



**An independent
investigation into the
care and treatment of
Harry Bosomworth by
Leeds and York
Partnership NHS
Foundation Trust and
The Leeds Teaching
Hospitals NHS Trust**

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Author: NICHE

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Niche Health & Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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Niche Health & Social Care Consulting

1 City Approach

Albert Street

Eccles

MANCHESTER

M30 0BG

Telephone: 0161 785 1000

Email: info@nicheconsult.co.uk

Website: www.nicheconsult.co.uk

Contents

- 1 Executive summary 1
 - Mental health history 2
 - Relationship with the victims 2
 - Offence 2
 - Internal investigation 2
 - Independent investigation recommendations 3
 - Recommendations 4
 - Good practice..... 7
- 2. Our independent investigation 8
 - Approach to our investigation..... 8
 - Investigation limitations 11
 - Contact with Ken and Roger’s families 13
 - Contact with Harry’s family..... 13
 - Structure of the report 13
- 3. Summary of the incident and History of Harry 14
 - Personal history 16
 - Care and treatment of Harry from 2013 up to the incident 19
- 4. Arising issues, comment and analysis 26
 - About Schizophrenia and treatment..... 26
 - Harry’s medication 27
 - Consideration of the Deprivation of Liberty safeguards (DoLS), the Mental Capacity Act (MCA) 2005, or detention under the Mental Health Act (MHA) 1983. 29
 - Risk assessment..... 30
 - Safety of others..... 33
 - Should Harry have had a walking stick? 34
 - Staffing..... 35
 - Mental Health Staffing..... 35
 - General Acute Ward Staffing 27/28 February 2015 37
 - Primary care issues 39
 - Bed rails, falls sensors and observations 42
 - Care Delivery problems 46

LTHT not taking account of the knowledge of the next of kin throughout his acute hospital stays.	47
The GP not making a referral to community psychiatric services in June 2014	47
Prescription sheets and administration records not being completed correctly on several occasions	48
Not seeking specialist mental health input quickly.	50
Not considering the use of legislative frameworks	50
Inappropriate use of Lorazepam	51
5. Internal investigation	63
Timeline of the internal investigation	63
Commissioning the internal investigation	64
Development of the terms of reference	65
The internal investigation team	68
The internal investigation terms of reference	69
Review of the investigation	73
Conducting the internal investigation	74
The scope of the internal investigation.....	77
6. Overall analysis and recommendations	96
Predictability and preventability.....	96
Background between 1962 and March 2009.....	103
Care and treatment in Leeds Teaching Hospitals NHS Trust between 11 September 2013 and 28 January 2015.	105

Appendices

1 EXECUTIVE SUMMARY

- 1.1 Harry Bosomworth, a 70-year-old gentleman, attacked and seriously injured Ken Godward and Roger Lamb on ward J19, St James's Hospital, The Leeds Teaching Hospitals NHS Trust (LTHT), on 28 February 2015. All three patients died within 4 months of the incident.
- 1.2 NHS England (North) commissioned Niche Health & Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of Harry Bosomworth, a critical analysis of the externally commissioned investigation of the incident described above, a review of the Trusts' progress against recommendations made following the incident, and a review of their governance and assurance mechanisms to ensure that actions have been embedded in practice. This report covers the first two parts of the terms of reference; we explain the reasons for this later. Niche is a consultancy company specialising in patient safety investigations and reviews. The terms of reference for our investigation are set out in appendix A.
- 1.3 The independent investigation follows the NHS England Serious Incident Framework (March 2015)¹ and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.²
- 1.4 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. It has not been established that there were homicides in this case, however the death of the patients that were attacked were treated as potential homicides by the police. As such this incident was considered by NHS England as serious enough to require an independent investigation.
- 1.5 The underlying aim is to identify common risks and opportunities to improve patient safety and make recommendations for organisational and system learning which could help prevent similar incidents occurring.
- 1.6 We would like to express our condolences to Ken, Roger and Harry's families. It is our sincere wish that this report does not add to their pain and distress and goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of Harry and the events on the night of the attack.

¹ NHS England Serious Incident Framework March 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf>

² Department of Health Guidance ECHR Article 2: investigations into mental health incidents <https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents>

Mental health history

- 1.7 Mr Harry Bosomworth was a 70-year-old gentleman. He is described by his stepdaughter as being a kind man who adored her mother and looked after her mother very well until her death. He was simplistic in his way, but he managed his life perfectly. His daughter told the investigation “he managed my mum; he did all the shopping, all the finances; as long as he didn’t have to bother with new things like technology”.
- 1.8 Harry was diagnosed with schizophrenia in his teenage years and had managed to live safely into his 70’s, with the support of regular medication to control the symptoms of his schizophrenia. Harry’s stepdaughter had come to care about him over the years that he was married to her mother and, because of the strong bond they had, supported him in the last years of his life. A few years ago (11 October 2013), he was diagnosed with oesophageal cancer which meant that he was in and out of hospital for various treatments in 2014/2015. During a hospital stay in February 2015 he attacked and seriously injured two patients on the ward. At the time Harry was an inpatient at LTHT and was in receipt of psychiatric liaison services from Leeds and York Partnership NHS Foundation Trust (LYPT).

Relationship with the victims

- 1.9 Both victims of Harry’s attack were only known to him as fellow patients in the four bedded bay that they all shared on ward J19.

Offence

- 1.10 The attack was investigated by the police but no charges could be brought against Harry because he died before the conclusion of their investigation. Roger’s death certificate states that he died from a fractured hip, caused by blunt force trauma. At the time of writing the report the cause of death of Ken will be confirmed at the Coroner’s inquest scheduled to conclude on or around 17 December 2018.

Internal investigation

- 1.11 LTHT and LYPT jointly developed terms of reference for an internal investigation, and the families of Roger, Ken and Harry were consulted on these. The Trusts then commissioned an independent investigator (the external independent reviewer) to undertake the internal investigation, commencement of which was appropriately delayed due to the police investigation that followed the incident.

We understand that both Trusts were keen to commence the internal investigation and pressed the police for permission to start.

- 1.12 The internal investigation commenced on 9 July 2015. A draft report was completed in mid-February 2016 and the final report was completed on 1 April 2016.
- 1.13 The internal investigation made several system-based recommendations that were appropriate and linked clearly to the findings. However, when we reviewed the internal investigation, we found that the terms of reference were not set appropriately and the investigation did not follow a recognised methodology for incident investigation. It failed to cover all of the aspects of the terms of reference, did not clearly identify all the problems, and left several unanswered questions about the attack and Harry's care and treatment. The draft report was shared with the Commissioners and NHS England who did not raise any concerns regarding the methodology, or that that it failed to cover all of the aspects of the Terms of Reference, and did not clearly identify all the problems and left several unanswered questions.
- 1.14 Additionally, we found that although the Trusts and the external independent reviewer engaged well with the families at the outset of the investigation, once the investigation had been completed the families were left with many unanswered questions. The process of attempting to seek answers to these questions has been unnecessarily distressing for them.

Independent investigation recommendations

- 1.15 The internal investigation made ten recommendations to improve practice which we fully endorse. We have included the recommendations from the internal investigation report in appendix F.
- 1.16 However, we have made a further 21 recommendations which need to be addressed in order to further improve learning from this event. We have made recommendations that either build on, or are different to the recommendations of the internal investigation report.

Recommendations

Recommendation 1

We recommend that LTHT and LYPT work together to ensure that the mental health needs of patients are properly addressed when they are admitted to an acute general ward. We would suggest that mental health, diagnoses and medications are included in the admission information and for people living with schizophrenia that there is a requirement to ensure that the patient's care is discussed at the earliest opportunity within a multi-disciplinary (mental health and general acute) team.

Recommendation 2

We recommend that LTHT and LYPT work together to improve the application of risk assessments and risk management in the acute hospital environment. The work should include training for staff leadership and role modelling from clinical leaders, and regular audit of practice to demonstrate an improvement. Risk assessment and management of mental health patients in the acute hospital environment should be included in the clinical audit programme.

Recommendation 3

We recommend that LTHT issue guidance to staff on general acute wards regarding the criteria to request one-to-one support for patients who are a risk to themselves or others.

Recommendation 4

We recommend that LTHT conduct a review of the case mix and safety of patients on J19 given the severity of violent incidents. This review should be conducted by security management specialists in conjunction with acute nursing staff on the ward and mental health specialists.

Recommendation 5

We recommend that the GP practice review all patients on their list that have a severe and enduring mental health diagnosis to ensure that there are no outstanding referrals to mental health services.

Recommendation 6

We recommend LTHT ensure that the learning regarding listening to families/carers is incorporated into staff training. The essence of this is to ensure that staff understand that carers and family of people with long-standing mental health problems have extremely valuable insight into the risks associated with missed medication.

Recommendation 7

We recommend that LTHT take steps to ensure that the record-keeping in relation to medication prescription and administration is of the required standard. We suggest that this is included in their clinical audit programme.

Recommendation 8

We recommend to LTHT that they take steps to ensure that when patients transfer wards that their records are transferred with them avoiding a delay in receiving staff accessing patient information.

Recommendation 9

We recommend that LTHT take steps to improve the knowledge and understanding of general acute staff in how and when to access specialist mental health input.

Recommendation 10

We recommend that LTHT take steps to improve the practical skills and understanding of general acute ward staff with regards to the use of Deprivation of Liberty Safeguards and the Mental Capacity Act.

Recommendation 11

We recommend that LTHT take steps to ensure that appropriate referral criteria are developed to advise pharmacy staff when they should seek advice from a pharmacist working in specialist mental health services, and a psychiatrist, in the cases of patients with severe and enduring mental illness such as schizophrenia.

Recommendation 12

We recommend that LTHT conduct a risk assessment when vulnerable patients may be in a bay with patients who are aggressive or agitated. We further recommend that LTHT take steps to ensure that where patients are inappropriately placed together that additional staffing is secured to maintain their safety.

Recommendation 13

We recommend that LTHT take steps to review their care planning documentation to ensure that there is an opportunity to describe an overview of the patient's care needs. We further recommend that LTHT include this in their clinical audit programme.

Recommendation 14

We recommend that LTHT ensure that the pharmacy service routinely carry out checks on prescription sheets to identify if patients have had repeated missed doses of the same drug. Where there are repeated missed doses, we recommend that LTHT ensure that pharmacy staff escalate these cases to the consultant and Ward Manager in charge of the patient's care.

Recommendation 15

We recommend that LTHT take steps to ensure that when patients are given intramuscular medication to calm them and to reduce an episode of aggression or disturbed behaviour, a plan is made to effectively look after them and maintain their safety when the medication effect wears off.

Recommendation 16

We recommend that LTHT and LYPT work together to ensure that there is clarity about where decisions regarding patients who are being treated by both Trusts are recorded. Furthermore, we recommend that both Trusts adjust their healthcare records policies accordingly.

Recommendation 17 – regarding future investigations at level 2.

We recommend to both Trusts and Commissioners that:

- a) Terms of reference documents include a version control and date by which they are finally agreed.
- b) We recommend that in future investigation reports the exact wording from the finally agreed terms of reference are included in the final report to ensure there is no doubt as to what they should cover. This should be included in internal investigation protocols for both Trusts and in the closure checklist process for Commissioners.
- c) Internal investigations are focused on the incident itself, not just the care and treatment of one patient.
- d) If families identify issues during the investigation that they wish to be addressed, that are not covered within the terms of reference, that the investigator requests a review of the terms of reference by the commissioner of the investigation. This should then consider if the families concerns and questions are adequately explained within the terms of reference, and if not expand them to cover the issues and identify any extra resources that are required and made available to the investigation team
- e) Complex Level 2 investigations are conducted with an investigation team (of more than one person) that comprises professionals with expertise in investigation techniques and specialist knowledge in the clinical areas to be investigated
- f) Future terms of reference for provider led investigations specify the level of investigation to be carried out and describe the incident to be investigated. To assist in clarity, terms of reference should include the date, location and a brief description of the incident and outcome.
- g) Future terms of reference must include the investigation methodology that the investigation team are expected to follow, and that this should be consistent with national guidance in place at the time.

Recommendation 18

We recommend that LTHT and LYPT consider how best to ensure that all learning from the incident that occurred on 28 February 2015 is captured. It would be appropriate to enlist the advice and support of the NHS England (North) Serious Incident team to do this.

Recommendation 19

We recommend that LTHT and LYPT report their progress on the above recommendation to the Local Safeguarding Adults Board, to ensure openness and to share learning. This is because this incident has wider safeguarding implications than within the local CCG.

Recommendation 20

We recommend that LTHT provide Ken's and Roger's families with a summary of the information contained in the statements that have been submitted to the Coroner which details their loved ones care and treatment.

Recommendation 21

We recommend that LTHT offer to meet with the families to address their unanswered questions and discuss changes that have been made following this incident, including:

- how staffing levels are calculated and delivered on medical wards; and,
- how safeguarding is practised and how the safety and security of staff and patients is supported on medical wards.

Good practice

- 1.17 The decision of the Trusts to commission the internal investigation from an independent person was commendable.
- 1.18 The external independent reviewer spent several days on ward J19 interviewing staff, observing practice, and discussing issues with the senior ward sister to understand how the ward operated.
- 1.19 On the 22 February 2015 the mental health liaison nurse assessing Harry contacted his stepdaughter for further information about the concerns that she had raised with staff in relation to his medication and in particular his olanzapine. The statement from the senior clinical nurse stated that it was standard practice to obtain and double check information in relation to a patient with a member of their family. We view this as good practice that we do not always see elsewhere.
- 1.20 The pharmacy team performed beyond LTHT standards in their efforts to confirm that Harry was taking his medication between 28 January 2015, when Harry was

admitted to ward J96, and 12 February 2015 when he was discharged to Corinthian House Care Home.

2. OUR INDEPENDENT INVESTIGATION

Approach to our investigation

- 2.1 This independent investigation follows the NHS England Serious Incident Framework (March 2015)³ and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services⁴. The terms of reference for our investigation are set out in appendix A.
- 2.2 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. It has not been established that there were homicides in this case, however, the death of the patients that were attacked were treated as potential homicides by the police. As such this incident was considered by NHS England as serious enough to require an independent investigation.
- 2.3 The investigation process should identify areas where improvements to services might be required which could help prevent similar incidents occurring. In particular, this independent investigation was asked to review the adequacy of the internal investigation (terms of reference point number 3) and to determine if there were any additional key lines of enquiry that would warrant further investigation. The overall aim of any investigation process is to identify common risks and opportunities to improve patient safety and make recommendations about organisational and system learning.
- 2.4 NHS England (North) requested that we review the care and treatment of Harry. We are aware that the next of kin for Ken and Roger have also requested a review of their loved ones' care. We have not been able to review the care of Ken and Roger as part of our investigation; we explain this later in our report, however, we hope that our report goes some way to answering the outstanding questions that Ken and Roger's family have. It is our understanding that a review of Ken's and Roger's care has not been shared with the families to date. We discuss this later in the report and have made recommendations regarding this.
- 2.5 The terms of reference ask us to review and assess compliance with local polices, national guidance and relevant statutory obligations (point number 11). Where we have reviewed local guidance, we have referred to this in the text.

³ NHS England Serious Incident Framework March 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-frmwrk-upd.pdf>

⁴ Department of Health Guidance ECHR Article 2: investigations into mental health incidents <https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents>

Where we have considered other guidance, we have referenced this in the text and added a foot note for the publication we refer to.

- 2.6 NHS England (North) requested that we review the actions that both Trusts have taken following the completion of the internal independent investigation. These issues are covered in point numbers 12, 13 and 14 of the terms of reference included in appendix A but will be covered in a separate report at a date to be confirmed. We have agreed this course of action with NHS England (North) prior to the production of this report and have discussed this further in the section below entitled investigation limitations. We have annotated appendix A to show which aspects of the terms of reference we have not been able to examine and therefore are not addressed by the report.
- 2.7 The investigation was carried out by Chrissie Cooke and Sue Denby for Niche, with expert advice provided by Dr Susan Benbow, consultant psychiatrist, and David Taylor, specialist pharmacist (mental health). Our investigation team will be referred to in the first person in the report. The report was peer reviewed by Nick Moor, Partner, Investigations & Reviews and Emma Foreman, Associate Director, Niche.
- 2.8 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance “Independent Investigations of Serious Patient Safety Incidents in Mental Health Services”.⁵
- 2.9 In order to review the care and treatment provided to Harry we reviewed the original internal investigation, care records, supporting information and staff statements from LTHT, staff statements from LYPT, staff statements from Corinthian House Care Home, and statements taken by the West Yorkshire Police. We triangulated this information and sought assurance against the standards outlined in the LTHT and LYPT policies in place at the time of the incident (28 February 2015) so as to examine the care and treatment Harry received and identify any care and service delivery problems, the contributory factors and possible root cause. We have included a fishbone diagram at appendix E. Recommendations have subsequently been made to promote learning and prevent recurrence.
- 2.10 NHS England (North) commissioned Niche to carry out a Level 3 investigation using the NHS England Serious Incidents Framework. Terms of reference had been agreed with the families and NHS England (North), NHS England (Directorate of Commissioning Operations – DCO), LTHT, LYPT, and the local CCG. The Level 3 investigation terms of reference set out that a start-up meeting for the investigation was to be held with the intention of agreeing contact details

⁵ *National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

and explaining a little more about the process of investigation that Niche intended to carry out. This occurred on the 8 February 2017.

- 2.11 Following this, Niche completed interviews with the external independent reviewer and the families of the people affected by this incident. Niche also contacted lead people at both Trusts to commence the process of collecting documentation and contacting staff that we wanted to interview. Further clarification was then requested from LTHT and LYPT of NHS England (North) regarding the scope of the investigation. A face-to-face meeting was held between the stakeholders identified in the paragraph above to further discuss the process. From this, two main concerns were identified:
- 1) that re-interviewing the staff would be extremely distressing for some of them; and,
 - 2) the internal investigation had been of good quality and stakeholders felt that there was nothing to be gained by re-investigating the incident.
- 2.12 During the summer of 2017 Niche suspended its activities in relation to this investigation at the request of NHS England (North) whilst further discussions were held regarding the scope and scale of the investigation. This suspension caused a three-month delay in commencing our investigation report. We kept the families affected by this incident informed of the delay and the reasons for this.
- 2.13 In September 2017 NHS England (North) supplied Niche with revised terms of reference (see appendix A). Alongside this came the request that Niche should use the clinical records, the internal investigation report, and the staff witness statements to form the basis of their investigation. The Trusts had requested that their staff were not approached for interview until Niche had reviewed the staff statements and identified additional lines of enquiry. NHS England (North) communicated the changes within the terms of reference to the families.
- 2.14 We understand that stakeholders were of the opinion that the internal investigation report was of good quality and there were no additional key lines of enquiry to be explored. NHS England (North) asked Niche to produce an interim report that covered Harry's care and treatment and to conduct a critical evaluation of the internal report in order to confirm this. Following this a timescale would be agreed for Niche to carry out the review of the Trusts' action plan.
- 2.15 In September 2017 Niche requested staff statements/transcripts, various policies and reports from LTHT. Most of these were sent in October 2017. At this point Niche were informed that staff transcripts/statements for LYPT would need to be requested directly from LYPT. This request was made in October 2017.
- 2.16 It is agreed practice as part of the framework agreement for independent investigations with NHS England that independent investigations will not commence our documentary review until they are in receipt of all of the documents that they have requested. This is to ensure that effort is not

duplicated effort and time wasted spent reviewing documents in isolation that will have to be re-reviewed at a later date. We notified NHS England (North) that we had not received all of the documents that we had requested in November 2017 and January 2018. We received the last batch of statements from the Trusts in February 2018, at which point our review of documentation progressed.

- 2.17 In February 2018 the Coroner requested an update from NHS England (North) on the progress of the report. In March 2018 a whistle-blower contacted the Health Services Journal who ran a story regarding the delays in our investigation. Following this the Coroner made a formal request that a report of our investigation should be supplied to the Coroner's office by 1 May 2018.
- 2.18 NHS England (North) have since negotiated additional time with the Coroner's office to allow for comments and factual accuracy checks to be completed on our report.

Investigation limitations

- 2.19 When we complete our independent investigations, it is our normal practice to reinvestigate the incident, pull together a comprehensive chronology, and identify care and service delivery problems in accordance with root cause analysis methodology. Following this, it is our normal practice to explore contributory factors and possible root causes through process of analysis. For this we would normally use root cause analysis tools and techniques and explore our findings through discussions with people involved in the incident. Through this process we are able to get behind what happened and explore why certain decisions were made. As set out above our instructions were not to reinvestigate the incident but to use clinical records, staff witness statements/transcripts and the internal investigation report as sources of evidence. Because of this we have not been able to speak to the staff concerned to fully establish some of the facts surrounding the incident and investigate contributory factors.
- 2.20 Another limitation with the investigation is the passage of time. When speaking to the people that we did interview their memories and recollections of events were diminished by the time lapse.
- 2.21 We note that the original investigation describes that agreeing the availability of staff to attend for interviews was a challenge, as a number of staff had moved on from both Trusts to take up other posts both in and outside the NHS. The internal investigation was not specific about whether this meant that some staff were not interviewed as a result.
- 2.22 Building on the Trust report, we have compiled a comprehensive chronology of events leading up to the attack. We have also provided a further detailed chronology from the time when Harry was diagnosed with schizophrenia so that

we could understand the background and pattern of Harry's mental health and relapse whilst he was being treated for, and in the context of, his declining physical health. For clarity, we have detailed Harry's care and treatment in periods of time relating to:

- Background between 1962 and March 2009.
- First admission to LTHT 11 September 2013 to ward J26.
- Second admission to LTHT 5 November 2013 to ward J42.
- Third admission to LTHT 9 May 2014 to ward J26 and ward J93.
- Fourth admission to LTHT between 9 and 30 June 2014.
- At home between 1 July 2014 and 25 January 2015.
- Fifth admission between 27 January and 12 February 2015 to ward J96 and ward J97.
- Admission to Corinthian House Care Home between the 12 and 19 February 2015.
- Sixth admission to LTHT between 19 and 28 February to ward J28 and ward J19. For this admission we have provided detail about his care and treatment on a daily basis.

2.23 Caldicott Guardian⁶ approval was obtained to access Harry's records from LTHT, LYPT, Harry's GP and Corinthian House Care Home. As part of our investigation we would normally interview staff who were on duty at the time of the incident and staff that had been involved in the care and treatment of Harry. However, due to the nature of the incident and the fact that the incident had already been investigated by the police and by the internal investigation NHS England (North) instructed us to review the staff transcripts/witness statements instead of interviewing them ourselves. We reviewed 74 staff transcripts and witness statements that were obtained by the police and by the Niche lead investigator between March 2015 and August 2017. We therefore limited our interviews to the following:

- the external independent reviewer;
- LTHT Risk Manager;
- a solicitor from DAC Beachcroft;
- the stepson and stepdaughter of Ken;
- the partner of Roger; and

⁶ Caldicott Guardian – a senior person responsible for protecting the confidentiality of patient and service user information and enabling appropriate information sharing. Each NHS organisation is required to have a Caldicott Guardian; this was mandated in 1999 by Health Service Circular HSC 1999/012. Caldicott Guardians were subsequently introduced into social care in 2002, mandated by Local Authority Circular LAC 2002/2.

- the stepdaughter of Harry.

2.24 A full list of all documents referenced is at appendix B.

2.25 The draft report was shared with NHS England, LTHT, LYPT, the external independent reviewer and the solicitor from DAC Beachcroft for factual accuracy checks. This provided opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

Contact with Ken and Roger's families

2.26 Contact for the victims' families was with the stepson and daughter-in-law of Ken and with the partner of Roger. In our discussions with them we asked how they would like their loved ones to be represented and referred to. They asked us to make sure that we included reference to both people as individuals and not just victims. They also asked us to refer to them by their names i.e. as Ken and as Roger. They shared with us correspondence that they had received from LTHT, notes of meetings that they held with the external independent reviewer, information sent to them by the police, and some email correspondence between themselves and the investigator.

Contact with Harry's family

2.27 Contact for Harry's family was with his stepdaughter. Harry's stepdaughter also wished for people to understand Harry as an individual and asked that we refer to him as Harry, not as 'the perpetrator', which we have done. Harry's stepdaughter provided us with copies of correspondence and copies of her diary where she had entered comments regarding Harry's care.

2.28 We met with all three of the families together, at their request, on 1 May 2018 and again on 17 May 2018 prior to finalising the report.

Structure of the report

2.29 Section 3 provides a summary of the incident and sets out the details of the care and treatment provided to Harry. We have included a full chronology of his care at appendix C in order to provide the context in which he was known to services in LTHT & LYPT.

2.30 Section 4 examines the issues arising from the care and treatment provided to Harry and includes comment and analysis.

- 2.31 Section 5 provides a review of the Trust's internal investigation. We have not reported on the progress made in addressing the organisational and operational matters identified, this is to form part of a later report.
- 2.32 Section 6 sets out our overall analysis and recommendations.

3. SUMMARY OF THE INCIDENT AND HISTORY OF HARRY

- 3.1 Mr Roger Lamb was a 79-year-old gentleman who was described by his partner as extraordinary. Largely self-taught, Roger was widely read, very articulate and deeply reflective. He possessed an acute musical ear, played trumpet in a band in his youth, and loved both jazz and classical music. Although he was a very private person he was interesting, engaging and easy to converse with. From his earliest years he was influenced by eastern philosophy and practised yoga and martial arts. He was very socially aware and felt deeply what he perceived was the intrinsic unfairness of society, which led him to stand as an election candidate in 1997. His partner would like Roger to be remembered for the courageous actions he took in the incident. Roger was so concerned about the safety of others that he forced himself from his hospital bed, with no concern for his own safety, and tried to intervene when a fellow patient was being attacked.
- 3.2 Mr Ken Godward lived in Leeds for all his life. He was married for 23 years and was a loving stepfather to Andy and Paul. Ken was a quiet, much loved, generous man, a keen gardener, and would do anything for anybody. He had a close connection with St James Hospital in Leeds and was a volunteer DJ on the hospital radio there for several years. His brother had a learning disability, and Ken had promised his parents that, come what may, he would always look after him. After their parents died Ken's brother lived with, and was cared for, by Ken and his family. Towards the end of his life Ken developed a number of serious health problems. At the time of his death he was suffering from Alzheimer's disease and we were told by his family that he also had a terminal liver condition. He was extremely vulnerable.
- 3.3 Mr Harry Bosomworth was a 70-year-old gentleman. He is described by his stepdaughter as a kind man who adored her mother and looked after her very well until her death. He was simplistic in his way, but he managed his life perfectly. "He managed my mum...he did all the shopping, all the finances as long as he didn't have to bother with new things like technology". Harry was diagnosed with schizophrenia in his teenage years and had managed to live safely into his 70's with the support of regular medication to control the symptoms. Harry's stepdaughter had come to care for him over the years that he was married to her mother and, because of the strong bond they had, supported him in the last years of his life. Harry suffered distress and upset when he experienced hallucinations, his stepdaughter said they terrified him. A few years

ago, Harry was diagnosed with oesophageal cancer which meant that he was in and out of hospital for various treatments in 2014 and 2015.

- 3.4 All three were patients on Ward J19 on 27 February 2015. Ward J19 is a 29-bedded ward in St James' Hospital, Leeds. The ward is primarily focused on the acute/short-term treatment of people with diabetes but takes patients who have other conditions (we have made Recommendation 4 about reviewing the case mix on the ward).
- 3.5 The average admission/discharge rate during December 2014 to February 2015 was six patients every 24 hours. Many of the patients on the ward had more than one condition, including mental health problems. The ward is laid out in a "race track" design with four bedded bays and side rooms for patient care, clinical areas for preparation and administration of treatments, and two nurses' stations. The nursing staff that work on the ward are split into teams and look after allocated groups of patients. The typical nursing staffing establishment was four registered nurses and two healthcare assistant/clinical support workers on duty during the day, and two registered nurses and two healthcare assistants on duty overnight. The day staff work from 7.30 AM until 8 PM, and the night staff work from 7.30 PM until 8.00 AM.
- 3.6 On 27 February 2015 Harry, Roger and Ken were patients in beds 10, 11 and 14 in a four-bedded bay. Both Roger and Ken were quite poorly. As referred to above Ken was at the end of his life. Harry had previously been confused, but for the late afternoon and early evening of 27 February had been increasingly noisy and agitated. The fourth bed in that bay became empty during the evening as the patient requested a move due to some of the behaviour that Harry was displaying.
- 3.7 At 7:30 PM four nursing staff commenced their nightshift. They received handover from the day staff which indicated that Harry's condition/behaviour had worsened during the afternoon/evening. Once handover had been completed Staff Nurse 1 went to see Harry to assess his condition. She attempted to give him his evening medication but he refused this, shouting and swearing at her and hitting out. She spoke to the junior doctor on-call about changing Harry's medication to an intramuscular injection, and with her colleague Staff Nurse 2 went to administer this. On approaching Harry they decided that they would need assistance from security staff due to his behaviour and they withdrew. A little while later three security staff attended and Harry was restrained while the nurses administered an intramuscular injection to calm him. This had the desired effect for a couple of hours.
- 3.8 The next thing that is known is that Harry started to become noisy and agitated again at about 3.00 AM, when he was given more lorazepam. Staff Nurse 1 reports going into see him at 6.30 AM and finding him banging on the wall with his walking stick, which she removed from him and placed at the end of his bed. Health Care Assistant 1 attempted to take Harry's temperature and blood

pressure at about 6.55 AM but was threatened verbally by Harry and had to withdraw. She went to inform Staff Nurse 1 of this and as she was coming out of the side room she heard a bang.

- 3.9 Staff went into the four-bedded bay to find Harry standing over Roger, with a walking stick in his raised hand, and Ken was on the floor. At that point Harry was disarmed, security was called (at 7.12 AM) and Harry was removed from the scene. Nursing and medical attention was given to both Roger and Ken. The injuries that both patients had sustained were serious. Ken died on 3 March and Roger died on 5 March 2015.
- 3.10 We have not been asked to consider the cause of either Roger's or Ken's death. This will be addressed at the Coroners inquests which we understand will be held after 1 May 2018. Roger's death certificate states that he died from a fracture of the right neck of femur (hip), secondary to blunt force trauma. We understand that Ken's death was due to sepsis, due to acute bronchopneumonia and acute pyelonephritis due to Alzheimer's disease and secondary to blunt force trauma. Harry died on the 9 May 2015 due to the progression of his oesophageal cancer.
- 3.11 A chronology of the events directly leading up to the incident are included in appendices.

