have afforded the review of the mental health services provided by LYPFT to LTHT more 'impartiality', and afforded LTHT a greater understanding of the service which it was being provided by LYPFT. For example, the Independent Investigation Team acknowledges that in order to minimise the impact of repeated questioning upon participants in an adverse incident, an element of 'joint working' can be indicated. However, Trainee Psychiatrist 2 was interviewed by LTHT with his employer, LYPFT being present. This does not accord with good investigative practice.
- 20.23 The Independent Investigation Team notes that Trainee Psychiatrist 1 was not included in the Internal Investigations undertaken by LTHT and LYPFT.
- 20.24 The Independent Investigation Team is of the view that greater consideration should have been given in the internal investigation conducted by LYPFT as to the longitudinal history of MS's risk profile when planning for a relapse of a crisis situation, as on 10 April 2015.
- 20.25 The Independent Investigation Team has highlighted its concern that it would disagree that discharge planning from MS's in patient stay at Bootham Park Hospital was 'robust', not least because risks identified in the discharge letter of 15 April 2015 were not the same as the SAMP risk assessment, and MS was not provided with a detailed crisis plan.
- 20.26 The Independent Investigation Team is disappointed that the issue with MS's discharge summary of 15 April 2015 was not referred to in the internal investigation conducted by LYPFT given the concerns raised by LYPFT staff about lack of information about risk, and which are enumerated upon further at Chapter 14 of this report.
- 20.27 A further concern for the Independent Investigation Team was the omission of any reference to the difficulty which clinicians outside Bootham Park Hospital had in accessing information contained within MS's paper records.

20.28 **Learning identified by Internal Investigation:**

20.29 The transportation 'package' used

20.30 The Independent Investigation Team is of the opinion that the death of MS could have been avoided if MS had been transported in a suitably equipped ambulance with a suitably trained crew which accommodated the risk which he presented.

20.31 This is a conclusion reflected in all three internal reports. In addition, the Coroner at the Inquest into MS's death stated;
'It is clear that the transport and personnel allocated were not appropriate with MS's condition'.

20.32 It is clear to the Independent Investigation Team that transport options were available which could have accommodated the level of risk which MS posed.

20.33 Lack of organisational understanding

20.34 In addition, all three organisations identified a further problem at the core of MS's care;

'A consideration of the ward sister's conversation with the ERS Medical [SRCL Group Company] mental health call handler perhaps demonstrates a mutual lack of understanding of their respective organisations needs and expectations and perhaps an all too understandable willingness on both sides for this patient transfer to take place'.

20.35 Consequently, if MS was to be transported to hospital in a vehicle which met his needs, then all three organisations would have had to have acted differently.

20.36 Failure to meet mental health care needs

20.37 The Independent Investigation Team has recognised that were it not for his physical injuries on 7 April 2015, it is likely that MS would have been admitted to a psychiatric hospital. However, it is clear to the Independent Investigation Team that MS did not receive care whilst on the acute ward which met both his physical and mental health needs.

20.38 The LYPFT and LTHT internal reports identified difficulties with the model of service in place at the time of MS's care with regard to the ALPS service. Essentially, the ALPS service does not appear to have been integrated into the overall care which MS received, with his physical and mental health care needs being delivered separately.

20.39 Omissions from learning lack of leadership in the transfer process

20.40 In addition, on the evidence afforded it, the Independent Investigation Team is of the opinion that the investigations did not identify the overall lack of

leadership in relation to MS's care. This was particularly striking in relation to the manner in which travel was arranged for MS. Three organisations, each providing different aspects of care were involved. However, there was a lack of understanding between those organisations that they were in fact providing different limbs of the *same service* due to the fact that all three services were populated by individuals who, at key points in the timeline concerning the organisation of MS's transfer to hospital, appeared to the Independent Investigation Team to be unfamiliar with the process, both from the point of view of their own organisation, but also in relation to the role of the other organisations.