Personal history

Background between 1962 and March 2013

- 3.12 We sought as much information as possible about Harry's care and treatment for his mental health from when the family told us he was first diagnosed as having schizophrenia; this was in 1962 when he was 18 years of age. No further information is available following this until 13 October 1980 when Harry was 36 years old and he was seen at home by his GP after complaining of noises in his head and being controlled by external forces.
- 3.13 Harry was formally diagnosed with paranoid schizophrenia and anxiety with depression. Despite this, he coped easily with family life and activities of daily living. However, he did not work, and his stepdaughter told us this was because he could not understand instructions very well. Harry told the GP that he was able to date the onset of these symptoms to March 1979 when he gave up work to look after his mother full time.
- 3.14 He told his stepdaughter about how his schizophrenia had developed and how he was happy with his medication. He used to say "as long as I have my music on and I am alright, I feel safe". The music was to help with the voices he occasionally heard.

- 3.15 Harry was discharged from the mental health outpatient clinic where he had been seeing the consultant psychiatrist back to his GP on 13 November 1985. The GP was asked to maintain him on the antipsychotic medication (at the time this was thioridazine⁷) and to let the consultant psychiatrist know if there was any deterioration in his condition.
- 3.16 In line with practice at the time (as the Care Programme Approach (CPA)⁸ was not implemented until 1990), Harry appeared to be only seeing the consultant psychiatrist as an outpatient, with no care coordinator appointed or a crisis plan in place other than this advice to the GP.
- 3.17 In 1990, when Harry was 46 years old, his stepdaughter told us that he stopped taking his medication on the advice of her older sister. His stepdaughter told us that this period of time gave a valuable insight into how he deteriorated without medication. Within five days she saw the difference in him. Three or four days later he smashed windows in a shopping centre and hit his wife. Records indicate that he was subsequently arrested by the police, however there is no further information about whether he was charged with an offence related to this. There is also no other information to indicate that Harry had a forensic history.
- 3.18 Following this incident Harry realised his mistake, took himself to the GP and asked for admission to St Mary's Hospital in Leeds where he remained for about a week. He started taking his tablets again, learned from this episode and said "I will never, ever do that again".
- 3.19 When his wife died in 2000 Harry was devastated and confused. He stayed in the same house and his stepdaughter took care of the funeral and also the practical and financial matters. For the first five or six years after this he appeared to be coping well, but then he started drinking at home in 2006 – 2007 which progressed to drinking every day, starting in the morning. His stepdaughter said that he started to feel very ill and fatigued, was transfused with five or six pints of blood, and felt well again. Following this he told his stepdaughter that he needed to do something about his drinking and start taking responsibility for it, so that he had periods of time when he stopped drinking.
- 3.20 Harry was subsequently referred by the GP to the consultant psychiatrist at LTHT St James's Hospital on 10 of January 2001 for supervision of his care following new guidance on thioridazine treatment (this medication was being withdrawn from the market). The referral letter indicated that he had a period of not taking

⁷ Thioridazine is a piperidine typical antipsychotic drug belonging to the phenothiazine drug group and was previously widely used in the treatment of schizophrenia and psychosis. The branded product was withdrawn worldwide in 2005 because it caused severe cardiac arrhythmias

⁸ Department of Health: "The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services. HC(90)23/LASSL(90)11 DoH (1990)". This aimed to provide a framework for effective mental health care for people with severe mental health problems and included the requirement to appoint a care coordinator. Following this, the NHS mandate 2004 - 2005 introduced crisis plans to help people recover from episodes of ill health.

his medication when the GP found 400 thioridazine tablets in his cupboard at home. The consultant psychiatrist at St James's Hospital saw Harry and did not change his medication.

- 3.21 Harry was seen again by the consultant psychiatrist the following month, then six months later, and then in April 2002 when Harry reported that he had had several episodes of paranoia which caused him considerable distress. He was advised to take an extra thioridazine tablet at these times, however, when Harry was seen again in October 2002 he reported that the extra tablet had worsened his paranoia. He therefore remained on the previous treatment regime although he reported being bothered by loud noises in his flat especially at night.
- 3.22 When Harry was seen by the consultant psychiatrist in April 2003 he reported that his delusions had worsened; whenever he saw anybody who was accidentally looking at him he felt paranoid and, on one occasion, he approached a person and asked what they were looking at. He was worried that this may result in a fight. Harry agreed to an increase in his thioridazine, and he also agreed to see his GP immediately if he experienced any further deterioration in his mental health. When Harry was seen again in July and October 2003 he reported that his fears and paranoia had abated, but not completely, on the increased dose of thioridazine. In March 2004 Harry reported being lethargic and sedated on the higher dose of thioridazine and so this was reduced to three times a day instead of four.
- 3.23 In March 2005 Harry commenced on olanzapine⁹ 10 mgs at night as thioridazine would no longer be available from June 2005. The olanzapine was increased to 15 mgs at night in December 2005 when he reported that people looked at him strangely in public and he believed an intruder had been in his property. When Harry was seen again in June 2006 he said he was much more settled on this dose of olanzapine.
- 3.24 Harry was reviewed every six months and was reported as stable apart from two occasions in April 2008 and March 2009 when he reported that he had been issued a prescription for less than the 15 mgs of olanzapine and as a result he had experienced several bouts of brief persecutory fears which abated when he was able to obtain his correct amount of medication. This was brought to the attention of the GP. As Harry was approaching the age of 65 years a discussion took place with him about transferring to the older age psychiatrist. He preferred to be transferred to the care of the GP who was asked to refer him accordingly if his condition deteriorated.

⁹ Olanzapine is an antipsychotic medication used to treat schizophrenia and bipolar disorder. It is usually classed with the atypical antipsychotics, the newer generation of antipsychotics.

- 3.25 We understand that Harry continued to live safely in the community, into his late 60's whilst taking his olanzapine regularly, until he was diagnosed with cancer in 2013.

Care and treatment of Harry from 2013 up to the incident

- 3.26 We have carried out a detailed review of Harry's care and treatment. This detail is set out in appendix C, we have summarised the key points from this review below.

11 September 2013 - ward J26

- 3.27 Harry went into hospital in the summer of 2013 to have investigations for tiredness and weight loss. At an outpatient appointment in October 2013 he received a diagnosis of cancer of the oesophagus. At the time his granddaughter said that he found it difficult comprehending complex information and had a very poor short-term memory. It was noted that he was living on his own with no input from statutory agencies.

4 November 2013 - ward J42

- 3.28 As treatment for his oesophageal cancer, Harry was required to have a stent inserted to keep his throat open. He went in to hospital to have this procedure.

9 May 2014 - ward J26 then J93

- 3.29 Harry was admitted for a third time after it was found that he had progression of his oesophageal cancer and a new stent needed to be inserted. Harry was discharged after treatment on 30 May 2014 with a plan to continue his olanzapine 15 mg at night.

At home - 30 May 2014

- 3.30 In June 2014 the oncology department stopped Harry's medication when he went for radiotherapy. Further information about this is not available. He was, however, struggling to use the dosette box (an aid to assist in taking medication at the right time) that had been provided. Action was taken to attempt to get Harry to use this but on 9 June his stepdaughter asked the GP to see him and he was admitted to hospital for a fourth time.

9 June 2014 - ward J29

- 3.31 On this admission it was noted that Harry had taken all of his medication for the whole day and the next morning, which was an overdose. At this point Harry was known to be living with and treated for schizophrenia. He had poor short-term memory and was prescribed olanzapine 15 mg at night. On 13 June Harry had a gastroscopy and a new stent inserted and at that point his olanzapine administration became erratic.

- 3.32 Records show that Harry's olanzapine medication was reviewed with a pharmacist who said that due to the long half-life he was likely to be okay without olanzapine for eight to ten days. The pharmacist also advised a referral to the mental health liaison team if he needed to be nil by mouth for longer period or if his symptoms worsened.
- 3.33 Harry went back to theatre when his stent slipped, and had another inserted on 19 June 2014. On 20 June, nursing records indicate that Harry had been having hallucinations overnight. He was given his medication intramuscularly because he could not have oral medications.
- 3.34 Oral olanzapine started again that night. Harry continued to have olanzapine given to him and on 26 June a ward round recorded a recent psychotic episode. The plan was to refer Harry to the mental health liaison team and to commence discharge planning.
- 3.35 On 28 June Harry was noted as being unsettled, confused and paranoid overnight; Lorazepam was given with good effect. It was noted on both the 28 and 30 of June that a psychiatric review was needed before his discharge. We have not found evidence that this was requested or took place. Harry was discharged to his home on 30 June 2014 with a discharge summary requesting the GP to refer him to community psychiatry due to the episodes of possible psychotic behaviour on the ward. The medication on discharge included his usual medication of olanzapine 15 mg at night. We have not found evidence that the GP referred Harry to community psychiatry (see section on primary care issues).

At home – from 1 July 2014

- 3.36 Harry stayed at home for the rest of 2014. Whilst at home Harry was using a dosette box with varying levels of success. In December 2014 his stepdaughter noticed he was not taking all of his medication and started to visit him every couple of days. She found empty packets of olanzapine on his bedroom floor which to her indicated that he had been taking them, however, she was concerned that in the previous two weeks that may have been a bit 'hit and miss'.

27 January 2015 - ward J96 then J97

- 3.37 On 27 January 2015 Harry was assessed by his GP and admitted to Ward J 96 as a result of his deterioration in condition. On admission he was diagnosed with a tumour related anaemia and received six units of blood. He was only supposed to be staying in hospital for a short time for the blood transfusion, however, he had a seizure and collapsed whilst on the ward. At this point it was thought that olanzapine may be causing seizures, but staff started to query whether Harry was taking it. Extensive investigations took place to try and establish whether Harry had been taking this medication. The view was that he had not because there was no community pharmacy that could confirm delivering it. Additionally, there was a discussion with the stepdaughter who said that Harry had not taken

his medication for some time but did not know for how long, and that last time she visited he had a bowl filled with tablets he had not taken. The pharmacist fully believed after this that Harry was not taking his medication. This was however incorrect.

- 3.38 In the meantime, Harry's medication charts on the ward went missing. It has not been possible to ascertain whether Harry had his olanzapine between the 27 and 29 of January 2015 or on 1 February 2015. A temporary prescription and administration record was written including olanzapine 15 mg as regular medication, however, there was no stock on the ward and the nurses had to order it from pharmacy. Again, he did not receive his night time dose. We have commented on the erratic nature of Harry's olanzapine administration in section five.
- 3.39 Records of 2 and 3 February indicate that Harry became unsettled and paranoid, he was talking to himself overnight and hearing voices. Given this, the possibility of a psychotic relapse should have been considered. It was our understanding that the nursing staff intended to access psychiatric input to Harry's care, which was readily available through the mental health liaison services based in the hospital.
- 3.40 On 3 February 2015 Harry had another seizure. The medical staff evaluated all that they knew about Harry's condition and, based on the lack of signs of a psychotic relapse and that Harry had not had his olanzapine for a couple of days, decided to stop his prescription until an anti-epileptic drug had chance to take effect.
- 3.41 Harry's stepdaughter raised concerns about this course of action and the fact that Harry was not receiving his olanzapine. The medical staff explained that the most important issue was to get Harry's seizures under control and went ahead with their plan.
- 3.42 On 6 February pharmacy staff confirmed that Harry had been receiving his olanzapine in the community for a while (length of time unknown), having his prescription delivered to him at home. During his stay the team agreed that Harry, due to his health needs, should not return home on discharge and plans were made to transfer Harry to a community care home. Harry was discharged on 12 February 2015 with no prescription for olanzapine. The discharge note said that he had not been taking it for many years and was well without it. At the time of his pre-transfer assessment the care home manager noted that he was not showing any signs of psychosis or confusion.

12 February 2015 - Corinthian House Care Home

- 3.43 Corinthian House is a 72-bedded care home for people with dementia and palliative care needs. Harry's stepdaughter arrived on ward J97 on 12 February to find that Harry had been discharged to Corinthian House, without any prior

discussion with her. When she got to Corinthian House on the 15 February she told us she found him confused, rambling and not able to recognise her. He was hostile, swearing and seeing things. The admission assessment noted that he had schizophrenia and that he was unable to maintain a safe environment. However, no care plan was developed.

- 3.44 On 16 February Harry's stepdaughter rang the hospital to say that the care home was not an appropriate place for him and that he needed his olanzapine. She was concerned that without it he could turn violent. The ward sister checked and rang her back to say that Harry did not get a prescription for this because he had not been taking it for years. This information was passed to the care home manager who noted this and that the information from the stepdaughter contradicted the discharge summary from LTHT St James's University Hospital which said that the olanzapine had been stopped as he had not taken it for many years and was well without it.
- 3.45 In the following days and nights Harry's behaviour deteriorated, he was wandering and 'vocalising' but not aggressive. The care home staff discussed his care with the Corinthian House GP. However, this behaviour deteriorated further and Harry's stepdaughter told us that she insisted that he was seen by the GP to reinstate his olanzapine. The Corinthian House manager acted upon this, after listening to Harry's daughter, and made a referral to the GP for further advice.
- 3.46 Records show that the Corinthian House GP rang Harry's previous GP to discuss this, but the olanzapine was not prescribed. As Harry's behaviour deteriorated further investigations were carried out to determine if Harry had delirium from an infection. Harry's stepdaughter told us that she repeatedly attempted to get his olanzapine reinstated.
- 3.47 The Corinthian House record of behavioural concerns for Harry on the 18 February 2015 indicated that from 6 .00 PM until 9.30 PM he was out of his room, threatening, shouting and swearing at staff. The manager asked the Corinthian House GP to assess Harry again. The GP took a blood and urine sample from Harry and prescribed antibiotics (Trimethoprim) for a suspected urinary tract infection. It was noted that the request for information from Harry's usual GP had not been responded to.
- 3.48 On the 19 February 2015 a statement from a registered nurse on duty that day at Corinthian House indicated that Harry had been quiet until about 10 AM, however, after that he became agitated and verbally abusive to both staff and residents, and at one point said he was going to kill them all. The doors of the other resident's bedrooms were kept shut.
- 3.49 As Harry's behaviour deteriorated that day, he was cared for on a one-to-one basis. All the rooms at Corinthian House are single rooms and Harry had therefore been nursed in one since his admission there. On 19 February 2015 results of tests suggested that Harry had an infection (the GP thought a urinary

tract infection) and was dehydrated. This could have accounted for his increased agitation and confusion. Corinthian House decided that they could no longer meet his needs and the local GP made the decision to transfer Harry to St James's University Hospital Accident & Emergency (A&E) department.

19 February 2015 - ward J28 then J19

- 3.50 Harry was admitted via the A&E department to J28. He was agitated, confused and aggressive, shouting and swearing at staff. His tests showed that he could have kidney damage as a result of his dehydration and infection, or a bleed in his stomach. On admission Harry's stepdaughter again said that his agitation was due to the olanzapine being stopped.
- 3.51 Tests showed that Harry did not have a urine infection and the plan was to treat him for acute kidney injury and possible hyperactive delirium and psychosis. Psychiatric advice was obtained over the phone, which was to prescribe as required Lorazepam and Haloperidol if the agitation worsened. Harry would probably need the olanzapine restarting but could wait for a psychiatric review the next day.
- 3.52 Harry had all his physical health needs assessed and care was planned appropriately in line with these. Harry had bed rails in place. His stepdaughter noted in her diary 'still no olanzapine' for this date.
- 3.53 Over the next few days Harry's physical needs were met and he received treatment for dehydration. He was tested again for a urine infection. During this time Harry's stepdaughter made several requests for his olanzapine to be re-introduced. Records show that she reiterated her concern that he could be aggressive without it. Ward staff state that Harry was confused during this time.
- 3.54 On the 22 February the mental health liaison service recorded that they received a referral for Harry, which was three days after it had been advised. Records show that the psychiatric team made an appropriate diagnosis and were cognisant of the risks to Harry. They requested Harry's historical psychiatric records (from LYPT) at this point. There was a plan to review Harry further. The psychiatric team decided that Harry should have olanzapine started straight away at a reduced dose of 2.5 mg. The cautious approach, rather than putting Harry onto the 15 mg dose he had been taking, was because no one was sure when he stopped taking it. This approach appears to be in line with prescribing guidance¹⁰ on the control of agitation and disturbed behaviour in schizophrenia or mania in the elderly.
- 3.55 It was also recorded that a Mental Health Act assessment may be required if Harry wanted to leave the ward, in order to detain him if necessary so he could receive further assessment and treatment. It was mentioned that he may lack mental capacity, but no formal mental capacity assessment was made. This plan

¹⁰British National Formulary <https://bnf.nice.org.uk/drug/olanzapine.html#monitoringRequirements>

was communicated verbally to the medical team looking after Harry on J28, with a request to re-start the olanzapine. However, what was prescribed was a once only dose given that afternoon.

- 3.56 Over the next few days Harry received psychiatric and physician review. On 23 February his olanzapine was re-prescribed but later in the day he suffered a seizure and the records indicate that this was withheld because he was too drowsy to take it.
- 3.57 Harry was transferred to J19 on 25 February 2015 because he required a longer period of medical observation and investigation. Just before his transfer his stepdaughter spoke to medical staff asking about restarting the olanzapine because she thought that Harry was hallucinating. The medical staff planned to get a psychiatric review.
- 3.58 On admission to J19 the medical staff who were assessing him there were concerned to learn that Harry had been on psychiatric medication which had been stopped. It was confirmed at this time that Harry's urine had no infection but that he had test results that indicated an abnormal kidney function and anaemia. There continued to be uncertainty about whether Harry was having his olanzapine and whether this medication was a contributory factor to seizures that he was having.
- 3.59 At this time Harry did not present as being agitated and his behaviour did not give any cause for concern. On 25 February Harry was seen for the third time by somebody from the psychiatric liaison team, and Harry's stepdaughter spoke to her about her concerns. She again reiterated the need for Harry's olanzapine to be increased up to the 15 mg he had been on for 50 years. Harry's stepdaughter also reiterated that he was hearing voices. She thought that he had been hallucinating and that his obsessive compulsive behaviour was getting worse. The plan at that time was to review Harry again the next day and consider increasing his olanzapine.
- 3.60 Harry was reviewed on 26 February by the psychiatric liaison team who considered whether he had tolerated the reintroduction of his olanzapine. They noted that he had not had olanzapine since 22 February and that he had had seizures. The records indicate that he had not been showing any psychotic symptoms and was not distressed or agitated. This was despite the stepdaughter informing them of her concerns about Harry's behaviour and the need for him to have olanzapine. The plan, therefore, was to use olanzapine 2.5 mg as required plus Lorazepam, and that the psychiatric liaison team would review Harry daily to assess his mental state and risk.
- 3.61 The doctor who tried to see Harry later that day, spoke to several nurses and doctors on ward J19 about Harry but were unable to see him despite trying twice. The records state that "the patient was unavailable to be seen by me". We understand from records and statements that Harry was off the ward having

investigations and then when he returned he was having his lunch. Meal times are a protected time when patients are not to be subject to visits from professionals where possible.

- 3.62 Harry's general nursing care plan was reassessed and redeveloped, with a care plan for confusion and disorientation which included monitoring the patient and reducing risks of self-harm or injury as a result of this. Level 2 pharmacy reviews were also undertaken on 26 and 27 February. We have not found any evidence that these reviews considered his psychiatric medication regime.

27/28 February 2015 – the night of the incident

- 3.63 Harry was reviewed again on 27 February by the mental health liaison team. The mental health liaison team registered nurse found him to be very drowsy. He briefly engaged and said "you're wasting your time, I'm going to die".
- 3.64 Throughout the course of 27 February Harry's behaviour and confusion deteriorated. Harry became more confused in the evening and was getting difficult to manage. At 7:15 PM Harry was reported as being very aggressive, abusive, and hitting and kicking out at staff. He was mobile and able to get to the toilet but a bit unsteady on his feet. Harry was being nursed in a four-bedded bay and the nurse who was looking after him on the night shift went to see him once handover had been completed. Harry had continued to be agitated, shouting and swearing, and had refused his oral Lorazepam when she offered it to him. Steps were taken to change Harry's oral medication to intramuscular injection and at around 9:00 to 9:30 PM security officers attended the ward and assisted the registered nurses whilst they administered the injection to Harry.
- 3.65 Harry quietened down at this point until about 03:00 AM (28 February 2015) when he became loud and started shouting again. It appears that no further assessment had been made to plan for the eventuality of medication wearing off. Records indicate that the registered nurse that was looking after him checked on him regularly and attempted to reassure Harry through the night which helped quieten him down. We have established that the curtains were drawn around Harry's bed and the doors into his bay were closed in the night. At about 06:30 AM Harry was found to be banging on the wall behind his bed with his walking stick. The registered nurse that was looking after him removed his walking stick from him, placed it at the end of his bed, and left the bay. At 06:55 AM healthcare assistant attempted to take Harry's observations, however, she had to withdraw because he was very agitated and verbally threatening her. She stated in her police statement that she went to inform the staff nurse on duty about Harry's threatening and abusive behaviour.
- 3.66 A little later (approximately 07:00- 07:10 AM), Harry was discovered standing over Ken and Roger with his walking stick in his hand. Harry was disarmed, restrained and security officers were called to the ward. Harry was physically

escorted into the day room on the ward whilst Ken and Roger were given treatment for their injuries (these are further detailed in appendix C).

- 3.67 Harry was cared for/supervised by two security officers throughout the day, in the day room, and was assessed under the Mental Health Act before being transferred to a mental health inpatient bed. We established that the transfer occurred between 11 PM and midnight on 28 February 2015.

4. ARISING ISSUES, COMMENT AND ANALYSIS

About Schizophrenia and treatment

- 4.1 The term 'schizophrenia' is a word that many people do not understand and may make people feel uneasy. It is one of several disorders called 'psychoses'. The Royal College of Psychiatrists¹¹ (RCP) describe schizophrenia as a disorder of the mind that affects how a patient thinks, feels and behaves. Its symptoms are described as 'positive' or 'negative'. Symptoms may include:
- Hallucinations - these can occur in any sensory modality e.g. someone might hear voices that seem real to them or see things that are not seen by others.
 - Delusions - abnormal beliefs that are not shared by other people and are not explained by a person's background, culture or religion (e.g. other people are reading your thoughts).
 - Disorganized thinking or trouble organizing your thoughts and making sense to other people.
 - Little desire to be around other people.
 - Trouble expressing yourself clearly to other people.
 - Lack of motivation.
- 4.2 Schizophrenia can be successfully treated through a combination of: medication to help control the more disturbing symptoms of the illness; support from families and friends; psychological treatments and support services such as day-care and employment schemes. The RCP makes it clear that if patients stop taking their medication the symptoms of the illness will usually recur. This can take from anything between a couple of days to 12 months. They advise that withdrawing from regular antipsychotic medication should be done carefully and slowly, and

¹¹Royal College of Psychiatrists, Health Advice, Problems and disorders
<https://www.rcpsych.ac.uk/healthadvice/problemsanddisorders/schizophrenia.aspx>

they also state that patients' medication should be reviewed by their psychiatrist at least once a year.

- 4.3 Olanzapine is one of the medications available that works in the brain to treat schizophrenia. It rebalances dopamine and serotonin to improve thinking, mood, and behaviour. The British National Formulary (BNF) advises that for adults the oral dose should be 10 mg daily, adjusted according to response, with the usual dose being 5–20 mg daily. Doses greater than 10 mg daily should only be prescribed after reassessment. When one or more factors are present that might result in a slower metabolism (for example, female gender, elderly, and non-smoker), a lower initial dose should be considered, and a more gradual dose increase up to a maximum of 20 mg per day.

Harry's medication

- 4.4 We examined the circumstances in which Harry was not prescribed and administered olanzapine during admission to LTHT, and whether the rationale for this could be seen as reasonable and in line with guidance. We also examined whether Harry taking his olanzapine could have been measured by blood serum levels and whether blood loss, and subsequent blood transfusions associated with anaemia, could impact on blood serum levels of olanzapine. We took senior pharmacological advice and found that these issues, and the advice, were additional key lines of enquiry which would have warranted further consideration in the original investigation.
- 4.5 We have included the detail regarding how and when Harry received olanzapine in the appendix C which looks at Harry's care and treatment.
- 4.6 We note this was a line of enquiry from the internal investigation. However, we have explored the stopping of olanzapine due to Harry's seizures in more depth below.
- 4.7 Harry was in contact with mental health services when he was first diagnosed with schizophrenia. He was discharged from secondary mental health services in 1985, and his GP was asked to maintain his prescription of the antipsychotic medication that he was taking at the time. This was thioridazine. The prescription of thioridazine was changed to olanzapine as thioridazine was being withdrawn from the market. Harry coped very well with olanzapine and was stable apart from two occasions in 2008 and 2009. On these occasions he had received a prescription for less than his dose and had experienced several bouts of persecutory fears which were corrected when he obtained the right medication.
- 4.8 Harry first started having problems remembering to take his medication at the beginning of June 2014. He was provided with a dosette box to help him, but it transpired that he still needed help. He came into hospital on 9 June after having taken an accidental overdose of his medication, and at that point he was

reviewed and referred to the palliative care and oncology team. Due to having an oesophageal stent inserted, the olanzapine prescription was suspended due to Harry being nil by mouth. On 19 June, four days after his olanzapine prescription was suspended, Harry started to have hallucinations. Harry's olanzapine was restarted and he continued to receive this until he went home on 30 June 2014. He had a prescription of olanzapine 15 mg at night at this point. Harry's stepdaughter started to support him with taking his medication in December 2014 but was worried that he may not have been taking it consistently.

- 4.9 On 27 January 2015 Harry was admitted to hospital. His stepdaughter raised concerns that during the previous 3 to 6 weeks Harry had deteriorated and at that point she raised questions about whether he had been taking his olanzapine. She was concerned about the chances of Harry having a relapse of his schizophrenia. Extensive investigations were carried out by the pharmacy team to establish whether Harry had had his olanzapine dispensed to him; however, they could not find a pharmacy that had. Additionally, there was a discussion with the stepdaughter who said that Harry had not taken his medication for some time but did not know for how long, and that last time she visited he had a bowl filled with tablets he had not taken. She fully believed after this that Harry was not taking his medication but this was incorrect.
- 4.10 Olanzapine was prescribed on 2 February 2015 on the advice of the on-call psychiatrist. Following Harry having a seizure the reviewing doctor took the decision not to commence the prescribed olanzapine after speaking to a specialist clinical pharmacist and the stepdaughter. He was basing his decision on the risk of further seizures, and his concern that these could harm, and possibly kill, Harry. Over the next few days olanzapine was re-prescribed because of the psychiatrist's advice and then stopped because Harry had another fit. We found that Harry was without olanzapine for 22 days between the 1 and 22 February 2015, and only had two doses between the 22 and 27 February 2015.
- 4.11 We took senior pharmacological advice on this matter. Our view is that the olanzapine prescription should not have been stopped because of the seizures, and that when Harry refused his olanzapine on 25 February a discussion should have taken place about the implications of this and possible ways forward (see our discussion on legislative frameworks later in this report).
- 4.12 We understand that olanzapine can act as a contributory factor to seizures. However, we understand the risk to be very small and that an immediately active anti-seizure medication could have been prescribed, rather than waiting for the anti-epileptic medication (Lamotrigine) to reach therapeutic levels. This means that the olanzapine could have been prescribed and administered.
- 4.13 Harry's family asked us to examine whether a blood transfusion that Harry received, in January 2015, could have impacted on the olanzapine levels in his blood. We understand that in a situation where blood is lost, as in the case of

Harry, through anaemia due to his oesophageal cancer, a blood transfusion would be given to increase the haemoglobin, or red blood cells, in his blood, not the blood volume. The administration of blood transfusions, in this situation, would not impact on the blood serum levels for olanzapine. Therefore, the blood transfusion does not reduce the amount of olanzapine in the body.¹²

- 4.14 In mental health care it is common to check a patient's blood serum levels in the process of evaluating treatment (e.g. lithium, clozapine). We considered whether olanzapine could be measured through blood serum levels to check if Harry had been taking it. We understand that measuring olanzapine compliance in this way is not reliable and that clinicians are more likely to observe for early signs of relapse. As a result, blood serum levels for olanzapine are not used routinely in clinical practice to determine compliance.
- 4.15 We found that there was evidence that Harry had had a relapse of his schizophrenia after missing four days of his medication. In our view the physical health care staff did not appreciate the importance all the risks associated with uncontrolled schizophrenia. We found that the physical health needs of Harry were prioritised above his mental health needs.

Recommendation 1

We recommend that LTHT and LYPT work together to ensure that the mental health needs of patients are properly addressed when they are admitted to an acute general ward. We would suggest that mental health, diagnoses and medications are included in the admission information and for people living with schizophrenia that there is a requirement to ensure that the patient's care is discussed at the earliest opportunity within a multi-disciplinary (mental health and general acute) team.

- 4.16 We know that both LTHT and LYPT have undertaken developmental work to respond to the recommendations from the internal investigation report. LTHT now have a specialist assessment in place for all adult patients which encompasses mental health needs. This work partially addresses Recommendation 1 above.

¹² A simple way to view this is to take a 250ml cup with tea in and two spoons of sugar, if a further 250ml of tea is added it still has two spoons of sugar in. In addition, there is never very much olanzapine in the blood itself, approximately 50 mcg per litre, and that, as an example, losing two pints of blood would remove about 100mcg or 0.1mg olanzapine from the body.

Consideration of the Deprivation of Liberty safeguards (DoLS), the Mental Capacity Act (MCA) 2005, or detention under the Mental Health Act (MHA) 1983.

- 4.17 We examined whether the use of the DoLS¹³, MCA¹⁴ or detention under the MHA¹⁵ was considered during Harry's admission to LTHT between the 19 and 28 February 2015. In our opinion there was not enough consideration of the use of these legal frameworks during Harry's stay in hospital.
- 4.18 This also does not appear to be an area of care and treatment examined as part of the original investigation. In our view this was an additional key line of enquiry which would have warranted further consideration. This was an important issue that would have provided a framework in which Harry's care and treatment could have been considered.

Risk assessment

- 4.19 We reviewed the adequacy of risk assessments and risk management, including specifically the risk of Harry harming himself or others. We looked back at his history, the information provided by the stepdaughter, and risk assessments undertaken during his hospital admissions.
- 4.20 We have also examined whether the practice met the Department of Health (DoH) guidance on Best Practice in Managing Risk.¹⁶
- 4.21 Our view is that Harry should have been prescribed and administered olanzapine during his hospital admissions (see section on olanzapine).
- 4.22 In the section on olanzapine we discuss the erratic nature of Harry receiving his medication. Through our review of all of the records we noted that Harry's stepdaughter raised concerns that everyone thought he had stopped taking his medication for years. Her concern was that he was not receiving it at the time and he became aggressive when he was not taking it.
- 4.23 On the 22 February 2015 a Functional Analysis of Care Environments (FACE)¹⁷ risk assessment was undertaken, discussed, agreed and added to the LYPT

¹³ Deprivation of Liberty Safeguards forms and guidance, <https://www.gov.uk/government/publications/deprivation-of-liberty-safeguards-forms-and-guidance>

¹⁴ Mental Capacity Act (2005) <http://www.legislation.gov.uk/ukpga/2005/9/contents>

¹⁵ Mental Health Act code of practice <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

¹⁶ Dept of Health; "Best Practice in Managing Risk: Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services" June 2007

¹⁷ "FACE Recording & Measurement Systems" is the name of the company that produce several toolkits to assess risk and needs in health and social care, mental health, people with learning disabilities, young people, and people with substance misuse problems; to assess peoples' mental capacity, and as an assessment of needs for telecare.

records. A FACE risk assessment is a structured clinical judgement approach endorsed by the Department of Health (DH) Guidance on Best Practice in Managing Risk.¹⁸

- 4.24 The FACE risk assessment recorded a high risk of relapse with medication being the intervention to reduce this risk. The individualised action to be taken was recorded as, (following discussion with the on call senior registrar for psychiatry) “to restart olanzapine at a reduced dose today, 2.5 mgs straight away with an ‘as necessary’ dose of 2.5 mg for later in the evening”. It was noted that Harry would need a MHA assessment if he tried to leave the ward.
- 4.25 The descriptive risk summary noted that during assessment, Harry thought the window was a television, was very fixated on his uneaten porridge saying it was “glue”, and said he was not allowed to drink his juice because it was poisoned. Harry referred to two people in his room, that were not actually there, and used swear words to describe them. We have not found evidence that this was explored further at the time or that any measures were put in place to mitigate risk.
- 4.26 Harry’s stepdaughter was contacted for further information about the concerns that she had raised with staff in relation to his medication and in particular his olanzapine. The statement from the senior clinical nurse in liaison stated that it was standard practice to obtain and double check information in relation to a patient with a member of their family which we view as good practice that we do not always see elsewhere.
- 4.27 The 2009 Department of Health guidance on Best Practice in Managing Risk states that a risk management plan is only as good as the time and effort put into communicating its findings to others. In this respect our view is the risk assessment and management plan was not effective. We note that the internal investigation drew attention to closer collaborative working in their recommendation four. However, we have gone further and made a more specific and detailed recommendation in this area below.

Recommendation 2

We recommend that LTHT and LYPT work together to improve the application of risk assessments and risk management in the acute hospital environment. The work should include training for staff leadership and role modelling from clinical leaders, and regular audit of practice to demonstrate an improvement. Risk assessment and management of mental health patients in the acute hospital environment should be included in the clinical audit programme.

The FACE risk profile is part of the toolkits for calculating risks for people with mental health problems, learning disabilities, substance misuse problems, young and older people, and in perinatal services.

¹⁸ Dept of Health (2009) “Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services.”

- 4.28 We are aware that LTHT and LYPT have undertaken some development work to improve risk assessment and risk management. Leeds Liaison Psychiatry Hospital Mental Health Team now have guidance in place regarding sharing information with acute services and there is documentation and guidance available for acute staff regarding risk assessment for patients with challenging/aggressive behaviour. This work partially addresses Recommendation 2 above.
- 4.29 On 23 February 2015 the mental health liaison team consultant psychiatrist stated that she noted the content of the FACE risk assessment, however, this was not recorded or referred to in the notes that she made.
- 4.30 On 25 February 2015 when Harry was transferred to ward J19, he was placed in a bay area with three other male patients and no recommendation was made to move him to a side room. He was being reviewed daily by the mental health liaison team. However, no advice was asked for, or given to the ward by this team about whether Harry should be cared for in a single room or a four-bedded bay area of the ward. This should have been discussed in terms of managing the risk identified in the FACE risk assessment of the 22 February 2015.
- 4.31 In terms of managing the high risk of relapse for Harry, our view is that the decision to restart the olanzapine was the right intervention to make, and the decision to assess Harry under the MHA 1983 if he tried to leave was also appropriate. However, there was no evidence of communication or guidance for the ward staff if Harry refused to take the olanzapine or to ascertain that they knew what to do in the event of having to apply the MHA holding powers of section 5(2) or 5(4). Only Registered Nurses for mental health or learning disabilities that can use holding powers under section 5(4) of the Mental Health Act ('the nurses holding power'), and these nurses are not usually employed on acute medical wards. However, a general physical health doctor can use a section 5(2) to detain a patient on a general acute ward.
- 4.32 The records indicate that the information about the plan to restart the olanzapine was fed back to the ward doctor and they were advised to use this in an oro-dispersible form. The prescription chart indicates that olanzapine 2.5 mgs was prescribed as a once only medication at 1.55 PM and it was given at 4:45 PM. Oro-dispersible olanzapine 2.5 mgs was also prescribed as an 'as necessary' medication, however, there was no start date and it was not administered.
- 4.33 We found that the risk management plan was not updated from the 22 February 2015 although the mental health liaison team assessed Harry daily apart from the 24 February 2015. On the 26 February 2015 the mental health liaison team reviewed Harry again and he was thought to be a low risk of violence towards others.
- 4.34 We have not been able to find evidence of how the assessment on the 26 February 2015 concluded this, given the feedback from the stepdaughter.

Furthermore a specialist nursing assessment that was undertaken on the 26 February 2015 documented that Harry was agitated, anxious, worried, confused and disorientated. We believe that the risk assessment was erroneous, as Harry's previous presentation, reported by his step-daughter was that Harry had relapsed on two occasions in his history and on one of them he became aggressive and violent. This was misunderstood by those caring for him as a low risk (i.e. once in 50 years), rather than being seen in perspective, i.e. being violent once during his two relapses.

- 4.35 On the 27 February 2015 the statement of the mental health liaison team specialty doctor indicated that, following the assessment that day, the ward was advised to continue his one-to-one nursing special and to contact the on-call mental health liaison team should they have any concerns or need advice out of hours. We understand that the mental health liaison team specialty doctor believed that Harry was already on one-to-one observation, and advised that these should continue. The information regarding the one-to-one special was not evidenced in the records for Harry and the stepdaughter cannot recall Harry ever being on one-to-one observations.
- 4.36 The Department of Health (DoH) guidance on Best Practice in Managing Risk states that one-to-one care is often required and should be provided while the dose of psychotropic medication is titrated upward in a controlled and safe manner.
- 4.37 Our view is that Harry was probably psychotic, but that a one-to-one level of observation at close proximity may not have been the most appropriate intervention given his aggressive behaviour when approached, especially as the day and evening of the 27 February 2015 progressed. However, a level of observation which kept Harry in view at all times from a prescribed distance would have meant that Harry would have been observed getting out of bed before the incident and action could have been taken to prevent the incident occurring.

Recommendation 3

We recommend that LTHT issue guidance to staff on general acute wards regarding the criteria to request one-to-one support for patients who are a risk to themselves or others.

- 4.38 We know that LTHT and LYPT have worked together to develop the guidance recommended in Recommendation 3. LTHT Acute wards now have comprehensive guidance in place that supports them to make an assessment regarding a patient's enhanced care needs and the process by which to request one-to-one support for patients who are at risk to themselves or others. We have seen evidence that training has been delivered and the documentation is being used from a recent clinical audit report.

Safety of others

- 4.39 We also note that, at some point during the night, Health Care Assistant 2 recalled that a patient whose bed was located close to Harry in bed 11 complained to the nursing staff about his behaviour and was subsequently moved to another bed away from Harry at his request. A further staff statement recalled that this patient was not happy to be close to Harry. We also know from a further staff statement that the patient in the side room opposite Harry's bay complained about his shouting. However, we do not know if Ken or Roger, located in the same bay as Harry, complained. We were informed by his family that Ken was so poorly that he could not have complained. We have not examined their care records, so we cannot say how their safety was considered.
- 4.40 We conducted an analysis of all the incidents reported in the preceding 11 months. We noted that at times there were episodes of violence and aggression on the ward (approximately two incidents a month) and patients have been at risk in the preceding 11 months to this incident of injury from weapons that patients have brandished, flying glass/smashed crockery and direct attacks from other patients. We would like to have explored the wards approach to managing violence from patients and the public with staff to better understand contributory factors, however, we had to rely on the documents that we refer to earlier in our report.

Recommendation 4

We recommend that LTHT conduct a review of the case mix and safety of patients on J19 given the severity of violent incidents. This review should be conducted by security management specialists in conjunction with acute nursing staff on the ward and mental health specialists.

Should Harry have had a walking stick?

- 4.41 In terms of risk, we also looked at whether Harry needed to have a stick, given this was used as a weapon. This was not explored in the original investigation. We note that a statement from one member of staff indicated that although she only cared for Harry on a couple of occasions she recalled that he was very possessive about his stick as he needed this for walking.
- 4.42 We found that Harry had a post seizure fall assessment and a falls prevention plan completed on the 2 February 2015 indicating that he had difficulty with walking and balance. The question asking whether walking aids were in reach says that this was not applicable between the 2 and 12 February 2015.
- 4.43 A patient handling and movement risk assessment and plan of the 10 February 2015 indicated that he needed one person to assist him with general mobility to get in and out of bed, with walking, sitting and standing, transferring seat to seat, lying to sitting in bed, showering and bathing. However, the equipment section

which included indicating whether a stick was required was not completed and neither was an associated movement plan. Adult specialist assessments completed on the 27 January and the 19 February 2015 indicated that he was independent but unsteady and used a stick.

- 4.44 Following our review of the records we have concluded that Harry needed his stick to mobilise and was keen to keep hold of it. We therefore conclude that his having a walking stick was appropriate.

Staffing

- 4.45 We considered, as part of our independent review of Harry's care and treatment, how the numbers and types of staffing contributed to the quality of Harry's care and treatment. Later in our report we discuss what the internal investigation looked at with regards to staffing on ward J19.

Mental Health Staffing

- 4.46 Harry was not reviewed by the mental health liaison team on the 24 February 2015 as planned. Records clearly indicate that Harry was to be reviewed daily from the 22 February 2015. We examined records to understand why this was, given that the plan was to review him daily. We also examined whether this, and any staffing levels on ward J19 impacted on the incident of the 28 February 2015. We found that this was an area that was not explored in the original investigation. The information we had available to review this was minimal, did not include an examination of work load, and is taken from available records and staff statements taken at the time.
- 4.47 Statements from the mental health liaison team suggest the reason that Harry was not seen on the 24 February 2015 may have been due to work pressures and volumes of referrals received by the team.
- 4.48 The statement from the mental health liaison team consultant psychiatrist states that the possible reasons for the lack of review on the 24 February 2015 were:
- Harry was not considered in need of urgent review on the 24 February 2015;
 - that he could be managed on the ward in accordance with the current plan; and
 - ward staff knew how to access the mental health liaison team if they had any concerns about Harry.

- 4.49 We found that staff statements indicated that they knew how to, and did, refer to the mental health liaison team. One staff statement indicated that only medical staff could refer to them, however the LYPT Hospital Mental Health Team for Older People Service operational policy 2014 (we understand that this is the mental health liaison team) is clear that they accept referrals from a range of professionals.
- 4.50 The staffing levels for the mental health liaison team are defined in the operational policy as being:
- Two consultant psychiatrists - 1.2 whole time equivalent (WTE).
 - One clinical team manager.
 - Five band six registered mental nurses.
 - One band six occupational therapist.
 - One specialty doctor.
 - One band three mental health worker.
 - One core specialist trainee in psychiatry.
 - One academic foundation year two doctor (0.5 WTE).
 - One band five general administrator (0.5 WTE).
 - Two band three administrators.
- 4.51 We understand that the mental health liaison team have one consultant psychiatrist present each day and both are present on a Wednesday. Holiday cover is provided by consultant psychiatrist colleagues, and out of hours cover is provided by on call consultant psychiatrists who do not work in liaison but work within the wider old age psychiatry services.
- 4.52 At weekends the liaison team is comprised of two registered nurses who will review and assess patients, with senior cover provided by the higher trainee on call doctor during the hours of 9 AM to 5 PM. At the weekend, rather than awaiting referral from various wards, which is what happens during the week, the two liaison nurses on duty will carry out a sweep of the LTHT acute medical floors.
- 4.53 The liaison team holds a multidisciplinary meeting every weekday lunchtime apart from Wednesdays, during which all new patient admitted under the care of the service are discussed. The MDT meetings are attended by the whole team comprising doctors, nurses and healthcare support workers. Sometimes it is not possible for the whole team to be present, for example, due to sickness, holidays or team members being engaged elsewhere with patients.

- 4.54 However, the mental health liaison team always try and ensure that a senior member of the team is present; the team member that initially sees that new patient will provide the team with an update after that patient's history presentation and their current treatment plan. The MDT meetings provide a useful opportunity for patients to be discussed amongst the team and for patients' plans to be agreed. In addition to the daily MDT meetings, the mental health liaison team also has weekly meetings each Wednesday. This meeting is an opportunity to review any patients under the team's caseload where further advice and discussion is needed regarding on-going management. During these meetings the existing patient history presentation and current treatment plan is discussed amongst the team.
- 4.55 We only found one statement from the advanced nurse practitioner in LTHT A&E which commented on the availability of the mental health liaison team. She stated that it is generally not easy for patients with complex physical and mental health needs to obtain psychiatric input in A&E, and that often a patient needed to be admitted to a medical bed and be deemed medically fit before they get liaison psychiatry input for mental health problems.
- 4.56 At the time of the tragic event of the 28 February 2015 we understand there were no policies for the mental health liaison service to A&E however a standard operating procedure (SOP) is now in place.
- 4.57 In summary, based on the information available to us, we did not find that staffing levels in the mental health liaison team impacted adversely upon the events of the 28 February 2015.

General Acute Ward Staffing 27/28 February 2015

- 4.58 On LTHT ward J19 there are 29 beds. These are arranged in five four bedded bays, and nine single occupancy side rooms. Staff work in teams with one registered nurse caring for to 10 patients on the day shift, and one registered nurse to 15 patients at night. We understand that for 29 beds there should be four registered nurses and two clinical support workers during the day, and two nurses and two clinical support workers at night. If patients require one-to-one care, then extra staff are requested.
- 4.59 A pre-printed handover sheet provided a summary of each team's patients and relevant information. This handover sheet was kept by the nurses for the duration for the shift and disposed of confidentiality at the end of the shift. We understand the use of handover sheets to be routine practice in acute hospitals, however, we have not been able to examine evidence of the handover note to the night shift of the 27 February 2015.

- 4.60 Handover took approximately 30 minutes and was undertaken by each team whilst the other nurses remained out on the ward. The doctors had separate handovers and following a ward round there was a multidisciplinary meeting which included nursing and medical staff, physiotherapists, occupational therapists and the discharge coordinator
- 4.61 Most of the nursing staff worked a 12.5 hours shift (including breaks). Some staff worked 7.30 AM to 3.30 PM or 12.00 MD to 8.00 PM, or a twilight shift which was 12.5 hours (including breaks) from late afternoon onwards. Staffing levels were apparently short on the late afternoon of 27 February 2015 with statements indicating that there were two registered nurses instead of three.
- 4.62 This information conflicts with the information that there should be four registered nurses and two clinical support workers during the day. This indicates that there were staffing shortages that may have impacted on the care delivered to patients. This may have meant reduced observation of the patients in Harry's bay. We do not have any information on the dependency of the other patients on the ward on the afternoon or night shift.
- 4.63 We are mindful that having the required number of staff provides the time and opportunity to reflect on care provided in a way which is not possible when staffing levels are low. We are not able to say whether having the required numbers of staff on duty would have provided the opportunity to reflect and request extra staffing to provide Harry with one-to-one care as he deteriorated on the evening and the night of the 27 February 2015.
- 4.64 The ward had twice weekly consultant ward rounds. These were covered by senior registrar doctors if the consultant was not available. The first priority each morning was for the consultants on the acute medical wards to review all the patients in their bed base.
- 4.65 Consultant handover took place at 9:00 AM every day when the day and night medical teams met. All consultants in acute medicine were present. Patients discussed were those who were critically ill, those requiring urgent medical reviews, and any deaths which occurred out of hours and admissions to critical care. At the time of Harry's admission in February 2015 a lunchtime multidisciplinary team meeting took place daily.
- 4.66 Across the medical wards, during the day, there was a medical registrar doctor on duty and at least two consultants who were present until after the ward round was complete. There was one doctor based on the ward throughout the night and a senior registrar doctor covering two wards.
- 4.67 On ward J19 there were a minimum of four junior doctors who are usually split along the lines of two juniors to one consultant. At the time there were two consultants on Ward J19 so two juniors would see one consultant's patients with the other team reviewing the other consultant patients. There was some flexibility

if one consultant was very busy, however, the junior doctors would try to stay working with the same consultant and the same patients. We understand that the split between night and day shifts were never so long that the junior medical staff did not know the patients on the ward at the time.

- 4.68 However, one core trainee stated that sometimes there were problems in calling the senior clinicians for assistance. The consultants were based in another wing of the hospital and not on J19. A foundation year doctor stated that greater supervision and support from higher grade doctors would help with the management of challenging patients.
- 4.69 We found that the nursing staff statements were consistent and clear in explaining how the nursing complement was organised each shift, and in understanding their specific duties and tasks for each shift.
- 4.70 In summary we are unable to confirm what impact the staffing levels on the night of the 27 /28 February 2015 had on the incident. We believe that the care hours offered per patient was low and therefore are of the opinion that it was possible that there were not enough nursing staff on duty on the night shift.

Primary care issues

- 4.71 We examined the primary care issues as an additional key line of enquiry which we believe would have warranted further consideration in the original investigation.
- 4.72 In terms of Harry's history, he was reviewed every six months by a consultant psychiatrist on an outpatient basis. He was reported as stable apart from two occasions in April 2008 and March 2009 when he reported that he had been issued a prescription for less than the 15 mgs of olanzapine; as a result he had experienced several bouts of brief persecutory fears which abated when he was able to obtain his correct amount of medication. This was brought to the attention of the GP.
- 4.73 The Care Programme Approach (CPA) was introduced in 1990 with the aim of providing a framework for effective mental health care for people with severe mental health problems and included the appointment of a care coordinator. Following this, the NHS mandate 2004-2005 introduced the idea of crisis plans to help people recover from episodes of ill health. Harry was only seeing the consultant psychiatrist as an outpatient and did not have a care coordinator appointed or a crisis plan in place.
- 4.74 As Harry was approaching the age of 65 years a discussion took place with him about transferring to the older age psychiatrist. He preferred to be transferred to the care of the GP who was asked to refer him accordingly if his condition

deteriorated. Harry was discharged from the mental health outpatient clinic on 12 March 2009. The GP was asked to maintain him on the antipsychotic medication and to let the consultant psychiatrist know if there was any deterioration in his condition.

- 4.75 When Harry was discharged from LTHT on 30 June 2014 the discharge summary asked the GP to refer him to community psychiatry as “he has had two episodes of possible psychotic behaviour on the ward, though he is currently well and stable”.
- 4.76 The following day a telephone call was made to the GP practice who confirmed that the last time the consultant psychiatrist had seen Harry was in 2009. The medication on discharge included his usual antipsychotic medication (olanzapine) 15 mgs at night. We could not find any evidence of a referral being made to community psychiatry.
- 4.77 On 3 July 2014 the GP records indicate that a telephone consultation took place with the pharmacy technician at Leeds Community Health to discuss Harry’s medication timings as he was getting muddled with his new dosette box. The records state the GP would write to community psychiatry, however, we could not find evidence that this communication took place.
- 4.78 On 26 and 27 January 2015 Harry was seen at home by the GP after being asked to see him by the stepdaughter. Harry was reported to be deteriorating physically, and not wanting to eat. He was getting weaker and his breathing had declined. The GP records indicate that a review of his paranoid schizophrenia took place. We found that this review included blood pressure and pulse, advice about smoking, alcohol, a specific annual physical examination, prompted because he had a mental health diagnosis, and annual bloods. The records refer to a review associated with “high risk drug monitoring – shared care”, however, no further information was evident and so we cannot say that Harry received a review of his mental health.
- 4.79 The NICE guidance¹⁹ on promoting recovery and possible future care in schizophrenia advises that GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and then at least annually. The health check should be comprehensive, focusing on physical health problems that are common in people with psychosis and schizophrenia. We could not find evidence that this guidance was adhered to in the primary care setting until 2013.
- 4.80 On 13 February 2015 the GP records indicate that Harry had been discharged from hospital and the problems were noted as blood transfusion, CT scan, “had a

¹⁹*Psychosis and schizophrenia in adults: prevention and management Clinical guideline [CG178]*
<https://www.nice.org.uk/guidance/cg178/chapter/Key-priorities-for-implementation#promoting-recovery-and-possible-future-care>

collapse” .It was also noted that a directive that Harry was not for attempted cardio-pulmonary resuscitation (CPR) had been discussed and agreed with his stepdaughter. The discharge summary from LTHT stated “Please note Harry has very poor compliance with medication and he has not taken dosette box in some time. Please review. We have stopped his olanzapine as he hasn’t taken it in many years and is well without it”. The records made by the specialist registrar for the gastroenterology oncology team on 2 February 2015 also recorded the above rationale for stopping the olanzapine.

- 4.81 On 17 February 2015 the GP records indicate that an initial post discharge review was undertaken following discharge to Corinthian House Care Home. Poor compliance with his dosette box was noted and that he “hasn’t taken olanzapine in a long time” The records indicated that a medication review was undertaken, however, this did not result in olanzapine being prescribed.
- 4.82 In terms of referrals to secondary care the NICE guidance recommends that for a person with psychosis or schizophrenia being cared for in primary care, consideration for referral to secondary care should be considered again if there is:
- Poor response to treatment.
 - Non-adherence to medication.
 - Intolerable side effects from medication.
 - Comorbid substance misuse.
 - Risk to self or others.
- 4.83 In terms of relapse the NICE guidance recommends that when a person with an established diagnosis of psychosis or schizophrenia presents with a suspected relapse (for example, with increased psychotic symptoms or a significant increase in the use of alcohol or other substances), primary healthcare professionals should refer to the crisis section of the care plan. Referral to the key clinician or care coordinator identified in the crisis plan should also be considered.
- 4.84 We found that on 30 June 2014 the GP was asked to refer Harry to community psychiatry due to Harry having experienced psychotic episodes. On 3 July 2014 the GP indicated that this was going to be done, however, no evidence was found that this was completed. On 17 February 2015 the GP was asked to review Harry’s difficulty with his dosette box which was undertaken, however, olanzapine was not prescribed. The GP could also have requested an opinion from community psychiatry on the prescription of olanzapine at this point.
- 4.85 Our view is that had the referral to community psychiatry been completed in June or July 2014 Harry would have had a specialist mental health review, including his medication, at an early stage of his advancing physical health deterioration.

We believe this was an important missed opportunity where consideration could have been given to the application of the CPA and the possibility of the appointment of a care coordinator given the complexities of Harry's physical and mental health care needs.

- 4.86 The care coordinator would have developed a care and crisis plan. They would also have been able to take a coordinating role across the different organisations and specialties involved with Harry's care and treatment, and would have kept contact with Harry and his stepdaughter through his hospital admissions for his physical health care needs.

Recommendation 5

We recommend that the GP practice review all patients on their list that have a severe and enduring mental health diagnosis to ensure that there are no outstanding referrals to mental health services.

Bed rails, falls sensors and observations

- 4.87 We explored the use of bed rails, falls sensors and observations to investigate whether any, or a combination of these, would have alerted the staff to Harry's behaviour on the night of the 27 and 28 February 2015 in a way which could have resulted in a preventative intervention.
- 4.88 Bedrails can be effective in preventing patients from slipping, sliding or rolling out of bed. Most patients who fall from bed will only have minor injuries, but some can have serious injuries like fractured hips, and patients die each year in falls from their bed. However, the National Patient Safety Agency identified several risks associated with using bedrails in hospital; for example bedrails not being fitted and used appropriately, patients climbing over the side and falling from a greater height than if they had fallen out of bed. Specialist guidance and assessment is required if bedrails are to be used.
- 4.89 To investigate this, we looked retrospectively at when bed rails were first introduced to Harry's care and we found:
- 9 May 2014 bed rails were in place as Harry was confused and at risk of falls.
 - 19 - 24 February 2015 records indicate that bed rails were in place.
 - 19 February 2015 a falls care plan was commenced and indicated that the Harry "required hourly rounding". However, the records are inconsistent in that a cross was entered in the record from the 19 until the 27 February 2015, rather than a tick to indicate that the checks had been carried out. A separate "hourly rounding" checks form had the checks signed as being undertaken every hour from 8.00 PM until 7.00 AM.

- 20 Feb 2015 records indicate he also had a falls sensor pad in place which alarms if the patient is trying to climb out of bed.
 - 23 Feb 2015 a statement by one registered nurse stated that during the night Harry was initially drowsy but getting in and out of bed. A care plan indicated that regular safety checks were needed to ensure Harry's safety whilst he was drowsy.
- 4.90 We could not find evidence in Harry's care records of an assessment to evaluate the suitability of bedrails for him. It is possible that staff implemented bedrails to prevent Harry from getting out of bed at certain times. This may have been intended to maintain Harry's safety, but this may have constituted a deprivation of his liberty, if Harry lacked mental capacity to consent.
- 4.91 With regards to observations, on the 26 February 2015 at about 6:30 AM the records indicate that Harry did not have bed rails attached as he was sat out in a chair. The registered nurse updated Harry's care plan and described him as being pleasantly confused and not aggressive. Harry was wandering around the ward, not speaking, but compliant with directions and taking his prescribed medication.
- 4.92 On 27 February 2015 the mental health liaison specialty doctor said to continue his one-to-one nursing special and to contact the "on-call psych' team" should they have any concerns or need advice out of hours. However, the information regarding the one-to-one special was not evidenced in the records for Harry or evidenced as having been communicated to the staff on ward J19.
- 4.93 On 27 February 2015 another registered nurse stated that regular safety checks of Harry were undertaken which comprised of asking him if would like a drink or to be accompanied to go to the toilet and checking that the environment was safe. These types of checks are consistent with the requirements for "hourly rounding".
- 4.94 On 27 February 2015 the night shift registered nurse stated that she did not think Harry required one-to-one care because he would settle down for short periods and was not aggressive towards other patients. Although she handed over to the night staff that they should "keep an eye on him" she did not request more formal observations or one-to-one care. She reported in her statement that nursing staff can implement "hourly rounding" of patients who are a falls risk, at risk of absconding, or because of mental health conditions.
- 4.95 The statement from the agency nurse employed on 27 February 2015 as a "safety guardian" to provide one-to-one care for another patient with mental health problems on the ward indicated that this was something she had been employed to do on a regular basis on ward J19. She also indicated that because of the nature of the problems with this patient, she placed herself at the door of his room rather than being inside his room.

- 4.96 This indicated to us that the ward was able to respond and provide appropriate one-to-one care for patients with mental health problems. A statement also indicated that if one-to-one care is required for a patient on ward J19 then “they usually provide more staff”.
- 4.97 On 27 February 2015 several accounts confirm that Harry had an intramuscular administration of Lorazepam between 9:00-9:30 PM. Records show that this was given at 9 PM, and it was reported that Harry slept on and off for the following four hours. As and when Harry awoke, registered nurse 1 went to speak to him to calm him down and he appeared to listen and went back to sleep. Records indicate that Harry “remained verbally abusive but in bed with side rails up all night”.
- 4.98 On 27 February 2015 one registered nurse stated that Harry was not, at that time, on “hourly rounding” as he was thought to be manageable on the ward with standard staffing levels. Records were, however, inconsistent as it was also reported that due to his behaviour Harry was on “extra rounding” where staff document at least every hour that they have seen the patient; this was thought to be adequate for Harry as he became more agitated when someone was close to him. We have not found evidence that hourly rounding was recorded.
- 4.99 The statement from this registered nurse indicated that, generally, patients are observed by all members of staff as they undertake their duties. There is always a member of staff moving about the ward as a result, and after midnight patients are checked to see that they are safe every 15 minutes.
- 4.100 On transfer from J28 to J19 on 25 February 2015 Harry was placed in a bay area of the ward and not a side room. We examined the floor plan of ward J19 and found that there are two single rooms next to each nursing station and other single rooms, as well as five bays with four beds each. It is not known whether any single rooms were available during the time that Harry was a patient there. This aspect of care was not examined in the original investigation.
- 4.101 On 27 February 2015 a night time assessment chart was commenced documenting preparation for bed, behaviour during the night, mental state, continence, medication, times in and out of bed and a summary. Harry was described as wandering around for most of the night, he was incontinent, and was assisted back to bed twice. As set out above the records were inconsistent.
- 4.102 On 28 February 2015, at about 3 AM Harry became loud and was shouting. Registered nurse 1 approached him with oral Lorazepam which he appeared to take with a drink. He appeared to be calmer after taking this although his mood appeared to be “up and down”. Records indicate that registered nurse 1 was “doing rounding” to check and reassure Harry through the night which helped quieten his shouting and decrease confusion.

- 4.103 The patient in the bay opposite Harry had an external agency worker sitting with them on a one-to-one basis because of their particular needs. There was also an agency worker with another patient close by who could raise an alarm should it be needed.
- 4.104 The agency nurse assigned to one-to-one care for the patient in the single room opposite stated that Harry was “rattling his bedrails all night” and that “during the night the nurses even shut the doors to the bay because of the shouting”. Further statements from nurses described Harry as shouting, physically aggressive when approached, verbally aggressive with bed rails up all night, with curtains were drawn around Harrys bed between 5 and 6 PM as the patient in the side room opposite the bay complained that Harry’s shouting was making him agitated.
- 4.105 We note the statement from the LTHT Clinical Director which stated that by default patients are cared for in a bed in a bay because side rooms are a limited resource. Of the 29 beds on J19, nine are individual rooms. In deciding which patients have side rooms several factors are considered. Of overriding importance is to use side rooms to isolate patients with known or suspected infections which are known to have a high risk of patient to patient transmission. Ideal care of patients with delirium can also include the use of side rooms, however, confused patients who are able to walk cannot usually be constrained to stay within the side room. Whilst it may be reasonable to conclude that, because Harry was mobile, a side-room was not appropriate at this time and that prevention of infection would be a higher priority, it could have been considered in conjunction with one-to-one care.
- 4.106 At the time of these events, there was no decision-assistance tool for determining when patients should have one-to-one care. However, the indications to consider one-to-one care would include the following markers of risk:
- when recommended by the liaison psychiatry team;
 - when a patient is confused and mobile and so at risk of falling with no other reasonable way of reducing the risk;
 - when the patient has already shown behaviour which could be harmful to themselves, to other patients, staff or visitors; and,
 - as assessed by the general professional judgement of the ward staff.
- 4.107 In considering one-to-one care, the ward nursing staff would usually seek advice from the matron. Further, a balance must be struck to avoid unreasonable constraint of patient movement, and to consider and minimise the risk that continuous observation can sometimes cause escalation of potentially harmful behaviours.