- 20.41 In response to this opinion, ERS Medical made the following representation to the Independent Investigation Team:

'The suggestion that ERS Medical [SRCL Group Company] was unfamiliar with its own service – in the context of PTS Ambulance provision and a request for a PTS Ambulance is not considered correct.

Perhaps reference again needs to be made to the contracts, in particular that there were 2 separate contracts, run and managed separately, one for PTS ambulance services, the other for mental health provision.

Had those booking the ambulance services understood the mental health risks and sought to book a suitably equipped mental health ambulance and crew this incident, almost certainly, would not have happened.'

- 20.42 The representation raises the question as to how staff at LYPFT and LTHT were made aware of the complexity of the contractual arrangements relating to the provision of an ambulance service by ERS Medical [SRCL Group Company] and the responsibilities which they had as a result. It also highlights the need for leadership within the process and the lack of clarity about the expectations of who was responsible for what. Equally, it does not address the issue that, despite deficiencies in the information required by ERS Medical's [SRCL Group Company] own processes, the transfer of MS was still allowed to proceed based upon changes made at management level within ERS Medical [SRCL Group Company] which were not documented.

- 20.43 Whilst the Internal Investigation Team identified a lack of understanding of mental health issues on the part of the acute nursing staff, the investigations failed to recognise a similar lack of understanding on the part of mental health staff as to what they could expect from their 'acute' colleagues.

- 20.44 January 2017 National Confidential Enquiry report:

- 20.45 In order to tackle this problem at a national level, a report entitled '*Treat as One: Bridging the gap between mental and physical healthcare in general*

hospitals', published by the National Confidential Enquiry into Patient Outcome and Death⁶ was published in January 2017. The report states:

'The divide between mental and physical healthcare needs to be reduced. This will require long-term changes in both organisational structures and individual clinical practice to produce a working environment where the mind and body are not approached separately...

...Liaison services by their very name expose the gap in the way the services are commissioned and provided, as they describe a service reaching from one place to another...

...the use of mental health one-to-one observation support needs to be available for patients in a general hospital setting. Organisations should determine whether this occurs via training of their own general hospital staff or by arrangement with the local mental health service. The sole use of security staff or other staff members who are not trained for this purpose must not occur'.

20.46 The report concluded that;

'In order to overcome the divide between mental and physical healthcare, liaison psychiatry services should be fully integrated into general hospitals. The structure and staffing of the liaison psychiatry service should be based on the clinical demand both within working hours and out-of-hours so that they can participate as part of the multidisciplinary team'.

20.47 The report was published after MS received care. However, the problems which were evident in his care are mirrored in the findings of the report. In particular, the Independent Investigation Team's finding that MS did not receive psychiatric care whilst a patient in hospital.

20.48 LYPFT have informed that Independent Investigation Team that they;

'Undertook a full review of the model of Liaison Psychiatry provided across LTHT and, as a result, have developed a number of work streams that are implementing a wide range of changes', which,

'have included the introduction of on-site 'out of hours' specialist practitioners to provide mental health assessment and support to any ward across LTHT; an increase in medical capacity to the liaison service; the development of a revised operational procedure and clinical pathways for the service; a pilot relating to the use of improved Information Technology to improve shared access to timely clinical records; and the development and delivery of a joint training programme for clinical staff across LYPFT and LTHT', and that,

⁶ The report has been compiled by: S Cross MBChB MRCPsych, MD(Res) – Clinical Co-ordinator (Liaison Psychiatry) South London and Maudsley NHS Foundation Trust, V Srivanasta FRCP (Glasg) MD – Clinical Co-ordinator (Acute Medicine) Guy and St Thomas' NHS Foundation Trust, H Shotton PhD – Clinical Researcher, A Butt BSc Psy (Hons) – Researcher, K Protopapa BSc Psy (Hons) – Researcher & M Mason PhD – Chief Executive.

'there is a process of review for the agreed actions within the LYPFT action plan which was produced as part of the internal investigation process. All of the 4 actions identified have been completed, and we are now at the stage of a normal review and revision process for the procedure relating to the safe transportation of patients from LTHT to a mental health unit'.