- 4.108 According to the statement from the Clinical Director, in the days before the tragic event of the 27/ 28 February 2015, none of these indicators had been noted to be present, until the evening of 27 February. The physiotherapist noted on 26th February that Harry had been independently mobile about the ward all day and appeared steady. However, at 7:15 PM on 27 February the nursing notes states, “Harry has been very aggressive and abusive to staff: hitting and kicks out, unable to give medications, tried to give medications throughout the day”, “Very confused and aggressive all day”, and “mobilised to toilet but unsteady on his feet”. This could have triggered consideration of the need for one-to-one care for Harry at that stage.
- 4.109 We found that the records were inconsistent about whether Harry was subject to “hourly rounding” and whether he had bed rails and a falls sensor in place on the 27 and 28 February 2015.
- 4.110 We are not able to say whether the use of bed rails or a falls sensor would have had any impact on the tragic event of 27 and 28 February 2015. We found, however, that a decision could have been taken to nurse Harry in a side room of ward J19 rather than a four-bedded bay on the 27 and 28 February 2015 therefore minimising the possibility of violence towards other patients.
- 4.111 We also found that a decision could have been taken to provide a “safety guardian” and a level of observation for Harry to keep him in eyesight at all times on the 27 and 28 February 2015 therefore minimising the possibility of violence towards others and potentially preventing the tragic events from occurring.
- 4.112 As stated above and identified in the internal investigation, Harry lived for many years in the community with olanzapine to control the symptoms of his schizophrenia. His stepdaughter grew to know him well and was aware of the risk Harry having a relapse if he did not take his medication. In fact, apart from his GP, Harry’s stepdaughter was the only person who knew Harry well. From the middle of 2013 until the incident occurred Harry’s next of kin and the person who knew him best repeatedly attempted to alert the staff that were caring for him to the need to treat Harry’s symptoms of schizophrenia.

Care Delivery problems

- 4.113 We identified several care delivery problems through our analysis of the care and treatment that Harry received. Care delivery problems are acts or omissions in the process of care.

LTHT not taking account of the knowledge of the next of kin throughout his acute hospital stays.

- 4.114 We found a care delivery problem in that the information obtained from the stepdaughter about the need for Harry to have his olanzapine, and the impact that this would have on him and potentially others, was not acted upon. We found evidence that Harry's step daughter voiced her concerns about this on at least nine occasions in the 12 months before the incident. We note that medical staff often listened to her concerns but did not give them the weight they should have done. We note the fact that staff did not have access to Harry's historical mental health records whilst he was in the acute hospital. This made it even more important to listen to the experience and knowledge of close family. The views of carers/families and friends, where these are available, may be crucial in highlighting risk issues either from the past or present. Carers are often very skilled in noticing early warning signs or triggers and chains of events leading to relapse. They may also provide information about successful risk management and recovery plans. Had medical staff taken her concerns seriously and given them weight, they may have looked more robustly for ways to continue medication that had controlled Harry's symptoms of schizophrenia for many years. The internal investigation found that not responding to the family's contributions and involvement was a contributory factor.

Recommendation 6

We recommend LTHT ensure that the learning regarding listening to families/carers is incorporated into staff training. The essence of this is to ensure that staff understand that carers and family of people with long-standing mental health problems have extremely valuable insight into the risks associated with missed medication.

- 4.115 We are aware that LTHT have undertaken development work in relation to Recommendation 6. There is now a carers charter in place and there is a campaign to encourage family and carers involvement in the wards. Both of these sets of guidance refer to the added value from family and carers perspective and partially address this recommendation.

The GP not making a referral to community psychiatric services in June 2014

- 4.116 We found a care delivery problem in that the GP did not refer Harry to community psychiatric services in June 2014 when requested to. Had this have been completed Harry may have been allocated a care coordinator and the emphasis on maintaining the management of Harry's schizophrenia may not have been lost.
- 4.117 We believe that an alternative to using oral medication may have been considered (for example long-acting depot injection), and if this was chosen

Harry may have continued to have a consistent dose of olanzapine that controlled his schizophrenia. This was not identified in the internal investigation despite the report stating that GP records from 2014 were considered.

Prescription sheets and administration records not being completed correctly on several occasions

- 4.118 We found a care delivery problem in that between the 15 and 18 June 2014, and on the 24 June 2014, the prescription administration records were not completed in accordance with the LTHT Medicines Code March 2014 (version 3 page 31) which states that when a prescribed medicine has not been administered for two or more doses, or where a dose to be given immediately ('stat') has been missed, the senior nurse on duty should be informed, and an incident report may need to be completed. We established that Harry had been prescribed olanzapine on 1, 2, 22, 23, 24 and 25 February and only received it twice (on 22 and 24).
- 4.119 Had the required escalation process been completed for either of these examples it may have been identified that Harry was at risk if his medication was not delivered. Action could have been taken to ensure that his medication was not missed again. The fact that missed doses were not escalated was not identified in the internal investigation.
- 4.120 We also established that there were recording discrepancies regarding Harry's Lorazepam administration. As an example, figure 2 below is taken from Harry's prescription chart for the period covering 22–28 February 2015. This shows a prescription to give Lorazepam 1 mg as required. The start date is 25/2 (25 February 2015) and both oral and intravenous routes are ticked, with IM (meaning intra-muscular) being written over the top.
- 4.121 The first dose appears to have been given on 25 or 27 February but in the 'route' box it appears that PO (standard abbreviation for the Latin 'per os' or by mouth) has been overwritten by IM. The next dose has been given on 26 or 28 February.

The route is recorded as IM and the dose on 27 February is recorded as PO.

When Required Medicines

CLANZAPINE				Date			
Dose: 25mg				Time			
Route: Oral				Dose			
Frequency: pm	Max dose in 24 hours: none	Administration instructions: DIRETS WU		Route			
On admission: <input type="checkbox"/>	Start date:	Additional information: new		Sign			
Pharmacist: [Signature]	Contact Number:	Sign: [Signature]	Pharmacy: US	Supply: 22/2/15			

LORAZEPAM				Date	27	28	29
Dose: 1mg				Time	03	06	09
Route: Oral				Dose	1mg	1mg	1mg
Frequency: 30 min	Max dose in 24 hours: 4mg	Administration instructions: SLEEP OR ASAP if possible		Route			
On admission: <input type="checkbox"/>	Start date: 25/2	Additional information:		Sign			
Pharmacist: To	Contact Number:	Sign: [Signature]	Pharmacy: C128/L	Supply:			

Figure 2: Screenshot of medication prescription and administration chart for 25-27 February 2015.

4.122 This record has not been completed accurately. It is possible that the first dose referred to is the IM injection which was given on 27 February 2015. However, there is no statement saying that Harry was given an IM injection of Lorazepam on the 26 February or 28 February at 6 PM, yet there is a record. The statements state that Harry was given oral Lorazepam at 3 AM on 27 February 2015. We cannot confirm from these records what Harry was given because these records have not been completed clearly enough. The internal report explores the fact that Harry was not prescribed olanzapine. The deficiencies in the overall quality of drug prescription and administration was not identified in the internal investigation.

4.123 We were informed that on the 25 February 2015 Harry was seen for the third time by a clinical support worker from the mental health liaison team at 2.30 PM and this review was only recorded in the mental health liaison older people's assessment documentation. We were informed that as Harry had just transferred to J19, his notes were in transit and not accessible to her. She did, however, discuss Harry with a doctor on the ward.

Recommendation 7
 We recommend that LTHT take steps to ensure that the record-keeping in relation to medication prescription and administration is of the required standard. We suggest that this is included in their clinical audit programme.

Recommendation 8

We recommend to LTHT that they take steps to ensure that when patients transfer wards that their records are transferred with them avoiding a delay in receiving staff accessing patient information.

We have seen evidence that LTHT have adjusted their policy on transfer and handover of care, which partially addresses Recommendation 8.

Not seeking specialist mental health input quickly.

- 4.124 We found a care delivery problem in that LTHT did not refer Harry for specialist mental health advice from the mental health liaison team on the 2 February 2015 when he started to experience seizures and his olanzapine was stopped, or for three days after LTHT were advised to refer him on the 19 February 2015 by LYPT.
- 4.125 As identified in the internal investigation, we have also identified that there was a lack of mental health skills and experience on the ward (see service delivery problems). This made it even more important that specialist mental health input was sourced. Had Harry had input on the 2 February his olanzapine may have been recommenced earlier, and he would have had specialist mental health oversight of his condition for longer before the incident.

Recommendation 9

We recommend that LTHT take steps to improve the knowledge and understanding of general acute staff in how and when to access specialist mental health input.

- 4.126 We are aware that LTHT and LYPT have worked together to ensure that the knowledge and understanding of general acute staff of how and when to access specialist mental health support has improved. We have seen evidence of training being developed and delivered by mental health specialists to some acute general staff over the course of 2017/2018. The work undertaken partially addresses Recommendation 9.

Not considering the use of legislative frameworks

- 4.127 We found a care delivery problem in that consideration was not given to assessing Harry under the Deprivation of Liberty Safeguards (DoLS)²⁰, the MCA or the MHA during his admission to LTHT between 19 and 28 February 2015 when he was assessed as being “incapacitous” (i.e. lacking in mental capacity), and was being subjected to care which involved restrictions, such as the use of bedrails, and being administered medication which required restraint. We found

²⁰ Deprivation of Liberty Safeguards(DoLS), came into force in England 1 April 2009

that, at the time of Harry's hospital stay, hospitals could give urgent authorisation for a DoLs in emergency situations whilst an assessment was being made²¹ and that this was not considered.

- 4.128 We also found that there was no thorough consideration of the use of the Mental Health Act other than suggesting to ward staff that he might need to be detained if he tried to leave the ward. Had Harry been assessed under either the MCA or the MHA this would have required the practitioners involved in his care to reflect on what was happening to Harry and formal recognition of his family's input. We found that this would have assisted in ensuring that Harry's mental health needs were being adequately considered. This was not identified in the internal investigation.

Recommendation 10

We recommend that LTHT take steps to improve the practical skills and understanding of general acute ward staff with regards to the use of Deprivation of Liberty Safeguards and the Mental Capacity Act.

- 4.129 We are aware that LTHT have provided training to the majority of their staff in application of the Mental Capacity Act (achievement of level 1 training is approximately 98%). This partially addresses recommendation 10.
- 4.130 We found a care delivery problem in that consideration was not given to prescribing immediately acting anti-seizure medication and continuing Harry's olanzapine which could have prevented a relapse of his schizophrenia. Had Harry been able to continue receiving his olanzapine his chances of schizophrenic relapse would have been significantly reduced. The internal investigation identified that not enough advice was taken regarding continuing Harry's olanzapine.

Recommendation 11

We recommend that LTHT take steps to ensure that appropriate referral criteria are developed to advise pharmacy staff when they should seek advice from a pharmacist working in specialist mental health services, and a psychiatrist, in the cases of patients with severe and enduring mental illness such as schizophrenia.

Inappropriate use of Lorazepam

- 4.131 We found that the psychiatric team had advised that Harry's olanzapine should be restarted on several occasions. At times they had also advised the use of Lorazepam. Lorazepam is helpful in the short-term management of behavioural disturbance and agitation. However, the BNF also advises caution as it can sometimes have a paradoxical effect of increasing behavioural disturbances,

²¹ Department of Health DOLS Code of Practice 2009

even in doses as low as 2 mg. Harry was given Lorazepam on the evening of 27 February and then an oral dose at 3 AM on 28 February 2015. We concluded that the use of Lorazepam on 27/28 February 2015 may have had a rebound effect and increased Harry's agitation and behavioural disturbances, and as a result may have been inappropriate. The internal investigation did not discuss the use of Lorazepam.

Ineffective risk assessment

- 4.132 We found a care delivery problem in the LYPT initial risk assessment of the 22 February 2015 was not updated thereafter in accordance with the LYPT clinical risk assessment and management procedure (dated January 2013, reviewed August 2017), shared with LTHT. A plan should have been developed to manage these risks more effectively.
- 4.133 This was discussed and explored in the internal investigation report. We have already made a recommendation regarding this.

Ineffective risk management

- 4.134 Associated with the assessment above, the management plan put in place covered food and diet and a recommendation to re-start olanzapine. This did attempt to mitigate the risks identified. However, in our opinion this was too limited. We believe there should have been a more comprehensive plan in place to manage the potential of Harry's agitated behaviour reoccurring including advice for LTHT staff. Had a risk management plan been developed consideration may have been given to use of legislative frameworks to protect Harry and those around him.
- 4.135 This was discussed and explored in the internal investigation report. We have already made a recommendation regarding this (see recommendation 2).

Ineffective observation

- 4.136 We found a care delivery problem in that appropriate nursing interventions were not put in place on 27 and 28 February 2015 to provide a "Safety Guardian" and a level of observation for Harry to keep him in eyesight at all times, therefore minimising the possibility of violence towards others. Had Harry been observed on a one-to-one basis any change in his condition may have been spotted earlier, and staff would have been near enough to prevent the attack.
- 4.137 The use of a one-to-one was referenced in the internal report, however, there was limited discussion about whether this would have prevented the attack. We have already made a recommendation regarding this (see recommendation 3)

Inappropriate care environment

- 4.138 We found a care delivery problem in that Harry was nursed in a four-bedded bay, high stimulus environment, in the same room as other vulnerable people. Furthermore, on the night of the incident Harry was nursed, at some point before the attack, with curtains drawn round his bed with the doors to the bay closed. We have been made aware that curtains were also used at some time to protect Harry's dignity and privacy.
- 4.139 However, we found that the combination of the curtains and the doors being closed increased the likelihood of staff not knowing what Harry was doing. Had the curtains been open staff may have noticed that he was not in his bed, and had the bay doors been open staff may have heard what was happening in time to prevent the attack. This was not discussed in any detail in the internal investigation. We recognise that in the current climate bed availability may mean that there is no choice about where a patient is placed, however some consideration needs to be made regarding each patients needs and risks.

Recommendation 12

We recommend that LTHT conduct a risk assessment when vulnerable patients may be in a bay with patients who are aggressive or agitated. We further recommend that LTHT take steps to ensure that where patients are inappropriately placed together that additional staffing is secured to maintain their safety.

- 4.140 As referred to above (with reference to Recommendation 3) we know that LTHT have issued comprehensive guidance to staff regarding the risk assessment of patients who may need enhanced care/1-1's. The clinical audit report that we have seen suggests that this is used regularly and has demonstrated an improvement in the use of documentation between 2016/17 and 2017/18. This partially addresses Recommendation 12.

Ineffective level 2 pharmacy reviews

- 4.141 We found a care delivery problem in that records indicate that level 2 LTHT pharmacy reviews were undertaken on the 26 and 27 February 2015. We did not find evidence, in any of the level 2 reviews that Harry's medical records were taken into consideration. We would have expected the review to look at whether the medicines were appropriate to Harry's medical conditions, taking into account any tests or results that had occurred whilst he had been an inpatient. There was also no identification that Harry had missed so many doses of prescribed medication.
- 4.142 Had the level 2 pharmacy reviews considered all the medications that Harry was prescribed and receiving (or not receiving) they may have identified that he was not getting his olanzapine when it was prescribed or that the Lorazepam may not be an appropriate prescription for managing Harry's schizophrenia. They may

also have identified when the mental health team had recommended recommencing the olanzapine and may have taken the opportunity to access specialist mental health pharmacy advice. This may have meant that Harry's olanzapine prescription continued despite him having seizures.

- 4.143 The level 2 pharmacy reviews were not discussed in any detail in the internal investigation report.

Lack of holistic overview of Harry's care

- 4.144 We found that although there was a plethora of nursing care assessments and care plans in place, there was no one record that described a holistic overview of Harry and his needs. This meant that it was difficult to understand what Harry needed and what was a priority. We have listed this as a service delivery problem as well. This lack of holistic overview meant that people may have lost perspective on what was more important in Harry's care. This led to the acute teams' who were caring for Harry losing 'situational awareness' of his condition and his care.
- 4.145 This lack of holistic overview for the acute team was not identified as an issue in the internal investigation report. The internal report identified that information was not shared effectively between services and recommended actions in relation to this (see appendix F and recommendations 2, 7, 8 and 9). We also identified that the acute physical care planning process and documentation made it difficult to have a picture of Harry's physical health and mental health needs.

Recommendation 13

We recommend that LTHT take steps to review their care planning documentation to ensure that there is an opportunity to describe an overview of the patient's care needs. We further recommend that LTHT include this in their clinical audit programme.

Repeated missed doses of olanzapine

- 4.146 We found that Harry only had two doses of olanzapine between the 1 and 27 February 2015 (on 22 and 24 February 2015). We understand that pharmacy services routinely review and escalate patients who have had missed doses. There was no evidence of escalation in his case.
- 4.147 The internal report sets out Harry's medication regime but does not make it clear that Harry having had only had two doses of olanzapine 2.5 mgs in 27 days was an issue, nor was it set out as a care delivery problem in its own right.

Recommendation 14

We recommend that LTHT ensure that the pharmacy service routinely carry out checks on prescription sheets to identify if patients have had repeated missed doses of the same drug. Where there are repeated missed doses, we

recommend that LTHT ensure that pharmacy staff escalate these cases to the consultant and Ward Manager in charge of the patient's care.

Lack of record-keeping

- 4.148 We found a care delivery problem in that one of the doctors on duty on the night of the 27 February 2015 did not make an entry in the records about his assessment of Harry. There was no evidence of a proper assessment or any record of what he found. His statement indicates that he found Harry to be confused and changed Harry's prescription to an IM injection. We felt this was a missed opportunity to seek advice from the on-call mental health team. This also reduced the level of communication to the rest of the team.
- 4.149 This was not identified in the internal investigation report.

Lack of a plan of how to care for Harry if his behaviour escalated again

- 4.150 We found that there was no plan of what to do for Harry once the Lorazepam had worn off. Lorazepam is an anxiolytic that is used to control and alleviate the symptoms of anxiety. Unlike other medication for treating depression, for example, it does not treat underlying causes. Therefore, once the effects of the Lorazepam had worn off it would be reasonable to expect Harry's behaviour to escalate as the underlying cause of his anxiety had not been removed. There was an opportunity to consider the use of the MHA, a Safety Guardian, a review of his medication, or to consider a side room, but we could find no evidence of this in his records. Had a plan been considered, there may have been enough time to action it before Harry became agitated again at 3.00 AM.
- 4.151 This was not identified in the internal investigation report.

Recommendation 15

We recommend that LTHT take steps to ensure that when patients are given intramuscular medication to calm them and to reduce an episode of aggression or disturbed behaviour, a plan is made to effectively look after them and maintain their safety when the medication effect wears off.

Service Delivery problems

- 4.152 Service delivery problems are problems with the way a service is designed or routinely delivered, these are often aspects that create 'accidents waiting to happen'.

A gap in health records policy

- 4.153 We found a service delivery problem in that the LYPT Health Care Record Policy January 2013 did not provide guidance to the mental health liaison team on where, and how, records of their assessment of patients in LTHT should be

recorded. Similarly, neither did the Liaison Psychiatry for Older People: The Hospital Mental Health Team for Older People Operational Policy 2014.

- 4.154 This was identified as a significant issue in the internal investigation report, and recommendations were made to improve communication in this regard.

Recommendation 16

We recommend that LTHT and LYPT work together to ensure that there is clarity about where decisions regarding patients who are being treated by both Trusts are recorded. Furthermore, we recommend that both Trusts adjust their healthcare records policies accordingly.

- 4.155 We are aware that LTHT and LYPT have undertaken some work to improve record-keeping in this way. There is now a Leeds Liaison Psychiatry Service Procedure for the use of mobile personal computer devices to create live and contemporaneous clinical case notes, in place. This partially addresses recommendation 16.

No guidance for staff regarding one-to-one nursing care for patients.

- 4.156 We found a service delivery problem in that, at the time, LTHT did not have a policy on providing one-to-one nursing care for patients, despite the fact that one-to-one care was being provided on a regular basis by “safety guardians” on ward J19. We understand that LTHT does now have a policy in place with a clear assessment tool to guide staff on the types of one-to-one supervision that may be required. We will review this in the next phase of our work.
- 4.157 This was not identified in the internal investigation report. We have already made a recommendation regarding this (see recommendation 3).

No requirement to assess someone’s mental health needs on admission to an acute hospital.

- 4.158 We found a service delivery problem in that the LTHT specialist nursing assessment undertaken on admission, where there is change in the patient’s condition and at discharge, does not offer the opportunity of assessing someone’s mental health needs other than psychological well-being and cognition, and whether the patient has a diagnosis of dementia.
- 4.159 This was identified in the internal investigation report and a recommendation was made to address this problem (see appendix F- recommendation 1). We have made a more expanded recommendation regarding the admission process (see recommendation 1).

Inadequate knowledge and skill of the Ward J19 nursing staff

- 4.160 We found a service delivery problem regarding training of acute ward staff. Our review of the records that we looked at and staff statements found that staff

reported only limited training and experience in mental health overall and no specific training in DoLS, MCA or the application of the MHA in an acute hospital setting. Staff statements drew attention to their lack of knowledge in mental health. We were surprised that the use of the MCA was not clearly considered in Harry's care.

- 4.161 Had the nursing staff been more cognisant of mental health needs, and the possibilities for supporting and protecting people with mental health needs, Harry may have had better observation and risk management plans in place, which would have significantly reduced the chance of the attack taking place.
- 4.162 This was identified in the internal investigation and recommendations were made regarding supporting staff with mental health skills.
- 4.163 However, the internal investigation did not consider or identify issues with DoLS or MCA knowledge and skills. We have already made recommendations regarding this (see recommendation 10).

Lack of adequate nursing resource

- 4.164 We found a service delivery problem in that there were reported staffing issues on the afternoon of the 27 February 2015, and only four members of nursing staff on duty to care for 29 patients on the night of the 27/28th of February.
- 4.165 There is a strong body of evidence to link shortage of nurses to care not delivered and poorer patient outcomes.²² The night staffing gave a ratio of one registered nurse to 14-15 patients and one member of staff to 7-8 patients.
- 4.166 Although we do not have any information regarding the dependency of patients on the ward at this time, we found it unlikely that this resource was adequate. Had there been more staff on duty there may have been more frequent staff presence in the bay that Harry was nursed in and this may have meant staff had the opportunity to intervene in the attack.
- 4.167 The internal investigation identified that there were no issues relating to staffing levels that impacted on this incident. We have made some recommendations regarding this (see recommendations 3, 4, and 12).

Lack of clarity regarding referral to mental health liaison

- 4.168 We found a service delivery problem in that some staff understood that although any member of staff can make the suggestion that a referral is made, referrals

²² (2013) Ball JE1, Murrells T, Rafferty AM, Morrow E, Griffiths P, "Care left undone' during nursing shifts: associations with workload and perceived quality of care".(British Medical Journal)

could only be made to the liaison team via a fax made by a member of the medical team.

4.169 However, the Operational Policy for the Mental Health Liaison Team (2014) indicates that referrals into the service are made by fax or telephone by acute hospital consultants, other multidisciplinary professionals, consultant old age psychiatrists and other mental health professionals.

4.170 This was discussed in the internal investigation. We have already made a recommendation regarding this (see recommendation 9).

Lack of holistic overview of patient care

4.171 We found a service delivery problem in that the plethora of LTHT assessment and care plans did not provide an overview of the patient as a whole and did not address mental health needs.

4.172 This was not identified in the internal investigation report.

4.173 Examples of assessments, care plans and charts which applied to patients during admissions to LTHT included:

- Adult specialist assessment
- Surgical assessment unit triage
- Transfer checklist assessment
- Venous thrombosis risk assessment
- Patient handling assessment
- Nutritional screening tool
- Methicillin resistant staphylococcus aureus (MRSA) assessment tool
- Post-operative care plan
- Care plan with problems and needs
- Care of a patient with symptoms relating to disease progression
- Infection prevention and control source isolation care plan
- Urinary catheter care plan
- Falls prevention care plan
- Pressure ulcer prevention care plan
- Hygiene care plan
- Bed rails care plan
- Oral nutritional support care plan

- Graded observation chart
- Fluid chart
- Stool chart
- Intentional rounding chart
- Neurological observation chart
- Weight chart

4.174 We have already made a recommendation regarding this (see recommendation 13).

Root Cause

4.175 We found that the major contributory factor or root cause to the tragic event of the 28 February 2015 was a lack of situational awareness between LTHT and LYPT about the impact of a relapse of Harry's schizophrenia, and the potential risk of harm to others. This led to Harry not being prescribed and administered his olanzapine for a period of 22 days between the 1 and 28 February, apart from on the 22 and 24 February 2015.

4.176 As a result of not being prescribed and administered his olanzapine he relapsed and began to experience psychotic symptoms.

4.177 Ineffective risk management planning, including advice from LYPT to ward J19 staff, meant that preventative actions were not put in place to ensure the safety of others.

4.178 As a result of his psychotic symptoms he attacked two other patients in the four bedded bay on ward J19 LTHT believing them to be intruders in his house who may have harmed others.

Predictability

4.179 We considered whether the tragic events of 28 February 2015 were predictable or preventable. We define predictability as being "the quality of being regarded as likely to happen, as behaviour or an event".²³ An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.²⁴

²³ <http://dictionary.reference.com/browse/predictability>

²⁴ Munro E, Rungay J, *Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry* (2000)176: 116-120

- 4.180 We have based our view in the knowledge of Harry's diagnosis of schizophrenia and the knowledge of the nature of his psychotic symptoms, the pattern of his illnesses and his relapses.
- 4.181 We consider that it was predictable that during a period of relapse, without medication, Harry would become 'paranoid' about people and we note that Harry had relapsed on two occasions in his history and on one of them he became aggressive and violent.
- 4.182 We acknowledge that LTHT and LYPT did not have access to the historical mental health records for Harry. We understand that these were requested on the 22 February 2015 by LYPT after Harry was referred to them, and that they arrived after the tragic event took place. However, even without these, and most importantly, all services had access to the information provided by Harry's stepdaughter.
- 4.183 In the past, between 1990 and 2005 in periods without antipsychotic medication, or when he had not been stabilized on a regular dose of 15 mgs olanzapine at night, he was physically aggressive on one occasion, verbally aggressive and threatening on every occasion, and concerned about noises and intruders in his flat on two occasions.
- 4.184 After this period of time, we found evidence to support our view from information taken from the stepdaughter and the LTHT and LYPT records.
- 4.185 In 1990 his stepdaughter said that within eight days of stopping his olanzapine he smashed the windows in a shopping centre and hit his wife.
- 4.186 Between 2002 and 2005, before Harry was stabilized on olanzapine 15 mgs at night, he had experienced several episodes of psychosis including hearing loud noises in his flat, believing that an intruder had been in his property and feeling that people were looking at him. On one occasion he approached a person and asked what they were looking at. He was worried this may result in a fight.
- 4.187 His stepdaughter told LTHT, LYPT and Corinthian House Care Home on many occasions that Harry could become aggressive without his medication.
- 4.188 On 20 June 2014 Harry began to hallucinate and could hear two male voices threatening him after not having olanzapine for four days.
- 4.189 On 18 February 2015 whilst in Corinthian House Care Home Harry was threatening, shouting and swearing at staff, and at one point said he was going to kill them all after not having had his olanzapine for 22 days.
- 4.190 On 22 February 2015, as part of a risk assessment process, Harry referred to two people in his room using swear words in a derogatory manner and felt his drink was poisoned. Harry had only had one dose of olanzapine 2.5 mgs in 25 days.

- 4.191 On 27 February Harry was constantly swearing and shouting “Nurse, nurse get here, we’re going to get killed” and other obscenities, including racial slurs that appeared to be directed at people.
- 4.192 We consider that the probability of violence, from the 18 February 2015, was high enough to warrant action by professionals to try to avert it, however, we do not think that the extent of the violence and the tragic event of the 28 February 2015 could have been predicted.

Preventability

- 4.193 Prevention means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore, for a homicide to have been preventable, for example, there would have been the knowledge, legal means and opportunity to stop the incident from occurring.²⁵
- 4.194 We consider that the tragic event of the 28 February 2015 was probably preventable. We have based our view on this using information from the GP, LTHT and LYPT records about the measures that were put in place in terms of the care and treatment provided for Harry and to safeguard other patients on the ward.
- 4.195 We could not find evidence of that the GP referred Harry to community psychiatric services in June 2014. Harry was not therefore offered the opportunity of having the Care Programme Approach (CPA) applied to his care and treatment, including the appointment of a care coordinator. This could have provided valuable oversight and coordination as Harry’s physical and mental health deteriorated.
- 4.196 Harry could have been referred by LTHT for specialist mental health advice from the mental health liaison team on the 2 February 2015 when he started to experience seizures and his olanzapine was stopped, rather than on the 22 February following his readmission to LTHT on the 19 February 2015. This would have allowed more time to request the historical mental health records, collate a risk assessment, and initiate appropriate treatment.
- 4.197 Harry could have been assessed under the MCA during his admission to LTHT between 19 and 28 February 2015. This could have offered a helpful framework in which Harry’s care and treatment could have been re-considered.
- 4.198 Harry could have been prescribed an immediately acting anti-seizure medication and his olanzapine could have been continued which would have prevented a relapse of his schizophrenia.

²⁵ <http://www.thefreedictionary.com/prevent>

- 4.199 The risk assessment of the 22 February 2015 was not updated, shared with LTHT, or had a management plan put in place to mitigate the risks identified including advice for LTHT staff.
- 4.200 A decision could have been taken to nurse Harry in a side room of ward J19 rather than a four bedded bay on 27 and 28 February 2015 therefore minimising the possibility of violence towards others.
- 4.201 A decision could have been taken to provide a “safety guardian” and a level of observation for Harry to keep him in eyesight at all times on the 27 and 28 February 2015 therefore minimising the possibility of violence towards others.

5. INTERNAL INVESTIGATION

- 5.1 The terms of reference for our independent investigation (see appendix A) instructed us to give an independent view of the quality of the externally commissioned internal investigation of the incident (referred to hereafter as the internal investigation). Due to the requirement to complete a report for the Coroner, we have not commented on the Trusts actions following the internal report. This will form a separate report, to be provided during 2018.

Timeline of the internal investigation

- 5.2 The incident itself occurred on 28 February 2015 on Ward J19 at St James's Hospital, Leeds. Our understanding from reviewing documents supplied to us was that the external independent reviewer was sourced through the Trust solicitors. Following some informal discussions, a letter of appointment was sent to the external independent reviewer on 14 May 2015. The letter requested that the investigation should not start until the police had given permission for the investigation to commence, and the terms of reference for the investigation were to follow. This is consistent with the LTHT procedure 26 in place at the time (see LTHT procedure paragraph 4.20 page 5).
- 5.3 There was a police investigation immediately following the incident which delayed the commencement of the internal investigation. The LTHT Procedure for the Reporting and Management of Serious Incidents November 2013 states that the recognised protocol must be followed for liaison and effective communication between the NHS, the Health & Safety Executive (HSE) and the Association of Chief Police Officers with regards to investigating patient safety incidents resulting in unexpected death or serious harm. This is set out in the Memorandum of Understanding: Investigating Patient Safety Incidents Involving Unexpected Deaths or Serious Harm, (the MoU) published by the Department of Health in February 2006. The Memorandum is further supported by Guidelines for the NHS, published in November 2006. We understand that this MoU has since been withdrawn, and NHS England are in the process of reviewing this. However, the Police College have issued guidance on investigating deaths and serious harms in health care settings²⁷ which states that "The MOU has now been withdrawn although it is acknowledged that much of the content is still relevant for conducting investigating in Healthcare settings and has been included within this guide." We found that this guidance was followed.

²⁶ Procedure For The Reporting And Management Of Serious Incidents (SI's) November 2013 – Leeds Teaching Hospitals NHS Trust

²⁷ An SIO's Guide to Investigating Unexpected Death and Serious Harm in Healthcare Settings – Revised 2015 (v10.6) <http://library.college.police.uk/docs/NPCC/2015-SIO-Guide-Investigating-Deaths-and-Serious-Harm-in-Healthcare-Settings-v10-6.pdf>

- 5.4 We established that, following pressure from both Trusts, the internal investigation was allowed to commence in July 2015 by speaking to the people that were not being interviewed by the police.
- 5.5 The police also agreed to share statements that they had taken during their investigation. These statements were shared, but a little while after the internal investigation had started. We established that a batch of statements were sent to LTHT's solicitors on the following dates:
- 26 June 2015 – 32 statements
 - 20 October 2015 – 15 statements
 - 12 December 2015 – 2 statements
- 5.6 The external independent reviewer was supported by two members of staff from the Trust solicitors and the work commenced on 9 July 2015 (see internal investigation report). On 13 January 2016 the police indicated that their investigation was closed. We understand that the police had been unable to interview Harry as he was so unwell and he died before any charges could be brought. The draft reports were submitted to both Trusts on 8 February 2016 and the themes of the report discussed with the families on 10 February 2016. The report was shared with staff to check for factual accuracy. The report was taken through various internal governance and quality assurance processes at both Trusts. The final report was dated 1 April 2016.
- 5.7 The internal investigation took 38 weeks from commencement to production of the final report.

Commissioning the internal investigation

- 5.8 It is normal practice within the NHS to set out terms of reference for any review, investigation or inquiry. This sets out the parameters for the work, including the dates, scope, level and information to be used. They often describe the methods to be used, outputs required and the timescales for delivery. These amount to 'instructions' to the investigation team on what to look at. Terms of reference were written for this internal investigation. The terms of reference amount to 2 pages and are included in appendix D.
- 5.9 There is no date or version control on the document, but we confirmed with LTHT that these are the terms of reference given to the external independent reviewer at the commencement of his investigation. Although they differ from the terms of reference referred to in the internal investigation report, we have compared the two documents and the differences are minor wording changes that, in our view, do not fundamentally affect the scope and depth of the investigation, therefore we did not explore the reason for the different versions.

- 5.10 The following two recommendations are designed to ensure that there is clarity regarding the scope and scale of the investigation, and to provide an auditable trail in case of any complaints or challenges to the report's findings.

Recommendation 17 – regarding future investigations at level 2.

We recommend to both Trusts and Commissioners that:

- h) Terms of reference documents include a version control and date by which they are finally agreed.
- i) We recommend that in future investigation reports the exact wording from the finally agreed terms of reference are included in the final report to ensure there is no doubt as to what they should cover. This should be included in internal investigation protocols for both Trusts and in the closure checklist process for Commissioners.
- j) Internal investigations are focused on the incident itself, not just the care and treatment of one patient.
- k) If families identify issues during the investigation that they wish to be addressed, that are not covered within the terms of reference, that the investigator requests a review of the terms of reference by the commissioner of the investigation. This should then consider if the families concerns and questions are adequately explained within the terms of reference, and if not expand them to cover the issues and identify any extra resources that are required and made available to the investigation team
- l) Complex Level 2 investigations are conducted with an investigation team (of more than one person) that comprises professionals with expertise in investigation techniques and specialist knowledge in the clinical areas to be investigated
- m) Future terms of reference for provider led investigations specify the level of investigation to be carried out and describe the incident to be investigated. To assist in clarity, terms of reference should include the date, location and a brief description of the incident and outcome.
- n) Future terms of reference must include the investigation methodology that the investigation team are expected to follow, and that this should be consistent with national guidance in place at the time

Development of the terms of reference

- 5.11 We established that the terms of reference were developed at a meeting between Executive Directors and the risk departments of LTH and LYPT. The draft terms of reference were then sent to the families of Harry, Roger and Ken for their comments. Following the families input, adjustments were made and these were sent to the external independent reviewer.

- 5.12 We established that both Trusts wished to have ‘fresh eyes’ on the situation, so they decided to find an investigator that was from outside either Trust to investigate. This decision should be commended as it is an area of notable good practice.
- 5.13 The Trusts told us that the local arm of NHS England (the Director of Commissioning Operations (DCO), previously referred to as Local Area Team) was engaged in and agreeable to the commissioning of the internal investigation from an external independent reviewer and agreed to the focus of the investigation. We heard that there were regular conversations between the risk team at LTHT and the DCO regarding this investigation.
- 5.14 At the outset of the investigation the cause of death for both Roger and Ken had not been confirmed. We believe that both Trusts confused the purpose of the internal investigation with that of a statutory investigation which is required after a serious crime is committed by a person in receipt of mental health services.
- 5.15 In these situations, there are always two NHS investigations: a local one carried out by the provider and a Level 3 independent investigation. This may appear to be duplication but the Level 3 investigation is intended to ensure that there is a high level of independence and scrutiny pertaining to the incident, in this case the care of mental health patients. The purpose of the local review is to examine care and systems surrounding everything affecting the event.
- 5.16 The Level 3 independent investigation must be commissioned by NHS England and must be conducted by external investigators.²⁸ This can only reasonably be commissioned once a decision has been made that the case fits NHS England criteria for an independent investigation. The investigation often takes place sometime after the event, once any criminal procedures have been completed. It is therefore vitally important that the incident itself is investigated locally as soon as possible after the event, to ensure that anything that needs to be rectified is done so as soon as possible.
- 5.17 The internal incident investigation should have investigated the incident, looking at the care and treatment of all patients and all the events leading up to the incident itself. As it was, there was no delay in the internal investigation because of this confusion. However it did affect the scope of the investigation and its final report, because the internal report only looked at factors relating to Harry’s care and treatment.
- 5.18 We recognise that the Trusts commissioned an independent person to do this as soon as possible, but, as explained in the sections above, the focus of the investigation was not correct.

²⁸ The NHS England Serious Incident Framework also describes that other Level 3 investigations can be commissioned by the commissioner of the service provider.

- 5.19 There is a responsibility for people commissioning serious incident investigations to engage with the families of those affected to ensure that the questions that they wish to be answered are included in the terms of reference. It is our understanding that the families had opportunity to comment on the terms of reference before they were finalised.
- 5.20 We would suggest that incident investigation reports should support the delivery of openness and compliance with the Duty of Candour. Therefore, we would expect the investigation report to provide answers to questions from the families affected. This was not explicitly set out in the internal investigation terms of reference but, in our opinion, was adequately covered in the paragraph within the terms of reference which states "Interview the families affected by the incident on Ward J19 in February 2015, ensuring their voices are heard. The investigation team will involve all the patient's families in the investigation as fully as possible to ensure their comments and concerns are heard and addressed".
- 5.21 However the families raised several points that they wished to be covered, some of which they were told did not fit within the terms of reference. We cover their requests in more detail later.
- 5.22 Our discussion with the families were extensive and they felt that there were many unanswered questions for them. We reviewed information they had sent to the Trusts in the development of the terms of reference and have summarised the questions the families had asked to be answered below:
- How their relatives ended up in a bay with someone who was very mentally ill?
 - The amount of moves that each patient had encountered before ending up on J19.
 - The communication with relatives about their care.
 - Was there enough staffing?
 - Was the ward well managed?
 - Was the mix of patients appropriate?
 - One of the patients attacked had his food and belongings stolen by another patient- the fact that this was happening meant he felt vulnerable and it was not being dealt with, there were also other incidents that frightened patients, how were patents being safeguarded?
 - Where were the staff on duty on the day of the incident?
 - Why did nobody come when patients called for help?
 - What was being done to keep all patient safe - i.e. why did some patients have specials?
 - Why was Harry not moved off the ward straight after the incident?

- 5.23 These questions seem entirely reasonable and most fit within the terms of reference that were set. It is our understanding that the internal investigation team were informed of the families' questions at the outset of the investigation when they met.
- 5.24 However, the external independent reviewer explained to the families that some of the questions did not fall within the remit of their investigation. They therefore did not investigate aspects of Roger and Ken's care, nor did they try to incorporate this into their investigation, nor did they discuss the families' requests with the Trusts. In our opinion this should have happened, although this might have required additional time and access to additional staff or records, which the Trusts would have needed to agree to.
- 5.25 We believe that the external independent reviewer should have gone back to the Trusts to ensure they understood what was being asked for by the families. They could therefore have agreed to have expanded the terms of reference to incorporate these issues, which would have led to a better quality investigation.

The internal investigation team

- 5.26 As reported above, the Trusts made a commendable decision to commission an external person to carry out this investigation. We understand that the external independent reviewer was sourced through the LTHT solicitors who provided names of people known to them that had conducted similar investigations in the past. We established that there was no advertisement or competitive tendering process conducted, and that the external independent reviewer was selected based on skills and experience. In our experience this is standard practice for a Level 2 investigation, and entirely appropriate.
- 5.27 The terms of reference for the internal investigation refer to an investigation team. We refer to either the external independent reviewer or the investigation team. When we refer to the investigation team we mean the external independent reviewer and the people that supported him in the conduct of his investigation.
- 5.28 We also established that there was no requirement for the external independent reviewer to seek additional advice from outside the Trust from any independent specialist. This was because the Trusts expected that specialist knowledge and advice would be provided by the experts/lead clinicians from within the organisations.
- 5.29 There is an inherent problem with this, in that the lead clinicians from within the organisation may be commenting and advising on their own practice. Given the gravity of this incident, to maximise the value of having a 'fresh pair of eyes' on this investigation it may have been appropriate to ensure that the external

independent reviewer had some additional input from an independent psychiatrist or physical health doctor, or at least people that were not involved in the incident or the care and treatment of the patients.

- 5.30 This meant that the investigation only benefitted from the external independent reviewer's view and that judgement was unchallenged during the investigation. The national guidance, the NHS Serious Incident Framework (SIF)²⁹ (para 2 page 8) states that Level 2 investigations are "comprehensive investigations - suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators".
- 5.31 We respect and acknowledge the external independent reviewer's skills, qualifications, experience and diligence in carrying out this investigation. However, we believe that an opportunity was missed to ensure that the investigation findings were subject to internal quality assurance and challenge prior to the completion of the report. We comment later on points that would have benefitted from other specialist input.

The internal investigation terms of reference

- 5.32 The terms of reference for the internal investigation stated that "this is an internal investigation into the care and treatment of patient HB following an incident". It asked the investigation team to:
- provide a chronological timeline of Harry's journey through services;
 - review the care and treatment of Harry, the adequacy of risk assessments and risk management;
 - consider the appropriateness of Harry's environment;
 - assess the leadership and management of the ward;
 - establish whether there were any underlying issues that impact on how the team functions and affect patient care;
 - ensure the families affected voices, comments and concerns were heard; and
 - consider if the incident was predictable or preventable.
- 5.33 The terms of reference required the investigation team to do this by:
- reviewing all clinical records;
 - interviewing staff and clinicians involved in his care;

²⁹ NHS England Serious Incident Framework <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framework-upd.pdf>

- interviewing families affected;
 - reviewing and considering management actions and communications following the incident; and
 - assessing compliance with policies guidance and obligations.
- 5.34 The terms of reference are similar in design to others we have seen for investigations and include much of the instructions we expected to see. Given the date that the internal investigation was commissioned we expected the NHS England Serious Incident Framework, in place at that time, to have influenced the design of the terms of reference.
- 5.35 This new national Serious Incident Framework published by NHS England was in place from 1 April 2015. It was preceded by an earlier version of the NHS Serious Incident Framework.³⁰ We recognise that NHS policies can take some time to become approved, so we also considered LTHT's policy and procedures that were in place in May 2015, which referred to the previous national guidance.
- 5.36 We established that the purpose of the investigation was to understand what happened, why it happened, how it happened and was there anything that could have been done to prevent it. The Trusts expected the investigation to look at systems within the Trusts, to see if there was any factor that could be improved on to prevent something like this happening again.
- 5.37 This purpose was appropriate and in line with the national guidance, but we found that the terms of reference did not spell this out. The terms of reference do not state 'investigate the incident that occurred' or establish what happened. Neither do they ask the investigation to look at why or how it happened or ask it to identify causes. The terms of reference focussed on Harry's care and treatment, which should be included, but misses other aspects that may have contributed to the incident or outcome. LTHT informed us that they did not expect a 'breakdown of the incident' because they knew what injuries had been sustained and they did not think the attack had been witnessed.
- 5.38 Based on the guidance in place at the time (referenced above) we believe that it would have been entirely appropriate for the report to have set out the chain of events on the 27/28 February 2015. Even though the opening statement says that the investigation is into the care and treatment of patient HB, it refers to the purpose of the investigation being to learn lessons that will help prevent further incidents of this nature. In our view it is not possible to identify issues that will prevent further incidents without fully understanding the circumstance of the incident and establishing the problems, contributory factors and root causes that occurred, using a systematic process.

³⁰ *National Commissioning Board Serious Incident Framework (2013)*

- 5.39 We were told that the families were led to believe that the incident would be investigated through looking at Harry's care and treatment and the timeline through the services. Because the incident itself has not been fully investigated, opportunities have been missed to establish the problems associated with the incident. This means that learning from the incident cannot have been fully exhausted and there may still be problems in place that have not been rectified. We have identified additional key lines of enquiry in a later section.
- 5.40 We are concerned about the time lapse between the incident occurring and any new root cause analysis investigation taking place. We are also aware that the incident was extremely traumatic for the people who witnessed it and caused significant distress for all of those involved. To reopen the investigation may be very difficult and may not yield much more to be learned. The national guidance on root cause analysis suggests, for those reasons, it is very important to only investigate once, and investigate right. We would suggest that utilising the right methods at the right time using the right people would prevent an incident being investigated twice. Whilst we do not recommend that this incident is investigated again, we have identified elsewhere in this report the deficiencies within the investigation that the Trusts may wish to consider for further investigation.
- 5.41 We believe that the terms of reference for the internal investigation should have stated that this was an independent Level 2 investigation into the incident that occurred on 28 February 2015 on Ward J19. This is because both the NHS England Serious Incident Framework indicates that it is the incident that needs to be investigated by the provider/s, or at provider level, not the perpetrators care and treatment.
- 5.42 The fact that the investigation team were not asked to investigate, or describe, the incident itself is a fundamental error that contributed significantly to the quality of the investigation report. We note that a timeline of events was included.
- 5.43 The terms of reference also did not describe the type of investigation to be undertaken, for example Level 2 investigation, only referring to an 'independent investigation'.
- 5.44 The scope of our terms of reference mean that we have not reinvestigated the incident itself. However, through the course of our investigation we have established events and occurrences that build on the internal investigation and will, hopefully, bring some further clarity to the course of events. We also set out additional key lines of enquiry later that warrant investigation.

Recommendation 18

We recommend that LTHT and LYPT consider how best to ensure that all learning from the incident that occurred on 28 February 2015 is captured. It would be appropriate to enlist the advice and support of the NHS England (North) Serious Incident team to do this.

Recommendation 19

We recommend that LTHT and LYPT report their progress on the above recommendation to the Local Safeguarding Adults Board, to ensure openness and to share learning. This is because this incident has wider safeguarding implications than within the local CCG.

- 5.45 The terms of reference limited the investigation to the months of January and February 2015. We believe that this restricted the scope of the investigation. When serious events manifest themselves, it is often due to a chain of events or omissions in care that can stretch back over many years. We recognise that there is often little to be learned from going back over decades, but a review of Harry's mental health care and treatment should have covered at least the preceding year. We have reviewed Harry's care and treatment in detail and it is evident from his records that issues with his medication began in the summer of 2014. There may have been an opportunity to divert the course of events at that time. We discuss this elsewhere in the report.
- 5.46 The terms of reference did not specify how the investigation team should conduct the investigation. We would have expected a statement to this effect to be included in the terms of reference. LTHT's own internal policy in place at the time refers to National Commissioning Board guidance that indicates this (page 22). The principles of root cause analysis (RCA) or significant event audit (SEA) and relevant NHS SIF guidance should be applied to all NHS investigations. Furthermore, the NHS England SIF that was in place in May 2015 states (page 8), "The recognised system-based method for conducting investigations, commonly known as Root Cause Analysis (RCA), should be applied for the investigation of Serious Incidents".
- 5.47 Although it was not specified, we would expect an experienced investigation team to apply recognised investigation tools and techniques, particularly those accepted as standard practice within the NHS. We believe that RCA investigation tools and techniques would be appropriate in reviewing the care and treatment of any patient when trying to find out if something has gone wrong.
- 5.48 We attempted to establish the methodology that was used to conduct the investigation. The external independent reviewer told us that RCA tools and methodologies were not used, despite referring to some in the report (page 28 paragraph 3) and the inclusion of a 'fishbone diagram'. There is no explanation in the report of how this was undertaken. There are also no notes or records of analysis that we could refer to.
- 5.49 The external independent reviewer was of the view that RCA processes could not be applied to this kind of review. He understood the investigation was established to look at the care and treatment of Harry and that RCA was not appropriate in this case. Whilst we agree that the terms of reference, in essence, were to review the care and treatment of Harry, we believe that this approach was flawed. As indicated above we believe that there was a need to investigate

the incident itself, because the incident was directly related to the impact or consequences of his care and treatment on that ward, not just his care and treatment over the preceding years, and it was the circumstance on the ward which exacerbated the incident.

- 5.50 In summary the commissioning of the investigation was flawed because the:
- terms of reference did not specify an investigation of the incident;
 - terms of reference limited the scope of the investigation;
 - terms of reference did not specify the use of root cause analysis tools and techniques; and
 - the Trusts appointed a single investigator rather than a team.
- 5.51 This contributed to the production of a report that did not address all of the problems associated with this incident, nor did it meet the expectations of families affected.

Review of the investigation

- 5.52 We were asked to consider whether the investigation fully satisfied the terms of reference. To do this we critically analysed and evaluated the investigation report, because, according to national guidance,³¹ the report should provide a record of the investigation. We interviewed the external independent reviewer, and one of the people assisting him, to supplement our information. We reviewed how the investigation was conducted, who the investigation team spoke to, the records and documents they reviewed, and at interview with the external independent reviewer we explored the conclusions the external independent reviewer came to.
- 5.53 We critically analysed Harry's records from LTHT, LYPT, Harry's GP and care records from Corinthian House. We spoke to the police sergeant on the police investigation and a manager at LTHT. We also reviewed 74 staff statements to clarify and confirm the points identified in the internal report. We reviewed the investigation by breaking down the terms of reference into key points and assessing it against each point.

³¹ *Guide to investigation report writing following Root Cause Analysis of patient safety incidents (2008-09) NPSA*

Conducting the internal investigation

- 5.54 We established that the external independent reviewer was supported by two staff from the Trusts solicitors, one of whom is a partner in the legal firm (DAC Beachcroft) that provides legal advice to the Trusts and Maria Mallaband (the company that operate Corinthian House). We established that these two people assisted in an administrative capacity to ensure that statements were obtained that could be used for the Coroner's inquest and to provide extra resource to the external independent reviewer. We found that the documents associated with the investigation were returned by the external independent reviewer to the Trusts' solicitors for storage.
- 5.55 We considered whether using the Trusts solicitors as part of the investigation created a conflict of interest. It was put to us during our investigation that the solicitors may have influenced the investigation and their involvement threatened the perception of this investigation being independent.
- 5.56 However, we established that the staff from solicitors had no input into the analysis and findings of the report and we did not find evidence of any conflict of interest.

Methodology

- 5.57 As set out above, we would expect an investigation of this type to have taken a RCA approach. Root cause analysis usually commences with evidence gathering which is then formulated into a chronology of events. The events and actions of people involved are then compared with what should have happened, either according to guidance, policy or best practice. This stage identifies care or service delivery problems. From this a detailed analysis of why the occurrence took place is undertaken. At this point human factors are considered, contributory factors, and the root cause is identified.
- 5.58 We established that the investigation obtained its information from interviewing staff and reviewing records and policies. The external independent reviewer also spent several days on ward J19 interviewing staff, observing practice, and discussing issues with the senior ward sister to understand how the ward operated, which we regard as good practice.
- 5.59 Statements were compiled in three ways:
- staff that were interviewed by the police wrote formal statements which they signed (typed and saved as part of the police investigation);
 - staff interviewed by the internal investigation had a statement compiled by the investigation team which they read and signed; and

- three Corinthian House staff statements were compiled and sent to the solicitor.
- 5.60 The police informed us that they only sent statements for the staff that the Trust requested. The investigation team were under the impression that the police sent all statements to the Trust. The police confirmed that they sent 32 statements to the Trust solicitors on the 26 June 2015, sent a further 15 on the 20 October 2015, and a final 2 on 12 December 2015. The content of the police statements did not cover some of the aspects that the external independent reviewer wished to explore, for example Harry's previous treatment, staffing levels on the ward etc. As a result some staff were re-interviewed by the internal investigation team.
- 5.61 Where the external independent reviewer interviewed staff, the interview was led by the external independent reviewer and notes were taken by one of the staff supplied by the solicitors, who then produced a statement for the interviewee to sign. The external independent reviewer also met with a group of pharmacy staff to explore the steps taken to establish Harry's olanzapine prescription/administration, the notes of which were made by one of the staff from the solicitors.
- 5.62 The dates the statements were signed vary significantly from March 2015 onwards, with most statements being dated March 2015 and January 2016. We believe that the variation is explained by there being different processes for obtaining them through the police and internal investigations. We understand that statements will have been formally written and signed after the interviews which explains some of the dates we saw. We believe this is a satisfactory explanation of the variation in dates.
- 5.63 We established from interviewing the external independent reviewer that he did not interview staff from Corinthian House but used statements that the staff had made and also reviewed Harry's care records. However, the statements we were given are dated July, August and September 2017. When we asked when they were obtained we were told that these statements were obtained after we (Niche) had requested statements. The first time we requested statements for staff at Corinthian House was 21 February 2018. We are therefore unable to explain how the information from the staff at Corinthian House was incorporated into the internal investigation. Our assumption is that the external independent reviewer was only able to use the care records that relate to Corinthian House.
- 5.64 We believe that the external independent reviewer had the opportunity to review all the statements supplied by the police before completing the draft report in February 2016. However, when we explored this with the external independent reviewer he stated that they did not review statements from the following four people:
- The Safety Guardian that was on duty at the time of the incident. This person was employed through an agency to provide one-to-one supervision and

safety care to another patient on the ward. This person was stationed outside bedroom three, opposite the bay where Harry, Ken and Roger were being looked after.

- The three security officers who assisted nursing staff on 27 February 2015 in the administration of medication to Harry.

5.65 Because these four statements were omitted from the internal investigation the investigation missed the opportunity to augment what the nursing staff reported, as we believe that the nursing staff only had part of the picture.

5.66 Reviewing the statements of the four members of staff above would have added useful information to the investigation team's perspective of the behaviour of Harry and the care being provided to him, and the situation on the ward. Examples of information that was not included in the investigation are as follows:

- the Safety Guardian had been asked to keep an eye on the patients that were at her end of the ward because the nursing staff were all at the other end of the ward;
- the Safety Guardian reported that Harry was noisy and disturbed from the moment she came on duty (7:50 pm, 27 February 2015), he was rattling his bed rails, shouting and swearing;
- the Safety Guardian reported that, before the incident, the curtains were drawn around Harry's bed, and the doors into the bay were closed;
- the security staff statements confirm that Harry was very agitated when they arrived on the ward; and
- there were discrepancies in nursing staff accounts of when the IM Lorazepam was given to Harry. The security officers' statements narrow down the timeframe for when it could have been given.

5.67 Another issue that did not come to light because these statements were not reviewed was the differing detail being offered. The Trusts believed the attack was not witnessed. However, two staff state that they saw some of it. The Safety Guardian reports that she was first on scene as Harry was attacking Roger and Ken. She reports that she disarmed Harry and threw his walking stick across the floor, as one of the healthcare assistants walked into the bay. However, this healthcare assistant reports that it was she that was first on scene as Harry was attacking Roger and Ken and she disarmed Harry and took his walking stick off him. We have not been able to establish whether these differing accounts were explored any further by the police.

5.68 It could be that there were two attacks, one where the safety guardian intervened and one where the Health Care Assistant intervened. Another explanation is that

one of the accounts is incorrect. It would have been helpful to understand this further. If, for example, one of the accounts is incorrect it may have led to a further examination of the events that night and may have uncovered other root causes or contributory factors. This may have also helped answer the family's questions about where the staff were at the time of the attack.

- 5.69 Another factor not explored is that one of the security officers stated that the panic alarm on J19 was found to be faulty when it was tested by one of the security supervisors. It is not clear from the statements when it was tested, if anyone had reported it, or if anyone had attempted to activate it at the time of the incident. It would have been useful to explore this further, to report on it, and to make recommendations to prevent a re-occurrence. It may also explain if there was a preventable delay in responding to the attack.
- 5.70 As stated above, we were initially of the opinion that all statements were available and reviewed by the investigation team. However, we only received some of them (the four above being omitted) when we first asked for statements from LTHT. The 33 statements we received from LTHT were for the staff that LTHT thought had been used in the investigation. We then explored this with the external independent reviewer and established that these four statements were probably not considered.
- 5.71 We asked for a list of the statements that the external independent reviewer considered but did not receive them in time for them to be included in this investigation. We think it is likely, based on conversations that we have had with the investigation team, that these statements were not considered. The fact that all statements that were available were not considered diminished the quality and content of the investigation, and the recommendations.

The scope of the internal investigation

- 5.72 The terms of reference for the internal investigation stated that "this is an internal investigation into the care and treatment of patient HB". It asked the investigation team to provide:
- "a clear chronological time line of patient HB's journey through services following the treatment of complications associated with his diagnosis of oesophageal cancer in Jan/Feb 2015 to his transfer to the Leeds and York Partnership Foundation Trust following the incident on 28 February 2015".
- 5.73 We believe that the chronology of events that was reported in the internal report is broadly representative of what happened with Harry's care and treatment. However, there is limited reference within the chronology to the timeline of events in the 24 hours before the incident. We have also found several examples of events or factors being recorded in the clinical notes that have not been

represented in the chronology, or elsewhere within the report. Earlier in this report we discussed the care and treatment of Harry and have identified which of these factors were not included in the report or in the chronology.

- 5.74 The terms of reference asked the investigation to provide “a factual account of the patient’s care prior to his transfer on 28th February 2015 with a particular focus on “the suitability of the environment he was in”. The terms of reference ask in another section that “the investigation team should also review the layout of the ward location of patients, staff and equipment.”
- 5.75 In our view this has been partially met within the report. We acknowledge that the investigator visited the ward to review the layout/area where Harry was placed. There is a detailed and factual account of Harry’s care prior to the 28 February 2015.
- 5.76 The report comments on the adequacy of the environment in relation to the skills of the staff looking after him. It identifies that patients with Harry’s co-morbidity “are no longer either infrequent or uncommon in acute trusts”. Later, on that page, it describes J19 as a medical ward that “specialises in diabetes care but often has a high percentage of older people with a wide range of medical conditions that present a range of challenging behaviours”. The report goes on to say that nursing staff have a high tolerance level for the levels of mental ill-health confusion and challenging behaviour that is presented by this group of patients.
- 5.77 We conducted our own analysis of incident reports for J19, for the period April 2014 to February 2015. We established that 9% of the incidents reported were for violence and/or aggression, at a rate of almost two incidents per month. This did not demonstrate that staff were subjected to a high level of violence and aggression. Further analysis indicated that the severity of the incidents was quite high with 12 staff assaults and 4 patients attacking other patients over the period. For further analysis we would need to be able to compare the data for ward J19 with other wards of its type, and with other hospitals data. We did not have access to this information for our investigation. Whilst we found nothing to disagree with in the report, they are not supported by the staff statements we read. Neither is there any analysis or evidence in the report, other than reporting that there was a high number of incident reports that feature violence or aggression.
- 5.78 The report comments that staff are not skilled in caring of patients with mental health problems, but the discussion is limited in this regard. Our review of the staff witness statements indicates that information was available to the external independent reviewer and we believe that it was entirely relevant and should have been included in the report in detail. The staff members interviewed report quite limited experience of working with people with mental health problems as part of their training, from as little as one day to three weeks experience. All staff had reported that they had received dementia training provided by the acute Trust. However, their descriptions of what they would be looking for when

assessing whether somebody had mental health problems was limited to looking for agitation and aggression. We believe that the report could have explored more of the training that was offered to staff and the practical support that is offered by mental health services for general nursing staff in acute hospitals. This could have led to more outcome based recommendations in the internal report.

- 5.79 The report states that staff had developed a tolerance for confusion and that “this higher tolerance also contributed to this incident as the nursing staff on J19 had little or no formal training in this area of care and have developed their own methodologies to manage and care for patients with challenging behaviour”.
- 5.80 However, this fact was not expanded upon to describe these methodologies, nor was there any explanation as to why tolerance and developing their own methodologies was inappropriate or how it contributed to the incident. We reviewed the staff witness statements in detail for evidence that the staff demonstrated a high level of tolerance for violence and aggression, and could find no clear reference to this. We established that the interviews with staff gave the external independent reviewer the impression that supported this, but that this was not clearly referenced in the statements. Whilst we do not disagree that these nurses had limited training and experience in caring for people with mental illness, the report would have benefited from more exploration of these factors and detailed recommendations on how to address the issues. We have made recommendations to address these (see recommendations 1, 3, 4, 9, 10, 12).
- 5.81 In considering the suitability of the environment that Harry was in we could find no reference in the internal report to a review of the layout of the ward, the physical environment that Harry was placed in, or a consideration of the level of stimulation, or otherwise, that Harry would have been exposed to. We confirmed that the external independent reviewer did not identify any factors that contributed towards the incident in this regard.
- 5.82 In our experience acute hospital wards in the current climate are likely to be busy, noisy environments. This ward in particular had a high turnover of patients (figures sent to us indicate 6 admissions or discharges a day) with several members of staff attending to the patients during the day, coming in and out of the bay.
- 5.83 When reviewing the care and treatment of Harry we found that in the period running up to the incident Harry was placed in a four-bedded bay with three other patients. It is our understanding that Harry was placed in a bed furthest from the door. We also established that the bay itself was near, but not in view of, the nurses’ station and had solid double doors with windows at the top.



Figure 3: Diagram of ward J19 - showing Harry's bed

- 5.84 From reviewing the staff statements, we established that on the night of the 27/28 February the curtains were drawn around Harry's bed and the doors into the bay were closed. The staff statements report that Harry was on hourly checks throughout the night. However, we could find no evidence of this in his clinical records. In addition, the Safety Guardian, who was looking after a patient in bed 3, reports being asked to 'keep an eye on' the patients at her end of the ward because all four staff were at the other end. The external independent reviewer did not explore why Harry had not been placed in a side-room on J19, particularly when he had been on previous wards, or where all the staff were during the night.
- 5.85 We found that this may have meant that the patients in Harry's bay were not adequately observed in the hours running up to the incident. This was because of the location of the bay in relation to the nurses' station, combined with the fact that the doors were closed.
- 5.86 The internal investigation was asked to consider "whether sufficient attention was given to information from patient HB's family and GP";
- 5.87 The internal investigation clearly recognises that despite Harry's daughter raising her concerns on several occasions this was not acted upon properly. The investigation considers that information handed over from the GP was given sufficient attention.
- 5.88 The internal investigation was asked to investigate the "management of his medications and the rationale for decisions made in this regard".

- 5.89 The internal investigation does look at the management of Harry's medications and the rationale for decisions made in this regard. The impression that is given from the report is that the medical staff looking after Harry's physical health care did not take specialist advice or consult adequately enough with mental health services.
- 5.90 The internal investigation was asked to "review the appropriateness and effectiveness of the care and treatment plans of patient HB in light of any identified health and social care needs, identifying both areas of good practice and potential areas of concern."
- 5.91 The investigation reviewed the appropriateness and effectiveness of care and treatment plans for Harry with regard to his identified physical health needs. It concludes that physical care was good. However, the report does not make reference to national clinical guidelines, for example NICE guidelines or clinical pathways or protocols set out in LTHT's policy and procedure framework or use of the legislative frameworks available to protect Harry. We would have expected to see clear reference to these guidelines and an explanation as to how the care delivered was in line with these. There is no reference to having confirmed the appropriateness of the physical health care/treatment plan with any other physician or registered nurse, or having taken advice regarding this. The report occasionally contradicts the assertion that physical health care was good by reporting the assessments were sometimes poorly completed. There are several comments regarding the care and treatment from a mental health perspective, identifying missed opportunities to provide a different intervention.
- 5.92 There is no reference to whether staff appropriately considered using legislation to support Harry's care, such as DoLS, MCA or MHA. There is also no reference to having confirmed the appropriateness of the mental health care with any psychiatrist or registered mental health nurse.
- 5.93 We recognise the skills and qualifications of the external independent reviewer, particularly their expertise in mental health and physical health nursing. However, it is our standard practice to triangulate our views with other professionals who may have had a different opinion. It would have added weight to the report's conclusions if there had been other professional input. We comment in detail on the adequacy of Harry's care and treatment later in the report and from this we have identified that the following care /service delivery problems were not clearly referenced in the internal report:
- Harry's GP not making a referral to mental health in June 2014.
 - Harry's prescription sheets and administration records not been completed correctly on several occasions.

- Staff looking after Harry not considering the use of legislative frameworks to support and protect Harry, particularly on the afternoon/evening of 27 February 2015.
- No consideration of the appropriateness of the use of Lorazepam.
- Ineffective observation.
- Inappropriate care environment.
- Ineffective level 2 pharmacy reviews.
- Care planning documentation leaving acute staff with a lack of a holistic overview of Harry's care.
- Repeated missed doses of olanzapine when it was prescribed for Harry.
- Lack of record-keeping.
- Lack of a plan of how to care for Harry if his behaviour escalated after administration of Lorazepam on 27 February 2015.
- No guidance for staff regarding one-to-one nursing care for patients.
- No requirement to assess someone's mental health needs on admission to the acute hospital.
- The lack of adequate nursing resource.

5.94 The delivery of Harry's care and treatment was criticised in the internal report for poor communication between mental health and acute teams and the prioritisation of Harry's physical health needs over his mental health needs. We agree with these issues being identified as contributory factors. However, we believe that the lack of situational awareness regarding the potential impact of Harry having a relapse of his schizophrenia was not recognised as the root cause.

5.95 The internal investigation was asked to "review the adequacy of any risk assessments and risk management, including specifically the risk of patient HB harming him-self or others and review any related issues for safeguarding vulnerable adults".

5.96 The report considers the adequacy and risk assessments and risk management, and has identified particular issues with the mental health teams risk assessment which had not been taken into consideration by the physical health team. The way that the facts are presented in the report indicates that lack of effective risk assessment and risk management was often an issue throughout the whole of Harry's care and treatment. We would have expected a section that discusses

the adequacy of risk assessment/ risk management at each stage in Harry's care process and an explanation of the impact that this had on Harry's care and treatment and the eventual incident. However, the report does identify examples of ineffective risk assessment and risk management and makes a recommendation regarding this.

- 5.97 We could find no reference to the investigation having reviewed safeguarding actions or systems. There is no reference to compliance with safeguarding training, or any reference to having reviewed practices or plans. There is no mention of the word safeguarding in the body of the internal investigation report. There is no reference to any vulnerable patients, no reference to Harry or Ken being vulnerable adults, or any discussion regarding patients' safety or protection of patients.
- 5.98 The internal investigation was asked to "review the interface, communication and joint working between all those involved in providing care to patient HB to meet his mental and physical health needs "
- 5.99 We found that the investigation considered the mental health input from LYPT as well as care from LTHT. It specifically reviewed communication between clinical teams and considered the interface and joint working between those involved. It also considered whether sufficient attention was given to information handed over from Harry's family and his GP. We agree with the points that the internal investigation report made regarding listening to Harry's stepdaughter.
- 5.100 The internal investigation was asked to "review leadership and management on ward J19, especially in regard to patient care, quality and safety" and "establish whether there are any underlying issues that may impact on how the team on ward J19 functions and consequently affect patient care. This could involve reviewing audit data, including ward health-check, incidents and complaints data".
- 5.101 The report examines clinical interfaces and hand offs, and describes that clinical leadership was fragmented. The report explores the reasons for this and makes appropriate recommendations that are linked to the findings.
- 5.102 These issues constitute a large amount of the report and we found that they were appropriate and, if the recommendations have been acted upon, will make a constructive difference to the delivery of care in the future. This only covers part of the leadership on the ward, and a large amount of the care that is delivered is dependent on effective nursing management.
- 5.103 We established during our interviews that the external independent reviewer believes that the ward was well-managed and led, particularly given the pressures and difficulties that the mix of patients presented. This is discussed in the report. However, the discussion is limited to one paragraph that states that there were no staffing issues that contributed to the incident other than the skills

and experience of the staff in caring for patients with mental illness. We have discussed staffing earlier.

- 5.104 There was no review of ward safety data, clinical audits or complaints. We found that this was inadequate. We were sent three clinical audit reports that we were told related to J19 for the period of Harry's stay. One of the reports had no mention of J19 (relating to oxygen prescription), the other two were quarterly audits and showed no significant problem with J19 record keeping. If there were no other formal audits taking place we would have expected a statement in the report that explained how the Ward Manager assures themselves of the quality of care delivered on the ward. We could find no reference to this in the internal investigation report.
- 5.105 We would have expected to see a thorough analysis of the staffing levels in place at the time and in the preceding days, based on the views of the Ward Manager and the staff on duty. We would have expected an analysis of the use of temporary staffing and sickness absence levels, a comparison of actual staffing against other wards within the hospital and standards that the Trust has set itself, national expectations and guidelines, and a comment on whether the staffing was adequate.
- 5.106 We would have also expected the report to set out how many staff were actually on duty, including any additional staff brought into special patients who needed one-to-one care. We would have expected to see an analysis of the tasks and duties required of the staff at night, and an understanding of how many hours of care would have been delivered for each patient against what was required. Other factors to take into consideration are the amount of tasks and duties that other staff on duty perform. Some clinical areas use housekeepers to ensure that patients have access to food and drink, and that equipment and linen stocks are maintained. Some clinical areas use pharmacy technicians to administer routine medications to patients, therefore freeing up nursing time for the duties. There was no description of any of this analysis in the report.
- 5.107 NHS trusts in England have been required to publish their safe staffing information since 2014. Therefore information was available to the external independent reviewer that would have helped understand whether the ward was adequately staffed or not. Most hospitals use a nursing dependency measurement tool which indicates on an ongoing basis whether additional staffing is required, this was also not examined in the investigation.
- 5.108 Our understanding of the staffing levels in place at the time is that for a day shift there would be 4 registered nurses and 2 healthcare assistants on duty. This gives a ratio of 65% registered nurses to 35% care staff. It also gives a ratio of one registered nurse to 7 patients (assuming that the coordinating nurse/nurse in charge of the shift is counted in the numbers). Notwithstanding the fact that some tasks and duties could be performed by other staff, in our view this appears to be a low complement for a 29 bedded general medical ward.

- 5.109 There was no analysis of the staff available at night. We have identified above that housekeepers and pharmacy technicians are useful additions to the ward team, however, these staff are mostly available during the day.
- 5.110 It is our understanding that on the night in question there were two registered nurses and two care staff on duty and at least one Safety Guardian (allocated to care on a one-to-one basis for one patient). This gives a ratio of one registered nurse to 15 patients and a ratio of one member of staff to 7 patients. Assuming that each member of staff was working an 11 ½ hour shift (excluding breaks), this gives approximately 1 ½ hours of care per patient overnight. As we have identified above there was no discussion of the staffing levels in place on the night of the incident.
- 5.111 If the staffing levels were as described above it would have been useful to understand whether that had any impact on patient care. To ascertain whether the staffing levels affected patient care we would have expected to see a discussion regarding key indicators that demonstrate good patient care.
- 5.112 For example, the investigation could have looked at the following sets of data for the ward:
- falls;
 - pressure ulcers;
 - catheter acquired urinary tract infections;
 - record keeping audits; and
 - complaints from patients.
- 5.113 This information is routinely collected by the hospital and is likely to have been made available if the external independent reviewer requested it. What is also collected by the hospital is information regarding staff and patient satisfaction via the Friends and Family Test (FFT). This information has been collected since 2013.
- 5.114 It is difficult to draw conclusions from the data set out above as it relies on a clear understanding of how the ward operates and what is being measured. However, if there had been high number of falls and pressure ulcers acquired on the ward, poor results from record-keeping audits, and several complaints from patients this may indicate problems with patient safety and delivery of nursing care. In fact, there were 10 incident reports for the preceding 11 months where staff have felt that low staffing numbers have contributed significantly to insufficient care delivery.
- 5.115 The external independent reviewer was asked to review the leadership and management of the ward. We recognise that the external independent reviewer

was reassured that the leadership and management of the ward was good. However, we would have expected to have seen an explanation of this finding supported by evidence that staff receive adequate training and support to do their job; for example, compliance with mandatory and statutory training requirements, access to supervision and appraisal, and an analysis of sickness absence rates and management.

- 5.116 There is no reference to any of these aspects in the report. Had this information been examined and reported in the investigation report, the findings that there were no staffing issues that contributed towards the incident would have been much better supported and robust. As it is, from reading the report there is no clarity about what the external independent reviewer considered, and there is no confirmation of any problems with care delivery.
- 5.117 The internal investigation was asked to “interview the families affected by the incident on Ward J19 in February 2015, ensuring their voices are heard. The investigation team will involve all the patient’s families in the investigation as fully as possible to ensure their comments and concerns are heard and addressed”.
- 5.118 It is our understanding that the terms of reference for the internal investigation were set in discussion between the Trusts. The families had the opportunity to comment on the terms of reference before they were finalised. We established that the external independent reviewer met with each of the families affected by this incident, initially to obtain their accounts, and then to maintain communication and provide an update of developments. All three families that we spoke to recall having regular contact with the external independent reviewer and the opportunity to talk about the investigation. They were complimentary about the level of communication they received from the external independent reviewer.
- 5.119 The families all reported to us that there were several points that they had asked to be considered in the investigation which they felt were not covered adequately in the report. The families are of the belief that they had raised these issues in the initial conversations with the external independent reviewer about the terms of reference, and believed that these issues would be considered as part of the investigation once the investigation had started. However, they were told that some issues would not be covered.
- 5.120 Below we have set out the points that the families were concerned about and commented on each individual one.

Recognition of all patients and families involved

- 5.121 Each family felt that there should have been information in the report about their loved ones and who they were, showing some recognition of the victims as people in their own right. It is correct that this information is not included in the

internal investigation report. Neither is it within the terms of reference that the external independent reviewer was given. However, if the investigation had been focused on the incident itself it would have been appropriate and normal practice to include a description about each of the patients affected. We have included a short paragraph regarding Ken and Roger and hope that this goes some way to meeting the family's request.

- 5.122 The families were concerned to understand how Ken and Roger ended up in a bay with somebody who was severely mentally ill. Ken's family asked for an explanation of the amount of moves that each patient had encountered before they ended up on J19. This information was not included in the internal investigation report. It is not within the terms of reference as an explicit point, however, if the investigation had been focused on the incident itself it would have been appropriate to include an analysis of how the patients came together at that point. This remains an unanswered question for the families.
- 5.123 Roger's family also believe that staff picked Roger up and put him into bed when he had sustained a fractured neck of femur. If this did happen it would have been against usual practice when someone has been injured in this way. This may have been necessary to remove Roger from further danger. Again, we have not been able to establish whether this happened or why. We believe that LTHT should have written an account of what happened to both Roger and Ken for the Coroner.

Recommendation 20

We recommend that LTHT provide Ken's and Roger's families with a summary of the information contained in the statements that have been submitted to the Coroner which details their loved ones care and treatment.

Concerns about Harry not receiving appropriate medication

- 5.124 Harry's stepdaughter in particular was concerned about the fact that she repeatedly said that she was worried about Harry not receiving his medication and the effect that it would have on his behaviour. We found that the investigation report did consider this and has referred to it. In our review of Harry's care and treatment we identified several dates where it is recorded that Harry's stepdaughter had raised the issue about Harry not receiving his olanzapine. We found that Harry's stepdaughter raised concerns about Harry not receiving olanzapine and the risk of him being violent with staff at the hospital on at least 9 occasions before she was listened to.

Communications with relatives about Ken and Rogers care

- 5.125 The report and investigation did not focus on the care of Ken and Roger. However, if the investigation had been focused on the incident itself it would have been appropriate to include this information. This remains an unanswered question, for which we have made a recommendation (see recommendation 21).

Whether there was enough staffing on the ward at the time, and whether the ward was well-managed?

- 5.126 We believe that the report discusses these issues in limited fashion. We have described above the elements that we believe are missing from the investigation and the report. We do not believe that the families have had an answer to this question, nor are we able to provide it. We also believe that the passage of time makes it difficult to provide an answer to the families. However, we believe that the families would appreciate an explanation of how staffing levels are managed on general medical wards at the current time.

Whether the mix of patients was appropriate?

- 5.127 The report does not discuss whether the mix of patients was appropriate in any detail. It does report on the number of patients with challenging behaviour/mental health problems, and identifies that the skills and experience of the staff were not likely to ensure that the care of these patients was delivered well. We believe this is an unanswered question and we have made a recommendation regarding this. (see recommendation 21).

What the ward and hospital were doing about situations that frightened patients, what was being done to keep all of the patients safe, and why did some patients have ‘specials’ and others, like Harry, not?

- 5.128 These three points relate to general safeguarding of vulnerable adults. In our view these questions would have been within the terms of reference, particularly under “review the leadership and management on ward J19, especially in regard to patient care, quality and safety” and “establish whether there were any underlying issues which may impact on how the team on Ward J19 functions and consequently affect patient care”.
- 5.129 We found that the issues that the families had raised had not been explained within the report. We heard one family describe their struggle to understand why this happened in a place that is intended to keep people safe. As discussed earlier there was no investigation of how the ward maintained the safety of patients in the internal report, other than a brief discussion about the provision of staff to provide one-to-one support.
- 5.130 The decision about whether Harry should have had a one-to-one member of staff allocated to him was not discussed in sufficient detail to provide the families with an understanding of why Harry did not have this care. We believe this remains an unanswered question for families and believe that the passage of time would make it difficult to answer this question today. However, we are of the opinion that the families may appreciate an explanation about how patients are protected and kept safe on general medical wards today.

Recommendation 21

We recommend that LTHT offer to meet with the families to address their unanswered questions and discuss changes that have been made following this incident, including:

- how staffing levels are calculated and delivered on medical wards; and,
- how safeguarding is practised and how the safety and security of staff and patients is supported on medical wards.

Why did nobody come when patients called for help?

- 5.131 This is not included in the report and is not technically within the terms of reference, because the investigation was not asked to analyse the incident in any detail. The families believe that the reason Roger attempted to intervene was because no one came when he called for help.
- 5.132 We believe that if the investigation had focused on the incident itself it would have been appropriately explained. We have been able to add to the findings of the internal investigation with regards to the location of the staff at the time of the incident, by establishing that one of the healthcare assistants had been in the bay 5 to 10 minutes before the incident, and the Safety Guardian was just outside the bay at the time of the incident.
- 5.133 We have also identified that the panic alarm on J19 was not working. As we have explained previously we are not able to state where the panic alarm was, whether anyone had attempted to activate it at the time of the incident, or if the fact that it was not working had any impact on the response to the incident. We believe this remains an unanswered question and that, because of the passage of time, it will be difficult to answer this question. However, we believe that the families would appreciate an understanding of the use of panic alarms on general medical wards.

Why was Harry not moved off the ward straight after the incident?

- 5.134 Ken's family report that Harry was known to be on the ward for some time after he had attacked them. We believe that an explanation for this should have been included in the investigation because it is set out in the terms of reference under "review the management, actions and communications in the aftermath of the incident at Ward J19 to identify areas of good practice and any issues of concern".
- 5.135 We have established that Harry was removed from the bay very shortly after the incident, certainly by 8.00 AM. Harry was moved to one of the day rooms where he was supervised by security officers whilst nursing staff attempted to get him transferred. We found that Harry was moved from the day room after midnight on

28 February 2015, which meant that he was on the same ward as the people that he had attacked and injured for several hours.

- 5.136 The internal investigation report does state “Consideration should have been given to removing HB from the ward post the incident to reduce his mental distress and to enable the ward to function more effectively”. However, no further comment is made.
- 5.137 Therefore this remains an unanswered question for the families of Ken and Roger. We believe that due to the passage of time it is unlikely that they will receive an explanation for this, however, we have made a recommendation regarding additional key lines of enquiry (see recommendation 21).
- 5.138 The internal investigation was asked to: “Review the management, actions and communications in the period following the incident on ward J19 to identify areas of good practice and any issues of concern”.
- 5.139 We could not find any discussion within the report of the management actions and communications following the incident. We explored this with the external independent reviewer when we interviewed them and were informed that this must have been an oversight, in that they forgot to include it.
- 5.140 The investigation therefore did not explore two issues which came to light during our investigation. These remain unanswered questions and mean that all learning from this incident has not been fully exhausted. The first question was why ward staff did not call the police directly after the attack. We established that ward nurses asked the site manager on duty, who indicated that relatives must be informed first. We established that the police were alerted to the incident almost two hours later when they attended the security office on another matter. The police note that this was 9.41 AM. We believe that due to the passage of time it is unlikely that the decision-making with regard to this will be established, however, we have made recommendations regarding additional key lines of enquiry (see recommendations 23 and 24).
- 5.141 We have been unable to explore this further, but found that this was neither appropriate nor necessary. The attack was obviously serious and not calling the police immediately meant that evidence could have been lost. Had the circumstances been different, i.e. had a prosecution been brought against any one, the delay in calling the police to the scene may have compromised the case.
- 5.142 We also established that Harry was not moved from the ward for several hours after the attack. We were not able to establish the reasons from this and it was not explored in the report. We understand that Harry was waiting for a MHA assessment. However, we found that the distress caused to the families knowing that Harry was still on the ward was unacceptable. We have not been able to establish whether the distress to families was considered in the decision-making processes.

- 5.143 The internal investigation was asked to “consider if this incident was either predictable or preventable.”
- 5.144 We found that the investigation did consider whether the incident was predictable or preventable and gave an explanation of the external independent reviewer’s opinion.
- 5.145 The internal investigation was asked to “review and assess compliance with local policies, national guidance and relevant statutory obligations”.
- 5.146 We found that there are only four explicit references to national standards and guidelines within the report. In addition, there are oblique references to practice being “in line with national guidelines and expectations”.
- 5.147 However, there is no reference to any documents or an explanation of how the external independent reviewer arrived at their conclusions. We would expect that an investigation report into incidents of this gravity should include specific references to standards, guidelines and expectations that have been published, for example reference to NICE clinical guidelines, or guidance on safe staffing issued by the National Quality Board etc.

Summary of findings of our critical evaluation of the internal investigation

- 5.148 Our terms of reference for this investigation asked us to critically analyse the externally commissioned investigation of the incident to identify certain points. We found that there was a detailed and extensive internal investigation report. The internal investigation report identified several acts or omissions in care and made several appropriate recommendations to improve the system in the future.
- 5.149 However, we also found several deficiencies/ omissions when we reviewed the report against the evidence we looked at. Our findings are set out below.

If the investigation fully satisfied the terms of reference

- 5.150 We found that, despite the detail and length of the report, the investigation did not fully satisfy the terms of reference. In short, the investigation did not review the management actions following the incident or consider clinical audit data, patient safety data, complaints data, or the layout of the ward, location of patients, staff and equipment. It also inadequately covered issues raised by the families, the appropriateness of Harry’s care and treatment, compliance with local policies, national guidance and relevant statutory obligations, or the nursing management of the ward.

If the terms of reference were appropriate for the incident investigation

5.151 We found that the terms of reference were not fully appropriate for the incident investigation because:

- they did not specify an investigation of the incident;
- they limited the scope of the investigation;
- they did not specify the use of root cause analysis tools and techniques; and,
- the Trusts appointed a single investigator rather than a team.

If the incident itself was fully considered

5.152 We found that the incident itself was not fully considered and have identified above several elements that were not taken into consideration in the investigation. We have covered these in the section discussing additional key lines of enquiry.

If all key issues and lessons were identified

5.153 We found that despite the detail and length of the report there were several key issues not identified through the internal investigation that we were able to establish in our investigation.

Any additional key lines of enquiry which would have warranted further consideration

5.154 We found that there were several additional key lines of enquiry which would have warranted further consideration. The majority of these relate to the fact that human factors have not been considered in the internal investigation.

5.155 When conducting root cause analysis investigations, part of the process requires an investigation of the reasons why something happens and at this point human factors should be considered. A simple way to assess human factors is to think about three aspects: the job, the individual and the organisation, and how they impact on people's health and safety-related behaviour.³²

5.156 When reviewing the staff statements, we could find very little evidence of human factors being discussed. One member of staff reports being under a lot of pressure and not having adequate time to complete required actions.

5.157 Other issues that we would have expected to be explored in relation to human factors would be aspects such as cognitive processing, team working, pressure to complete tasks and decision-making. We have identified several areas where

³² *Health and Safety Executive 1999; How to guide for implementing human factor in healthcare; taking further steps – volume 2; Clinical Human Factors Group- 2013*

the internal investigation failed to identify a care or service delivery problem and explore the underlying causes of the problem.

5.158 We have set these out in more detail above but in summary they are:

- The reason for radiotherapy stopping Harry's olanzapine in June 2014.
- The reason why the GP did not refer Harry to mental health services as suggested in June 2014.
- Whether consideration was given to Harry receiving long acting depot injections of olanzapine in June 2014.
- The reasons for medical staff not exploring the use of immediate acting antiepileptic medication in order to continue the use of olanzapine in January 2015.
- Why no consideration was given to assessing Harry under the MCA during his admission between the 19 and 28 February 2015 when Harry first started showing signs of lack of capacity to engage in his treatment.
- Why the historical mental health records for Harry were not requested until 22 February 2015.
- Why a Safety Guardian was not allocated for Harry on the evening of 27 February 2015 when Harry started to become aggressive and disturbed.
- Why Harry was not nursed in a side room on his transfer to J19.
- What the decision-making process was when curtains were drawn around Harry's bed and the doors to the four bedded Bay were closed.
- The dependency of patients on the ward in the afternoon and night of 27 February and 28 February 2015.
- The actual staffing on duty on the ward in the afternoon and night of 27 February and 28 February 2015.
- Where all the staff were located at the time of the incident.
- Why two different members of staff described themselves as being first on scene, alone, and disarming Harry, at the time of the incident.
- What impact the faulty panic alarm had on the response to the incident.
- Why police were not called to the incident.
- Why Harry was looked after on the same ward as the people he had attacked for 15 ½ hours after the incident.

5.159 We have made recommendations above (see recommendations 23 and 24) to both Trusts and the Local Safeguarding Adults Board to ensure that all the learning from this event is captured and reviewed.

If recommendations were appropriate and comprehensive and linked to the findings/conclusion of the investigation

- 5.160 We found that the recommendations that were made were appropriate, given the factors identified, and were clearly linked to the findings and conclusion of the investigation.
- 5.161 However, we believe that the recommendations were not comprehensive enough and have built on the internal investigation recommendations and identified further recommendations through our work.

If there was appropriate, meaningful, effective family engagement and treatment by the Trusts and the Investigator (adherence to Duty of Candour/Being Open etc.) during and following the investigation

- 5.162 We found that the Trusts attempted to engage with the families appropriately, but that they did not fully inform the families of what was happening following the incident. Families were informed by LTHT staff about the attack within a couple of hours of the incident taking place.
- 5.163 We believe that their understanding of what happened was mainly from the police officers investigating the incident. We were told that Harry's family did not know that Ken and Roger had died until the police told them that the investigation was being taken over by a murder investigation team. This was a great shock to Harry's family. We recognise that there was police family liaison officer communicating with the family, however, in our opinion the Trust could have better supported the families through this process.
- 5.164 We believe that there was no method of preventing the shock that the incident created, however, we found that all three families were disappointed with the communication from LTHT at the time.
- 5.165 We reviewed several letters that were sent from LTHT to the families (the earliest being 9 March 2015) apologising for the distress, stating the decision to appoint an external person to investigate, offering condolences and inviting them to feedback and comment on the terms of reference. We found that these actions were in line with expectations regarding Duty of Candour/Being open.
- 5.166 We also found that the external independent reviewer maintained a good level of communication with the families throughout the investigation process. Families were clear about why the investigation was delayed and also understood what the external independent reviewer were trying to do to gather facts. The families, and the external independent reviewer, thought that the report would provide a satisfactory explanation of what happened and why.
- 5.167 However, once the investigation report had been produced and fed back to the families it became clear that the families' questions had not been answered adequately.

- 5.168 We found that when one family member informed LTHT that they were not happy with the contents of the report and had some unanswered questions, they were offered a meeting. At that meeting there was a general discussion regarding the scope of the report and the family members questions were addressed individually with statements of reassurance. The family member had the opportunity to reflect after the meeting and decided that their answers regarding their loved ones care had not been adequately answered. They therefore wrote a letter asking for a separate investigation into the care and treatment of their loved one.
- 5.169 The family member received a letter back from the complaints department asking them to complete a complaints form, which they did. We found that this was inappropriate, the family member should not have been asked to make a formal complaint at this stage.
- 5.170 The family member then received letters from four different members of staff from the complaints department all offering their condolences. We found that this was upsetting for the family member and insensitive. The conclusion of the complaint was met with a letter from LTHT suggesting to the family member there any unanswered questions would be dealt with at the Coroner's inquest. We found that this was inappropriate and inadequate. We would have expected that given the serious nature of the incident and given the Trusts' desire to be open and transparent that a further separate investigation into the incident should have been commissioned.
- 5.171 In our discussions with all three families we found that they have conducted themselves with dignity whilst trying to ensure that NHS services understand their concerns. One family member stated:
- “The family struggle to understand how such a killing could happen in a hospital, a place that, more than anywhere else, should be a place of safety. Ken was a kind, gentle, and thoroughly decent man who should have been kept safe at the most vulnerable period of his life. He did not deserve to die in the terrible way that he did”.
- 5.172 Our impression is that this is the same view for all three families in that they have not felt that their concerns have been heard.
- 5.173 Around the beginning of March 2018 there were several press articles regarding the attack. The families were contacted by journalists and asked to give interviews or statements about their experience. Each family member we spoke to found this an extremely distressing and upsetting time. We established that the last contact from LTHT & LYPT with the families regarding the attack was in 2017. We confirmed with the families that they had had no contact with, or offer of support from, LTHT or LYPT during the press coverage of the attack. We were subsequently informed that the Trusts did not know that the families had been contacted by the press.

5.174 In summary, we found that the engagement of the families prior to and during the investigation was good and that the Trusts complied with their responsibilities under Duty of Candour. However, we found that the families felt that the Trusts made little effort to answer any outstanding questions and did not offer any support once the investigation report had been completed.

5.175 The Trusts sent the investigation team information, reports and documents that contained evidence of progress towards meeting the internal report's 10 recommendations. We assessed these to evaluate whether the actions had been completed, embedded and were having an impact. We concluded that Recommendation 6 had been completed, with strong evidence of embeddedness. We also found that 7 of the other recommendations (Recommendation 1,2,3,4,5,7 & 9) had been completed with strong evidence of completion.

6. OVERALL ANALYSIS AND RECOMMENDATIONS

Predictability and preventability

6.1 Predictability is “the quality of being regarded as likely to happen, as behaviour or an event”.³³ An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.³⁴

6.2 We considered whether the tragic events of the 28 February 2015 were predictable or preventable. We define predictability is being “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. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.

6.3 We found that it was predictable that during a period of relapse, without medication, that Harry would develop persecutory thoughts about people. We have set out a detailed rationale for conclusion earlier in this document. We found that the probability of violence, from 18 February 2015, was high enough to warrant action by professionals to try to avert it. **However, we do not think that the extent of the violence and the tragic event of the 28 February 2015 could have been predicted.**

6.4 Prevention³⁵ means to “stop or hinder something from happening, especially by advance planning or action” and implies “anticipatory counteraction”; therefore for

³³ <http://dictionary.reference.com/browse/predictability>

³⁴ Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. *The British Journal of Psychiatry* (2000)176: 116-120

³⁵ <http://www.thefreedictionary.com/prevent>

a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

6.5 We consider that the tragic event of the 28 February 2015 was, to an extent, preventable. We have set out a detailed rationale for our conclusion earlier in this document. We believe that:

- there was opportunity to oversee and coordinate Harry's physical and mental health care as his condition deteriorated;
- that there was an opportunity to assess Harry under the Mental Capacity Act which could have offered a helpful framework to deliver Harry's care and treatment;
- Harry could have been prescribed an immediately acting anti-seizure medication so that his olanzapine could have continued which would have prevented a relapse of his schizophrenia;
- there was an opportunity to put an effective management plan in place to mitigate the risks identified from Harry's relapse; and
- a decision could have been taken to nurse Harry in a side room on J19 rather than a four bedded bay, or to provide a Safety Guardian and the level of observation to keep Harry in eyesight at all times.

6.6 We have identified a number of care and service delivery problems throughout our review of Harry's care and treatment. We have made recommendations throughout our report that relate to the things that we have found that are designed to improve the way that the healthcare system functions and in order to prevent a recurrence of an event like this.

6.7 We wish to express our condolences to the families of Ken, Roger and Harry and to thank them for their continued perseverance in trying to understand what happened to their loved ones. We recognise that they will still have several unanswered questions and we are sorry that we have not been able to answer all of them. We have made recommendations regarding these points which we hope will be responded to by the organisations identified and bring some resolution for the families.

Appendix A – Terms of reference

The individual Terms of Reference for independent investigation 2015/8112 are set by NHS England (North). These terms of reference will be developed further in collaboration with the affected family members.

However, the following terms of reference will apply in the first instance;

- NHS England and the Investigator(s) will provide all affected families with a comprehensive explanation of the independent investigation and how it will be conducted, ensuring families have the opportunity to be involved in the investigation process and contribute to the investigation Terms of Reference.
- Involve Ken and Roger's families (the victims) as fully as possible in liaison with support organisations and or their advocate(s)
- Critically analyse the externally commissioned investigation of the incident to identify;
- if the investigation fully satisfied the terms of reference,
- if the terms of reference were appropriate for the incident investigation,
- if the incident itself was fully considered,
- if all key issues and lessons were identified,
- any additional key lines of enquiry which would have warranted further consideration,
- if recommendations were appropriate and comprehensive and linked to the findings/conclusion of the investigation,
- if there was appropriate, meaningful, effective family engagement and treatment by the Trusts and the Investigator (adherence to Duty of Candour/Being Open etc.) during and following the investigation.
- Build on the Trusts investigation utilising where possible validated investigation material (staff transcripts etc.).
- Conduct an evidence based review and gap analysis of the progress the Trusts have made, in implementing the recommendations and learning from their commissioned investigation - focus on the outcomes (changing practice) and impact (on stakeholders such as staff, service users and their carers) rather than process (developing a policy, providing training) unless specifically relevant.

- Review the systems and processes which would enable the Trust Boards to assure themselves that lessons were being learnt from this homicide case and other serious incidents.
- Review and consider the efficacy of systems that would demonstrate that recommendations and actions were being embedded within the organisation, and the lines of accountability within the Trust.
- Review the appropriateness of the treatment of Harry in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern
- Review the adequacy of risk assessments and risk management, including specifically the risk of Harry harming themselves or others
- Examine the effectiveness of Harry's care plan including the involvement of the service user and the family, in doing so;
- Consider and comment on the adequacy and effectiveness of clinical communication between the two Trusts involved in the care of Harry.
- identify any deficiencies in clinicians' knowledge of the importance of medication compliance in the treatment of patients with a history of severe mental health problem
- Review and assess compliance with local policies, national guidance and relevant statutory obligations
- Examine any resource issues and environmental factors affecting the ward where the incident occurred such as staffing capacity, skill mix, relevant experience of staff and suitability of the ward
- Review the effectiveness of governance and risk management systems within the organisation, specifically incident reporting by the ward area in relation to challenging behaviour by patients
- Explore whether any aspects of workplace culture potentially impacted on the incident
- Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing detailed rationale for the judgement
- Provide a written report to NHS England that includes measurable and sustainable recommendations
- Contribute to an action planning workshop with key stakeholders

- Assist NHS England in undertaking a brief post investigation evaluation
- Where required undertake an assurance (in collaboration with the relevant CGG) follow up review 6-12 months after the report has been published, to independently assure that the report's recommendations have been fully implemented and feedback the outcome to NHS England (North) and NHS Improvement via the regional team.

Appendix B – Documents reviewed

Witness statements

74 statements from staff employed by:

- LTHT
- Acclaim security
- Ensign ltd,
- LYPT
- Corinthian house,

From Leeds Teaching Hospitals NHS Trust

- Clinical records for Harry
- 12 months sickness absence for J19
Terms of reference for the internal investigation
- Site plan for ward J19
- Quarter 2 2014/15 nursing audit for J19
- Quarter 3 2014/15 medicines management audit
- Quarter 4 1415 nursing audit for J19
- Attendance notes from meeting with pharmacy team 26.11.15
- Being open duty of candour procedure January 2014
- Chronology of medical input to Harry's care – written by LTHT
- Clinical pharmacy operational standards August 2014 revision 4
- Activity query for patient admissions and discharge J19 December 2014 to February 2015
- Handover and transfer of care procedure 2014
- HB pharmacy investigation 2015 (LTHT)
- Health records management policy January 2014 (LTHT)
- summary of Hamish McDonald award for J19 May 2015
- J19 extract from Datix of reported incidents 01.04.14–28.02.15
- Medicines Code version 3.3 May 2014
- Medicines management policy January 2014
- Medicines reconciliation procedure January 2014

- Reporting and management of serious incidents procedure November 2013
- Ward description of J19 -student information- undated

From Leeds and York Partnership Trust

- Clinical records for Harry
- Health records policy January 2013 (LYPT)
- Liaison Psychiatry Operational policy 2014

From Corinthian House

- Clinical Records for Harry

Other

- GP records
- Harry's stepdaughters diary
- Correspondence between Leeds Teaching Hospital NHS Trust and the families affected,
- Correspondence between NHS England (Karen Conway) and the families affected
- Email correspondence between Kens family and the external independent reviewer
- Internal investigation Report
- Correspondence between West Yorkshire police and Ken's family
- Email between LTHT and external independent reviewer regarding appointment to internal investigation
- Letter from LTHT to external independent reviewer appointing him to external independent reviewer

Appendix C - Care and Treatment of Harry Bosomworth

Background between 1962 and March 2009

We sought as much information about Harry's care and treatment for his mental health as possible from when the family told us he was first diagnosed as having schizophrenia in 1962 when he was 18 years of age. No further information is available following this until the 13 October 1980 when he was 36 years old and he was seen at home by his GP after complaining of noises in his head and being controlled by external forces. He was diagnosed with paranoid schizophrenia and anxiety with depression. Despite this, he coped easily with family life and activities of daily living. However, he didn't work, and his stepdaughter told us this was because he couldn't understand instructions very well. Harry told the GP that he was able to date the onset of these symptoms to March 1979, when he gave up work to look after his mother full time.

He told his stepdaughter about how his schizophrenia had developed and how he was happy with his medication. He used to say "As long as I have my music on and I am alright, I feel safe". The music was to help with the voices he occasionally heard. Harry was discharged from the mental health outpatient clinic, where he had been seeing the consultant psychiatrist, back to his GP on the 13 November 1985. The GP was asked to maintain him on the antipsychotic medication (at the time this was thioridazine) and to let the consultant psychiatrist know if there was any deterioration in his condition.

At this time, Harry appeared to be only seeing the consultant psychiatrist as an outpatient and there is no evidence of a care coordinator being appointed or that there was a crisis plan in place, other than this advice to the GP. However, this would have been the practice at the time, as the Department of Health Care Programme Approach (CPA) was introduced later than this in 1990 with the aim of providing a framework for effective mental health care for people with severe mental health problems and including the appointment of a care coordinator. Following this, the NHS mandate 2004 - 2005 introduced the idea of crisis plans to help people recover from episodes of ill health.

In 1990, when Harry was 46 years old, the stepdaughter told us that he stopped taking his medication on the advice of her older sister. His stepdaughter told us that this period of time gave a valuable insight into how he deteriorated without medication. Within five days she saw the difference in him and three or four days later smashed windows in a shopping centre and hit his wife. Records indicate that he was subsequently arrested by the police, however there is no further information about whether he was charged with an offence related to this. There is no other information to indicate that Harry had a forensic history.

Following this incident, it is recorded that Harry realised his mistake, took himself to the GP and asked for admission to St Mary's Hospital, Leeds where he remained for about a week. He started taking his tablets again, learnt from this episode and said "I will never, ever do that again".

When his wife died in 2000, Harry was devastated and confused. He stayed in the same house and the stepdaughter took care of the funeral and the practical and financial matters. For the first five or six years after this he appeared to be coping fine but then he started drinking at home in 2006 – 2007, which progressed to drinking every day starting in the morning. His stepdaughter said that he started to feel very ill and fatigued, was transfused with five or six pints of blood and felt well again. Following this he told his stepdaughter that he needed to do something about his drinking and start taking responsibility for it, so that he had periods of time when he stopped drinking. Harry was subsequently referred by the GP to the consultant psychiatrist at LTHT St James's Hospital on the 10 of January 2001 for supervision of his care following new guidance on thioridazine treatment (this medication was being withdrawn from the market). The referral letter indicated that he had a period of not taking his medication when the GP found 400 thioridazine tablets in his cupboard at home. The consultant psychiatrist at St James's Hospital saw Harry and did not change his medication.

Harry was seen again the following month, at six months and then in April 2002 he reported that he had several episodes of 'paranoia' which caused him considerable distress. He was advised to take an extra thioridazine tablet at these times, however when he was seen again in October 2002 he reported that the extra tablet had worsened his 'paranoia'. He therefore remained on the previous treatment regime although he reported being bothered by loud noises in his flat especially at night. When Harry was seen in April 2003 he reported that his delusions had worsened, and whenever he saw anybody who was accidentally looking at him he felt 'paranoid' and on one occasion he approached a person and asked what they were looking at. He was worried that this may result in a fight. He agreed to an increase in his thioridazine, and if he experienced any further deterioration in his mental health he agreed to see his GP immediately. When he was seen again in July and October 2003 he reported that his fears and 'paranoia' had abated, but not completely, on the increased dose of thioridazine. In March 2004 he reported being lethargic and sedated on the higher dose of thioridazine and so this was reduced to three times a day instead of four. In March 2005 Harry commenced olanzapine 10 mgs at night as thioridazine would no longer be available from June 2005. The olanzapine was increased to 15 mgs at night in December 2005 as he reported that people looked at him strangely in public and believed an intruder had been in his property. When Harry was seen again in June 2006 he said he was much more settled on this dose of olanzapine.

Olanzapine³⁶ is an antipsychotic medication used in the treatment of schizophrenia. The British National Formulary (BNF) advises that for adults the oral dose should be 10 mg daily, adjusted according to response, with the usual dose being 5–20 mg daily. Doses greater than 10 mg daily should only be prescribed after reassessment, when one or more factors present that might result in a slower metabolism, for example, female gender, elderly, non-smoker. Where this is the case a lower initial dose should be considered and a more gradual dose increase up to a maximum of 20 mg per day.

³⁶ <https://bnf.nice.org.uk/drug/olanzapine.html#indicationsAndDoses>

Harry was reviewed every six months and was reported as stable apart from two occasions in April 2008 and March 2009 when he reported that he had been issued a prescription for less than the 15 mgs of olanzapine and as a result he had experienced several bouts of brief persecutory fears which abated when he was able to obtain his correct amount of medication. This was brought to the attention of the GP. As Harry was approaching the age of 65 years a discussion took place with him about transferring to the older age psychiatrist. He preferred to be transferred to the care of the GP who was asked to refer him accordingly if his condition deteriorated.

Care and treatment in Leeds Teaching Hospitals NHS Trust between 11 September 2013 and 28 January 2015

First admission 11 September 2013 to ward J26

On the 11 September 2013 Harry was admitted to the general medicine acute male admission ward J26 at Leeds Teaching Hospitals NHS trust after self-presenting to his GP with fatigue. He was treated over a three-day admission for anaemia by receiving two units of blood and he was discharged on the 13 September 2013. Records indicate that during this admission he was prescribed and administered olanzapine 15 mgs at night. Following this admission, he was 'fast tracked' for a colonoscopy and gastroscopy which were undertaken as an outpatient on the 2 October 2013.

He was told that he had cancer of the oesophagus and that the course of action would be to have an oesophageal stent (a tube to keep the passageway open) inserted and thereafter consider palliative care.

His granddaughter had been present in a review undertaken by the Department of Upper Gastrointestinal and Minimally Invasive Surgery and reported generally that H had a childlike affect, found it difficult comprehending complex information, had a very poor short term memory and was unlikely to remember or recall information discussed with him. It was noted that he was living on his own with no statutory input.

A letter to his GP following this review noted his past medical history of paranoid schizophrenia along with anxiety and depression as significant and that he was taking antipsychotic medication to help control this. Following this, Harry had consultations with a dietician and his GP about his weight loss and action was taken to supplement his diet in November and December 2013.

Second admission 5 November 2013 to ward J42

Harry was admitted for his initial stent insertion 5 November 2013 to ward J42 for elective surgery. An adult nursing specialist assessment was undertaken, he was commenced on a physiological graded response observation chart and a nutritional care plan. There were no complications following the stent insertion and Harry was discharged on the 6 November 2013. He was to be followed up by the dieticians at home and it was noted that "patient has all regular medications at home".

The prescription chart and administration record indicates he was prescribed olanzapine 15 mgs at night however it appears that this was not administered as the signature section is not signed and indicated that the dose was not available.

Third admission 9 May 2014 to ward J26 and ward J93

On the 9 May 2014 Harry was admitted to LTHT St James University Hospital medical oncology ward J26 with regurgitation and weight loss. It was found that he had a local progression of the oesophageal cancer and a further stent was inserted. He was later transferred to the oncology ward J93.

During his time as an inpatient on ward J93 Harry's physical healthcare was adequately addressed through the use of various care plans which included confusion, bed rails, falls prevention, pressure ulcer care, hygiene, catheter care, disease progression, nutrition, oral care and physiological observations.

Harry was discharged on the 30 May 2014 and the discharge summary asked the GP to refer him to community psychiatry as "he has had two episodes of possible psychotic behaviour on the ward, though he is currently well and stable".

The discharge summary asked the GP to continue prescribing olanzapine 15 mgs at night. Harry was also prescribed Fresubin™ energy drink three times a day (a food supplement), paracetamol 1 g four times a day (for pain relief), metoclopramide 10 mgs four times a day (for nausea), ferrous sulphate 200 mgs three times day (for anaemia), tranexamic acid 1 g twice a day (to prevent blood loss), simvastatin 40 mgs at night (for high cholesterol) and bisacodyl 10 mgs at night (for indigestion).

Records indicate that in June 2014 the oncology department stopped his medication when he attended for radiotherapy. Further information about this is not available, however evidence suggests it was a short term measure because it was reported that between the 3 and 9 June 2014 Harry started to get confused about his medication and was struggling to use the dosette box (a disposal plastic system for arranging weekly medicines) he had been provided with by the Macmillan team (cancer support services). However, he was not used to taking his medication from this and only took it as long as someone was there to help him.

The first dosette box he was given had pictures instead of words to indicate morning and evening doses and he couldn't understand what the pictures meant. The dosette box was then changed to one where he had to turn it over and then turn it back or it would bleep. Harry developed unusual ideas that when the dosette box made a bleeping sound he would think there was some ghosts present.

Arrangements were being made to teach him how to use this, and to assist further it was agreed to change his other medication to twice per day. This change would not have had a bearing on his olanzapine as this was prescribed once a day at night,

however overall Harry having his olanzapine between the 3 and 9 June was at this point in question.

On the 9 June 2014 his stepdaughter asked the GP practice to review him as she was concerned about his general state and his decline. He had previously refused to see a doctor but had fallen twice that morning and was generally frail, not able to eat anything, was very weak and not able to walk or weight bear. The records stated that he had not received medical or healthcare professional intervention in the last six months and needed to be assessed in hospital and admission arranged. This statement appears to correspond with the records of October 2013.

Fourth admission between 9 and 30 June 2014 to ward J29

On the 9 June 2014 Harry took an accidental overdose of the medication for the whole of the day and the following mornings medication, attended Leeds General Infirmary A&E department and was admitted to the acute medical assessment unit ward J29. On admission, the history of his presenting complaint detailed the fact that he was a known schizophrenic with poor short term memory and that he was prescribed olanzapine 15 mgs at night. It was also noted that his step daughter helped him with shopping and cleaning three to four times a week. The record of his diagnosis and problems stated that he had worsening of his oesophageal cancer symptoms, general deterioration and that he was not coping at home. He was referred to oncology and the palliative care team.

On the 13 June 2014 Harry had a gastroscopy and had a stent inserted, however the stent slipped and was found to be no longer in the oesophagus. Post stent insertion, the prescription and administration record indicates that he was prescribed “soluble- post stent” olanzapine 15 mgs at night, and although there was no start date recorded, it was recorded as being administered until the 14 June 2014.

After this the prescription administration sheet indicated that Harry ‘could not take the dose’ between the 15 and 18 June 2014, however no action was recorded on the omitted or delayed dose section of the chart. Due to this, we found that the prescription administration records were not completed in accordance with the LTHT Medicines Code March 2014 (version 3 page 31) which states that when a prescribed medicine has not been administered for two or more doses, or where a dose to be given immediately (stat) has been missed, the senior nurse on duty should be informed, and an incident report may need to be completed.

This was the first record of olanzapine not being administered whilst Harry was an inpatient in LTHT.

Harry was meant to have a further gastroscopy on the 16 June 2014 but this did not take place and the records indicate that the reasons for this were unknown. The outcome of the assessment was that he should remain ‘nil by mouth’, have a review by the oncology team and a review of the olanzapine prescription which could be

administered by an intramuscular injection or via a long acting (depot) as per the British National Formulary³⁷ (BNF) guidance.

We view this as an appropriate response to the fact that Harry could not take oral olanzapine, however there is no record of this advice being implemented. He remained 'nil by mouth' after this, and on the 17 June 2014 records state that nursing staff asked the doctor to review the plan and whether he was supposed to continue being 'nil by mouth'.

In preparation for a further stent insertion, on the 18 June 2014 Harry's medication was reviewed with a pharmacist who said that due to the long half-life of olanzapine he would "likely be ok" without olanzapine for approximately eight to ten days. At this point he had been without his olanzapine medication for three days since the 15 June 2014. We found that although the advice on the half-life of olanzapine was in accordance with the BNF guidance on olanzapine, there was no advice to indicate that Harry could have been prescribed intramuscular or a long acting (depot) olanzapine and the advice did not reference the importance of observing Harry for relapse. We believe there should have been psychiatric advice at this point due to the risk of relapse and the complexity of his physical and mental health needs.

We understand that without olanzapine, about 90 percent of patients with schizophrenia relapse in two years, about 50 percent in three months and relapse over one to two weeks wouldn't be unusual, with some people relapsing and requiring admission in one to four days.

The advice was to refer him to the mental health liaison team if he needed to be 'nil by mouth' for a longer period or if his symptoms worsened. Additionally, if the olanzapine was to be restarted after eight to ten days the dose should be restarted at 5 mgs and re-titrated up to 15 mgs at night. We found that the advice about the prescription of olanzapine in order to recommence treatment was reasonable, however our view is that olanzapine should not have been discontinued at all.

Harry had the stent inserted on the 19 June 2014 and the following day, the nursing records indicate that he had been having hallucinations overnight and said he could hear two male voices threatening him. At this point Harry had been without olanzapine for four days and it is our view that he appeared to be relapsing as a result with concerning psychotic features.

The nursing staff spoke to the medical doctor who advised not to give Harry his oral medications so soon after having the stent inserted. He was prescribed intramuscular lorazepam, which is a drug used for the short term treatment of anxiety and insomnia, panic attacks, conscious sedation prior to a procedure and status epilepticus. He settled slightly with this and he recommenced on oro-dispersible olanzapine in the evening.

³⁷<https://www.bnf.org/about/> BNF Publications reflect current best practice as well as legal and professional guidelines relating to the uses of medicines.

The prescription administration sheet states “refer to medical notes” on the 19 June 2015, and it appears that olanzapine was administered up until the 24 June 2015 although the records are not clear. A further prescription and administration record commenced on the 24 June 2014 with the same prescription for olanzapine and this was then administered up to the 29 June 2014.

At this point Harry was assessed as not having capacity to use or weigh information as part of the decision making process and that in his best interests, the treatment could not wait until he recovered capacity because he had a long standing psychiatric illness. We note that as capacity assessment is decision specific it shouldn't be taken to imply that he lacked capacity more generally. The family was therefore involved in the decision to proceed with the stent which was inserted on the 19 June 2014. Harry was advised that he could start having fluids and progress to a soft diet the following day. On the 20 June 2014 the nursing records indicate that Harry had been having hallucinations overnight and said he could hear two male voices threatening him. The nursing staff spoke to the doctor who advised not to give Harry his oral medications so soon after having the stent inserted. He was given lorazepam intramuscularly. He settled slightly with this and he recommenced on oro-dispersible olanzapine in the evening.

This is the first indication that Harry had been given lorazepam and it appears to have been given following him experiencing hallucinations. The BNF indicates that use of a benzodiazepines such as lorazepam may be helpful in the initial stages of treatment for mania³⁸ where there is behavioural disturbance or agitation however it should not be used for long periods because of the risk of dependence.

The BNF advises caution with the use of lorazepam as there may be a paradoxical increase in hostility and aggression reported by patients. The effects range from talkativeness and excitement to aggressive and antisocial acts. Adjustment of the dose (up or down) sometimes attenuates the impulses. Increased anxiety and perceptual disorders are other paradoxical effects. We understand that lorazepam can be disinhibiting even if prescribed at a dose of 2 mgs twice a day. Our view is that lorazepam should not be considered a suitable alternative to olanzapine in the treatment of schizophrenia as it is not an antipsychotic medication, however may be given as a short term measure.

Lorazepam 1 mg intramuscularly was also prescribed ‘as necessary’ to be administered intramuscularly up to a maximum of 4 mgs in 24 hours. This would appear to be in line with BNF guidance in the use of lorazepam for the initial stages of treatment for behavioural disturbance or agitation. The BNF advises that the dose should be 25–30 micrograms/kg every 6 hours if required with the usual dose of 1.5–2.5 mg every 6 hours if required.

³⁸ <https://bnf.nice.org.uk/treatment-summary/mania-and-hypomania.html>

We agree with the view that that lorazepam can be disinhibiting even if reasonably prescribed at a dose of 2 mgs twice a day. An immediately active anti-seizure medication and continuing the olanzapine should have been considered.

On the 22 June 2014 an infection prevention and control source isolation care plan (due to loose stools) was commenced and ended on the 23 June 2014 when the results of the sample came back negative for infection. This is the only record of Harry being nursed in a single room.

On the 24 June 2014 records indicated that the medication chart had needed to be rewritten for the previous two days and as a result the nursing staff had been unable to give Harry his prescribed medication.

The discharge planning records indicated that Harry was not being seen by the community mental health team however a note requested them to be reconnected with Harry so he could be followed up in the community. The following day a 'phone call was made to the GP practice and it was confirmed that the last Harry was seen by a consultant psychiatrist was in 2009.

On the 26 June 2014 the ward round recorded a "recent psychotic episode" with a plan to refer Harry to the mental health liaison team and commence discharge planning. Records stated that he was to be discharged with a dosette box for his medication and details were to be provided to the community pharmacy.

Records of the 27 June 2014 reiterate that it should be ensured that the mental health liaison team were aware of his discharge, and the Macmillan nurses attempted to contact them, without success, so that they could undertake a review of Harry before his discharge. The Macmillan nurse requested the doctor to prescribe the olanzapine for the morning, rather than the evening as he was used to, to "facilitate compliance". We understand from our specialist pharmacological advice that the time of day that olanzapine is prescribed would not make a difference as it has a long half-life. A half-life is how long a medication takes for half of the dose to be eliminated from the blood stream.

On the 28 June 2014, when he was noted as being unsettled, confused and 'paranoid' overnight, lorazepam was given with 'good effect' and it was noted on both the 28 and 30 June 2014 that a psychiatric review was needed before his discharge. We have not found evidence that a psychiatric review was requested or took place.

When Harry was discharged on 30 June 2014 the discharge summary requested the GP to refer him to community psychiatry due to two episodes of possible psychotic behaviour on the ward although he was currently well and stable. The medication on discharge included his usual antipsychotic medication (olanzapine) 15 mgs at night. We have not found evidence that the GP referred him to community psychiatry (see section on primary care issues).

At home between 1 July 2014 and 25 January 2015

On the 1 July 2014 the pharmacy technician at Leeds Community Health received a call from the social worker at St James's Hospital following Harry being discharged from there. The re-ablement team had raised concerns about Harry "double dosing" on his medication. Prior to his admission Harry had been prescribed simvastatin, bisacodyl and olanzapine 15 mgs at night. Following discharge further medication had been added including Fresubin™ energy drinks, paracetamol, metoclopramide, ferrous sulphate and tranexamic acid.

On the 2 July 2014 the pharmacy technician visited Harry at home. They discussed a telecare box as a compliance aid which 'beeps' and 'pops' out the medication at the required times of day. The community pharmacist completed an application for the telecare box with Harry, and the dispensing pharmacy was changed because the usual one Harry used did not administer telecare boxes. He understood how to use the telecare box and the community pharmacist discussed it with Harry's stepdaughter who seemed happy with the arrangements.

The GP spoke to the pharmacy technician on the 3 July 2015 and found that Harry was requesting to take his ferrous sulphate twice a day rather than three times a day as he was "getting in a muddle". It was agreed that this would be changed and there is reference to the GP writing to the community psychiatrist.

The community pharmacist reviewed Harry on the 4 July 2014 and he seemed to be using his dosette box with no problems. However, the community pharmacist received a call on the 10 July 2014 to say that he had attended A&E after doubling up on his medication, having taken all of his medication from the night of the 10 July 2014 and the morning medication from the 11 July 2014. Harry had apparently done the same the day before. Records indicate that the dose levels did not present a significant risk and he had been discharged after the A&E attendance.

The community pharmacist reviewed Harry on the 14, and 22 July and the 1 August 2014 and found that he was doing well, the new telecare box was working and he seemed to be taking his medication. The community pharmacist did not see him after this date and expected that the GP or district nursing staff would refer him back to her, had there been any concerns.

The practice nurse wrote to Harry on the 26 September, 5 December 2014 asking him to make contact for a flu vaccination and a standard blood test to ensure that his medication and blood was monitored regularly.

In December 2014, his stepdaughter noticed that he wasn't taking all of his medication for high cholesterol and so she started to visit him every couple of days to ensure that he did because she was concerned that he also might not have been taking his olanzapine. However, she found empty packets of olanzapine on his bedroom floor from present and previous years so she knew that he had in fact been taking them as he

always did. She was still concerned however that in the previous two weeks Harry may have been a bit 'hit and miss' about taking all of his medication.

Fifth admission between 27 January and 12 February 2015 to ward J96

On the 26 January 2015 Harry was assessed at home by the GP practice and admitted to LTHT medical oncology assessment ward J96 St James's Hospital, through the Primary Care Access Line (PCAL). The PCAL is a nurse led telephone service that allows GPs and other community practitioners to admit their patients directly to specialty beds thereby avoiding an A&E attendance.

His stepdaughter had raised concerns that during the previous three to six weeks Harry had deteriorated and was not wanting to eat, struggling to get out of bed and his breathing had declined.

Following admission, Harry was reviewed by a core medical trainee, a specialty registrar and a consultant in medical oncology. Harry was diagnosed with a tumour related anaemia and received six units of blood. We understand from our specialist pharmacological advice that a situation where blood is lost, followed by blood transfusions, would not impact on the blood serum levels for olanzapine as there is never very much olanzapine in the blood itself, approximately 50 mcg per litre, and that, as an example, losing two pints of blood would remove about 100 mcg or 0.1 mg olanzapine from the body.

A short admission was planned, however he had a seizure and a collapse whilst on the ward. The records detail Harry's history of paranoid schizophrenia and a query about his compliance with olanzapine which needed to be clarified with his GP was noted. On the 28 January 2015, a pharmacist started to undertake a medication history for Harry which is usually completed within 24 hours of admission. The pharmacist spoke to the community pharmacy that had set up the compliance aid for him, however on speaking to them they said that they had not dispensed anything for Harry since August 2014, despite the fact that he had insisted that his medication was delivered to him from this pharmacy.

The pharmacy staff contacted the GP to ascertain whether they had records of where his compliance aid was being dispensed. No records could be found. They could only confirm that weekly prescriptions were being generated. The pharmacist then re-contacted all the pharmacies that had already been contacted and also approximately a further ten in the local area. All denied knowledge of supply.

On the 29 January 2015 the records indicate that Harry's "first" medication prescription chart could not be found and a "second" medication prescription chart was commenced on the 2 February 2015. We are therefore not able to ascertain whether he had his olanzapine between the 27 and 29 January 2015.

Harry had bloods taken to examine haemoglobin, urea, electrolytes, liver function, clotting and a full blood count which were noted to be normal together with a

satisfactory response to the blood transfusion. The ward round that day focused on his physical health although there were aware that checks were being made to determine whether Harry had been taking his olanzapine.

On the 29 and 30 January 2015 pharmacists questioned his compliance with medication prior to admission and asked if the list of his medication could be reviewed and prescribed if appropriate. The record asked the doctors to note the entries. Given the confusion with the dispensing pharmacies it was decided to set Harry up with a new compliance aid ready for him on discharge and to ensure the dispensing pharmacy details were added to his records.

On the 30 January 2015 the pharmacist contacted the GP surgery to ascertain if there was any recent information in Harry's medical notes concerning contact with a community psychiatric nurse or letter from either primary or secondary care concerning medication reviews. The surgery was not able to provide any information and could not confirm who was collecting Harry's prescriptions or if he had a regular pharmacy.

The pharmacist telephoned Harry's step-daughter. She confirmed that to her knowledge Harry had not taken his medication for some time and that she had witnessed a bowl filled with tablets that he had accumulated. In addition, the records state that she said he had started to not take his medication when multiple medicines had been introduced by the GP. The pharmacist made an annotation in Harry's medical notes to say that it could not be confirmed if Harry was taking his medication.

On the 29 January 2015 the records indicate that Harry's "first" medication prescription chart could not be found and a "second" medication prescription chart was commenced on the 2 February 2015.

The aim was to discharge Harry home on the 30 January 2015 but this did not take place. The LTH investigation states that "the request from Harry's daughter to delay Harry's discharge was responded to positively and Harry's discharge was suspended until the community nursing and social care packages were in place".

On the 1 February 2015, Harry's medication prescription chart was sent to pharmacy, however there was a fault in the internal air tube delivery system and his medication chart went missing. We understand from the records that usually medication charts are in a folder kept either at the patient's bedside or with the medical notes and that it was not unusual for medication charts to be picked up by other members of the team for review, however on enquiry the medication chart could not be located.

A temporary prescription and administration record was rewritten by the on call doctor including olanzapine 15 mgs as a regular medication to be taken at night. However, there was no stock on the ward and the nurses had to order it from pharmacy.

The regular medication section of the prescription chart indicated that olanzapine 15 mgs at night was prescribed, however the start date was not entered, and on the 1

February records indicated that the dose was not available and on the 2 February 2015 records indicated that Harry 'could not take the dose'. No further action was recorded in respect of the missed olanzapine. Although the prescription was not crossed out as discontinued, further administration records after the 2 February 2015 for olanzapine were not evident.

Again, this practice was not in accordance with the LHTT Medicines Code March 2014 (version 3 page 31) which states that when a prescribed medicine has not been administered for two or more doses, or where a dose to be given immediately (stat) has been missed, the senior nurse on duty should be informed, and an incident report may need to be completed.

Records of the 2 and 3 February 2015 indicate that Harry became a little unsettled and 'paranoid', was talking to himself overnight and hearing voices. A referral to the mental health liaison team was discussed and thought appropriate. On the 3 February 2015 whilst in the company of the nursing staff, he began to fit, was shaking, unresponsive and incontinent of urine. He regained consciousness after about 15 minutes, and it was thought that he had experienced a seizure.

The specialist registrar for the gastroenterology oncology team spoke to Harry's stepdaughter. From this discussion his view was that Harry became confused when more than one tablet was introduced and they believed that Harry had not been taking his medication, including the olanzapine, and that this related to him having been prescribed new medication by the GP.

The specialist registrar for the gastroenterology oncology team stated that he understood that the olanzapine prescribed for Harry had not been administered because it was unavailable on the ward. However, he took the decision after speaking to the specialist clinical pharmacist, and the stepdaughter that, given that Harry had apparently not been taking his olanzapine, including lack of administration during the present admission and no documented concerns for a relapse in his mental state and risks of further seizures, not to commence olanzapine at that point.

Hence the prescription for olanzapine was crossed out and recorded as being stopped on his prescription chart. The reviewing doctor was aware of the BNF guidance that olanzapine can lower the seizure threshold and should be used with caution in epilepsy and in conditions pre-disposing to seizures. Despite the doctor correctly consulting the BNF guidance, this situation was in our view a missed opportunity to request a psychiatric opinion and refer to the mental health liaison team for advice.

We understand from our specialist pharmacological advice that the effect of olanzapine as a contributory factor to seizures is very small. An immediately active anti-seizure medication could have been prescribed and the olanzapine prescription could have been continued.

When the specialist registrar for the gastroenterology oncology team reviewed Harry on the 3 February he demonstrated a significant improvement in his cognition. He discussed with Harry the possibility of a transfer to a nursing or care home given his increasing level of need which he said he was happy with.

The stepdaughter said that she spoke at length to the nurse on the ward about the importance of reinstating his olanzapine. She noted that subsequent conversations with staff nurses through 'phone calls and visits warning of his by now confusion and memory loss and warnings of the possibility of him turning violent all resulted in the same feedback that they would note her concerns.

On the 4 February Harry was reviewed by core medical trainee 1. The main focus of the review was his physical health needs. The core medical trainee stated that they were unaware of his treatment for schizophrenia or of any concerns about this from staff or his family

On the 5 February 2015 a referral for continuing health care was completed as it was considered that Harry would not be able to live independently once he had been discharged from hospital. He was transferred from J96 admissions ward to the oncology ward J97.

On the 6 February 2015 the pharmacy that had been dispensing medication for Harry was confirmed, despite it being a pharmacy that had been contacted previously indicating they did not. The pharmacy said that he had not been in for the previous two weeks for them to deliver his medication which corresponded with Harry being an inpatient during this time.

On the 6 February 2015 Harry was reviewed by the same core medical trainee 1 that had reviewed Harry on the 4 February 2015 and the specialist registrar for the gastroenterology oncology team. The main focus of the review was his physical health needs. It was explained to him that returning home may not be appropriate because of the likelihood of him suffering from further seizures. He accepted that this would be the best option for him in the circumstances.

On the 7 February 2015 he suffered a further seizure. A brain scan (CT scan) was undertaken and no acute intracranial pathology was demonstrated. The plan was to check if he was taking his olanzapine, although the records state that it was recommended to hold off administering this as he was mentally stable. Advice from the mental health liaison team was not sought at this point.

On the 10 February 2015 Harry was transferred to the oncology ward J97 and he was reviewed by medical staff but this focused on his physical health, however he did not display any challenging behaviour or give rise to any concern from a mental health perspective.

On the 11 February 2015 discharge planning began and discussions took place with the dietician, physiotherapist and Harry's allocated social worker. He was noted to have a 'palliative diagnosis' and was expected to deteriorate over the next weeks and months. It was noted that he needed prompting to take his medication and monitoring for further signs of physical deterioration as well as assistance and prompting to eat and drink. The medication on discharge was tranexamic acid 1 gram twice a day, Fresubin™ energy drink twice a day, ferrous sulphate 200 mgs three times a day, tranexamic acid 1 gram twice a day, simvastatin 40 mgs at night, bisacodyl 10 mgs at night and olanzapine 15 mgs at night. It was noted that the pharmacy staff were to organise a compliance aid through Lloyd's pharmacy.

Another core medical trainee 2 documented in the discharge advice record that Harry had very poor compliance with medication and "had not taken his dosette box in some time. Please review this. We have stopped his olanzapine as he hasn't taken it for many years and is well without it". The rationale for stopping the olanzapine was provided from the records made by the specialist registrar for the gastroenterology oncology team medical on the 2 February 2015.

The rationale was explained as being because Harry was mentally stable despite not being prescribed olanzapine, he had suffered two seizures on the 2 February 2015 followed by an episode of collapse (with a reduced Glasgow global coma scale³⁹) and olanzapine is known to reduce an individual's seizure threshold. The statement from the core medical trainee 2 explained that the purpose of including this information in the discharge summary was to refer the query back to the GP for their consideration and action as appropriate.

A 'do not resuscitate' decision was discussed and agreed with his step daughter. An assessment was undertaken by the Corinthian House Care Home deputy manager who noted that his main complaint was oesophageal cancer, confusion at times, a history of seizures, urinary tract infections and a diagnosis of schizophrenia.

On assessment by the Corinthian House Care Home deputy manager Harry did not show any signs of confusion, anxiety, psychosis, depression or delirium. The outcome of the assessment was that his nursing needs outweighed any psychiatric needs and his mental health condition appeared to be stable and well managed, although the deputy manager knew that he was not taking any medication for his schizophrenia as it was not listed on his current list of medications. A generic pre-admission assessment form was completed but was not dated or signed.

Care whilst Harry was in Corinthian House Care Home between 12 and 19 February 2015

³⁹ <https://www.google.com/search?client=safari&rls=en&q=glasgow+coma+scale&ie=UTF-8&oe=UTF-8> The Glasgow Coma Scale provides a practical method for assessment of impairment of conscious level in response to defined stimuli.

Harry was discharged to Corinthian House Care Home on the 12 February 2015 and arrived there at 8.35pm. Harry's medication on discharge was two Movicol sachets twice a day, two senna tablets at night, tranexamic acid 1 gram twice a day, Fresubin™ energy drink twice a day, a Fresubin™ 5Kcal shot 30 mls three times a day and lamotrigine 25 mgs twice a day increasing to 50 mgs twice a day from the 16 February 2015 (on neurological advice).

Corinthian House Care Home is a care home for people with dementia and palliative care needs and we understand that at the time it had 72 beds over three floors and ten NHS funded 'winter' beds for patients who are fit for discharge from hospital but cannot go home directly. These patients can be admitted to Corinthian Care Home following assessment until a home care package can be put in place. Corinthian House Care Home began taking patients in this way from December 2014 to the end of May 2015 until the contract expired, and they did not retender for these services.

The stepdaughter visited ward J97 to find that Harry had been discharged to Corinthian house care home without her knowledge or any prior discussion with her. This was acknowledged as being not acceptable practice and the nurse concerned made a full apology to her. When she arrived there to see him she found confused, rambling and he didn't know her. He was hostile, swearing, seeing things and people that weren't there.

At Corinthian House Care Home an assessment of Harry's requirements was undertaken including whether he could maintain a safe environment, eating and drinking, his skin integrity, breathing, personal cleansing and dressing, communication, elimination, mobility, socializing, relationships, sleeping, pain psychological, end of life planning, controlling his body temperature, acute issues and short-term needs. It was noted that he was unable to maintain a safe environment due to his general condition and schizophrenia and that he was confused at times. However, a respite care plan was not drawn up following this assessment.

Harry was temporarily registered with a local GP, and if any further background information related to the patient's medical condition was needed then the original GP would be contacted.

On the 16 February 2015 Harry's stepdaughter rang the ward sister on ward J97. She was concerned that Harry "was in the wrong place and was a danger" and that he must have his olanzapine as she said he was mentally traumatized and "could turn violent". Her view was that he had cancer, uncontrolled paranoid schizophrenia, and was in an old people's home with no doctors.

The ward sister spoke to the Corinthian House Care Home Manager about the stepdaughters concerns that Harry had not been prescribed olanzapine on discharge from LTHT St James's University Hospital.

The stepdaughter told us that she saw the Corinthian House Care Home Manager and demanded that Harry see a GP. The Corinthian House Care Home Manager noted that

the information from the stepdaughter contradicted the discharge summary from LTHT St James's University Hospital which said that the olanzapine had been stopped as he hadn't taken it for many years and was well without it.

On the night of the 16 and 17 February 2015 Harry was noted to be awake all night talking to himself and wandering the corridors knocking on doors and 'vocalising' but not showing any signs of aggression towards residents or staff. Although he wasn't prescribed olanzapine at this point, he refused all his other medication.

The manager contacted the temporary local GP for further advice, and the local GP attended Corinthian House Care Home to assess Harry on the 17 February 2015. The local GP was not able to contact Harry's usual GP for further information and wanted to rule out any physical cause. It was agreed that a urine sample would be obtained and a blood sample taken the following day.

During the day of the 17 February 2015 Harry was verbally abusive to staff and was shouting and swearing. The stepdaughter met with the care home manager and expressed her deep concerns about his mental state and it was not an appropriate place for him. She informed her that he'd taken his olanzapine for 53 years. She emphasised that he was now hostile to even her and swearing, believing people were trying to poison him. The stepdaughter said that she demanded a doctor to visit Harry and reinstated his medication.

Records indicate that the temporary local GP called Harry's usual GP to find out further information about his olanzapine prescription. However, there is no record of olanzapine being prescribed as a result. The local GP was contacted and assessed him. A plan was made to collect a urine sample to rule out any physical cause however records indicated that they were not able to obtain a urine specimen for testing.

The Corinthian House Care Home record of behavioural concerns for Harry on the 18 February 2015 indicated that from 6 pm until 9.30 pm he was out of his room, threatening, shouting and swearing at staff. The Corinthian House Care Home Manager asked the local GP to assess him again. The local GP took a blood and urine sample from Harry and prescribed antibiotics (trimethoprim) for a suspected urinary tract infection. It was noted that the request for information from Harry's usual GP had not been responded to.

On 18 February 2015 the stepdaughter said that she rang Harry's own GP who was not available however she told the receptionist everything, who rang back to tell her that the hospital had taken him off his olanzapine. The stepdaughter then spoke to another Corinthian House Care Home local GP, who listened and said that she would write a prescription for the olanzapine and arrange delivery.

On the 19 February 2015 a statement from a registered nurse on duty that day at Corinthian House Care Home indicated that Harry had been quiet until about 10 am however after that he became agitated and verbally abusive to both staff and residents

and at one point said he was going to kill them all. He was cared for on a one-to-one basis in a side room (as he had been since admission), and the doors of the other residents were kept shut.

The local GP was contacted to assess Harry again, and said that the blood results indicated that he had a urinary tract infection and was dehydrated. Corinthian House Care Home decided that they could no longer meet his needs, and the local GP made the decision to transfer him to St James's University Hospital A&E department.

Sixth admission to LTHT between 19 and 28 February 2015 to wards J28 and J19

On the 19 February 2015 he was admitted to St James's University Hospital via the A&E department with increased confusion, agitation and acute worsening of his psychotic symptoms. It was noted that he had been treated with an antibiotic (trimethoprim) for a urinary tract infection. He was shouting and swearing at staff. Abnormal blood results indicated that he may have an acute kidney injury due to intravascular dehydration or a further gastrointestinal bleed. It was noted that he had schizophrenia and was prescribed olanzapine which he had recently stopped due to difficulties managing his dosette box. He was not engaging in the assessment but was not demonstrating challenging behaviour, signs of delusion or other signs of psychosis. He was admitted to J28 which is an acute elderly medical admissions unit. Patients under acute medicine are not under the care of any specific consultant. A member of the acute medicine team will see patients although the individual physician will vary from day to day due to the sessional nature of the job plans.

Harry was seen by a core medical trainee 3 on the 19 February 2015 who recorded his medication history which was then updated the following day by the pharmacist. The working diagnosis after assessment was a possible hyperactive delirium, psychosis secondary to stopping olanzapine and acute kidney injury.

A medication history recorded at this time included a note indicated that the olanzapine 15 mgs at night had been "recently stopped" as it had not been taken in years. When his stepdaughter was asked she said his agitation was due to the deprivation of the olanzapine. It was noted that he was using a multi-dose compliance aid.

Harry was diagnosed with a possible hyperactive delirium and psychosis secondary to his anti-psychotic medication (olanzapine) being stopped during his last admission due to the fact that he was thought to not be taking his medication and had suffered seizures. The test results received for a urine infection were negative.

The management plan included a note to discuss with the psychiatrist on call 1 for advice which was obtained, and the advice was to prescribe 'as necessary' oral lorazepam, and, or, haloperidol (an antipsychotic) if he became "acutely aggressive" however records indicate that this was not prescribed. The core trainee 3 was asked by the psychiatrist on call 1 to refer Harry to the mental health liaison team the following

morning and agreed that starting olanzapine on a low dose would be reasonable but to await the psychiatric review the following day.

The plan was to start the olanzapine 2.5 mgs at night regularly and an 'as necessary' prescription of 2.5 mgs olanzapine which was in line with BNF guidance⁴⁰ on the control of agitation and disturbed behaviour in schizophrenia or mania in the elderly. The BNF guidance states that an initial 2.5 - 5 mg should be prescribed, followed by 2.5 - 5 mg after two hours if required, with a maximum of three injections daily for three days.

The maximum daily combined oral and parenteral dose should be 20 mg, and when one or more factors present that might result in slower metabolism, for example, female gender, elderly, non-smoker a lower initial dose and more gradual dose increase should be considered.

An LTHT adult specialist assessment was undertaken. A falls care plan was commenced which detailed initial interventions in the first 24 hours and included checking whether the patient was in the most appropriate place on the ward for their needs, that is, close to the nurses' station, close to the toilet, and in the quietest area (considering other patient's needs). Although the interventions ask for the location of the patient to be documented, this was not completed. Following this, a bedrails care plan was put in place on the 19 February 2015, as a staff decision in Harry's best interests, (there is no evidence of a capacity assessment) as he was recorded as having impaired judgement due to sedation and, or, mental state. The bed rails care plan records indicate that bed rails were in place until the 24 February 2015, however the stepdaughter told us that although she and her husband visited every day, separately and at different times, she did not observe bed rails around Harry's bed.

Harry was reviewed again on the 20 February 2015 by a consultant physician 1 whose views were that he had a diagnosis of "probable psychosis and oesophageal cancer". He was disorientated with incoherent speech and "talking nonsense". He was repeating phrases such as "drinks like a fish". The management plan was to test his urine to exclude a urine infection, arrange an old age psychiatry review, push oral fluids, repeat bloods and if his kidney function improved to stop the intravenous fluids. Harry's stepdaughter made a note in her diary stating "still no olanzapine" and the records also note two discussions with his step daughter who felt that since the medication was stopped this led to this episode of confusion. She expressed concern that everyone thought he had stopped taking his medication for years, and her concern was that he wasn't receiving it at the time and he became aggressive when he wasn't taking it.

A pharmacist made a record seeking a review of the medication that Harry was taking for his seizures but did not mention the olanzapine.

20 February 2015

⁴⁰ <https://bnf.nice.org.uk/drug/olanzapine.html> #monitoringRequirements

On the 20 February 2015 the pharmacy support team printed the primary care summary care record for Harry in preparation for the pharmacist to undertake a medicines reconciliation assessment for his new admission. The primary care summary care record indicated that lamotrigine 50 mg 1 twice a day for two weeks was authorised but not issued on the 17 February 2015, and in the discontinued repeat medications section it stated that his repeat prescription for olanzapine 15 mg once a day was discontinued on the 17 February 2015.

We understand that LTHT aims to undertake a medicines reconciliation process within 24 hours of a patients' admission to hospital and the process aims to check that the inpatient medicines as prescribed by the doctor who first receives the patient into hospital, match the medicines that the patient was taking immediately prior to their admission and where there is any variation that this has been accounted for.

The Leeds Community Healthcare NHS Trust joint care manager asked the LTHT St James's University Hospital discharge facilitator to make an entry in Harry's notes which was done. This was because she was working in the community, had tried to contact ward J28 several times without success and wanted to pass on important information about Harry. She wanted to make it clear that Harry had accessed a 'winter bed' at Corinthian House Care Home and not a continuing care bed and could therefore not be transferred back to Corinthian House Care Home without a new referral.

The information recorded from Harry's stepdaughter was that Harry had not experienced any "schizophrenic episodes" for the last 40 years whilst on olanzapine and she felt his confused presentation was the result of him not having had his olanzapine in recent weeks. The stepdaughter rang the ward to say she was concerned about why Harry was not being treated for urinary tract infection. She was told that they did not think he had a urinary tract infection at that time but were yet to test for this. She expressed concerns that everyone thought Harry had stopped his olanzapine for years whereas he had been taking it. She was very concerned that he wasn't getting it as she said he became aggressive without it. The records state that this information would be passed on to a doctor. The ward also received a 'phone call from the local GP for Corinthian House Care Home to pass on the information that Harry's daughter was concerned about his olanzapine.

The records indicate that Harry's stepdaughter approached the foundation year doctor (FY1) with concerns that Harry was not acting like his normal self, that he had always taken his olanzapine for the past 53 years, but found the dosette box too complicated to use. Harry's stepdaughter said that Harry's symptoms had worsened since the olanzapine was stopped "last month by the hospital". The foundation year doctor stated in the records that Harry was referred to the mental health liaison team as she thought they were better placed to review the records and piece together why the olanzapine had been stopped. However, his stepdaughter told us that she demanded that Ward 28 staff asked a doctor or psychiatrist attend to Harry because of his increasingly abnormal and frightening behaviour combined with hallucinations, and after discussion with her the doctor didn't feel it was necessary to see Harry although he was in the next room.

She made a note in her diary on that day that she “managed to get heard about olanzapine”.

The FY1 recorded that the regular medication at that time for Harry was two Movicol twice a day, two senna twice a day, tranexamic acid 1 g twice a day, Fresubin™ energy drink twice a day, lamotrigine 25 mgs twice a day. The pharmacist verified the medication history by referring to the previous discharge summary, the primary care summary care record, information from Corinthian House Care Home, the discharge summary of the 12 February 2015 which stated that Olanzapine 15 mg once a day was recently stopped as it had not been taken in years. The pharmacist made a note to say “Not taking his olanzapine. Psych to review olanzapine with epilepsy meds - restart when lamotrigine stabilised 28 February 2015.”

We understand that during a patient’s inpatient hospital stay the pharmacy team reviews the inpatient prescription and record any action taken. We view the review to this point as being a level 1 review, which is a check of the prescription rather than a review involving the patient and their condition, and is when the pharmacist takes an overview of the whole prescription document and makes sure it is reasonable, legal and safe, and medicines are being administered and available.

A review by a consultant physician 2 on that same day made reference to the olanzapine having been stopped. However, a statement from the consultant physician 2 indicated that she was told by the stepdaughter that Harry had been taking olanzapine for 40 years, which she stated, was contrary to the discharge information. We examined the discharge summary referred to, of the 12 February 2015, which indicated that Harry “has very poor compliance with medication and has not taken dosette box for some time. Please review this. We have stopped his olanzapine as he hasn’t taken it in many years and is well without it”.

The consultant physician documented a management plan which included a referral to the mental health liaison team, to clarify the olanzapine with the stepdaughter, to consider restarting the olanzapine, to continue with intravenous fluids and repeat blood tests for urea and electrolytes, to do a urine dipstick test for infection and send a sample for microscopy and culture.

Registered nurse 4 stated that Harry was confused. He had a confusion care plan and a falls sensor pad which alarms if the patient is trying to climb out of bed as he was at risk of falls. It was recorded that he had impaired judgement due to mental state.

The stepdaughter explained about his confusion using the dosette box but said he would be able to take it regularly if it was dispensed in the packet. She said his symptoms had worsened since the olanzapine was stopped “last month by the hospital” because they were under the impression that he was not taking his medication, but that wasn’t the case he was just finding the dosette box too complex. A call was made to contact the mental health liaison team without success.

We note from staff statements that referrals can be made to the liaison team via a fax made by a member of the medical team however any member of staff can make the suggestion that a referral is made. However, the operational policy for the mental health liaison team 2014 indicates that referrals into the service are made by fax or 'phone by general hospital consultants and other general hospital professionals, consultant old age psychiatrists and other mental health professionals.

22 February 2018

The first contact Harry had with the liaison team was when ward J28 referred him on the 22 February 2015 following his admission with confusion and strange behaviour. This was three days following his admission on the 19 February 2015 and despite the advice of the on call psychiatrist to refer him to the liaison team the following day.

The mental health liaison team registered nurses 1 and 2 reviewed Harry at 11.14 am and this was recorded in the mental health liaison team older people's assessment record. The section on advice to ward staff was not completed. The form indicated that a FACE risk assessment had been discussed, agreed and added to the LYPT records.

The FACE risk assessment was completed and recorded a high risk of relapse with medication being the intervention to reduce this risk. The individualised action to be taken was recorded as, following discussion with the on call SPR to restart olanzapine at a reduced dose today, 2.5 mgs straight away with an 'as necessary' dose of 2.5 for later in the evening. It was noted that Harry would need a MHA assessment if he tried to leave the ward.

On review of his notes the liaison team noted that he had not had any contact with mental health services since 2011. He was responding to the television and referring and responding to two people in the room that were not there by using swear words. He thought that his drink was poisoned and he needed reassurance to drink it.

The stepdaughter was contacted for further information and the concerns that she had raised with staff in relation to his medication and in particular his olanzapine. The statement from the senior clinical nurse in liaison stated that it was standard practice to obtain and double check information in relation to a patient with a member of their family.

The records indicate that the stepdaughter was not able to provide the liaison nurses assessing Harry with a clear picture as to how long he had not been taking olanzapine for or why it had been stopped and that Harry always reacted as he was at this time without it, that is, initially confused, then obsessive traits followed by aggression. However, the stepdaughter told us that she always repeated to every nurse she spoke to that Harry had taken his anti-psychotic medication every day of his life for 53 years, and that during December 2014 he became confused with the dosette box but he was then supervised by herself and her husband.

The mental health liaison team registered nurses 1 and 2 noted that the reasons for stopping the olanzapine varied throughout his records and included a reduced threshold for seizures. He was thought to be not taking his medication and he couldn't use the dosette box compliance aid.

The mental health liaison team registered nurses 1 and 2 stated that because of not having a clear picture of how long he had not been taking his olanzapine for, the fact that he had been having seizures and was frail and physically unwell, it was necessary to cautiously reintroduce olanzapine and titrate it back up to a therapeutic dose. This view about re-titrating his olanzapine would appear to be in line with BNF guidance, however our specialist pharmacological advice suggests that an immediately acting anti-seizure medication and the continuation of olanzapine could have been considered.

A Mental Capacity Act 2005 assessment checklist was completed and it was noted that he was "incapacitous" and "no" was recorded against mental health act assessment. We found that this was not decision specific, and that this is a general term that would not be appropriate to use since the introduction of the Mental Capacity Act 2005 given that capacity is time and decision specific. The response "no" was recorded against mental health act assessment. We have presumed that this part of the assessment documentation was intended to act as a trigger point for further thought or discussion. This was not explored further in the original investigation, however a formal mental capacity assessment was not evident in the records, or a plan in the event of Harry refusing or unable to take his oral olanzapine.

The Mental Capacity Act (2005)⁴¹ sets out a two stage test of capacity and asks whether the person has an impairment of their mind or brain, whether as a result of an illness, or external factors such as alcohol or drug use; and whether the impairment mean the person is unable to make a specific decision when they need to. The MCA says a person is unable to make a decision if they can't understand the information relevant to the decision, retain that information, use or weigh up that information as part of the process of making the decision.

The impression was that he had delirium plus or minus a schizophrenic relapse due to olanzapine withdrawal. Records indicate that his olanzapine was stopped due to Harry having a seizure on his previous admission. The mental health liaison team registered nurses 1 discussed Harry with the on call out of hours' senior psychiatry registrar 2. She told the on call senior psychiatry registrar 2 that Harry had a diagnosis of schizophrenia and had been historically well managed in the community with olanzapine but at this stage the prescription of olanzapine had either been stopped or he had not been taking it for a period of about one to two weeks. The senior psychiatry registrar thought that possibly the olanzapine had been stopped because Harry had suffered a couple of seizures.

The on call senior psychiatry registrar 2 was informed that Harry was agitated and appeared to be hallucinating, was shouting and swearing, displaying challenging

⁴¹ <https://www.nhs.uk/conditions/social-care-and-support/mental-capacity/>

behaviour on the ward and an 'as necessary' dose of lorazepam was given. Following a detailed discussion, the on call senior psychiatry registrar 2 was of the view that giving Harry the lowest doses of olanzapine 2.5 mgs would be a good starting point with a further immediate dose of 2.5 mgs given 'as necessary' "tonight" if the initial dose was tolerated and a review by a consultant psychiatrist the following day.

The records indicated that his regular prescription of olanzapine was stopped due to him experiencing a seizure on his last admission. He was hearing voices, thought the window was a television, and was swearing at two people he thought were in the room, and that he wasn't allowed to drink his juice. It was noted that an antibiotic had been prescribed for a urinary tract infection on the 18 February 2015. The impression was that he had "delirium plus or minus schizophrenia relapse due to olanzapine withdrawal".

This information was not entered in the medical records by the senior psychiatric registrar. He stated that there was an agreement in the psychiatric liaison team that the person seeking his advice did this. The liaison nurse therefore made the entry in the medical records which was stated by the on call senior psychiatric registrar 2 as a summary of the conversation they had. A 'phone call was made to the stepdaughter to advise her accordingly.

The records indicate that this information was fed back to the "ward medic" and they were advised to use an oro-dispersible form of olanzapine. The prescription chart indicates that the olanzapine 2.5 mgs was prescribed as a once only medication at 1.55 pm and it was given at 4.45 pm. Oro-dispersible olanzapine 2.5 mgs was also prescribed as an 'as necessary' medication however there was no start date and it was not dispensed.

The reasons for prescribing olanzapine 2.5 mgs included the fact that Harry was an elderly man who was also physically unwell with the cause of his seizures unknown. It was thought that 2.5 mgs would give him symptomatic relief whilst not making him more physically unwell and that a higher dose could have caused over sedation and increased his risk of falls.

The mental health liaison team registered nurse 1 noted that evidence of a history of significant risk behaviour was unknown, there was significant risk of accidental self-harm and risks to his physical condition, including risk of falling and a nutritional risk. Risk of harm to others was recorded as "low apparent risk" although the records state that the stepdaughter said that he could become aggressive when he didn't have his medication.

The descriptive risk summary noted that during assessment, Harry thought the window was a television, was very fixated on his uneaten porridge saying it was "glue", and said he wasn't allowed to drink his juice because it was poisoned. Harry referred to two people in his room and used swear words to describe them. The risk assessment also noted that his stepdaughter was very concerned that his olanzapine had been stopped

and felt that his mental health had deteriorated because of this, and said that he could become aggressive when he didn't have his medication.

A high risk of relapse was noted and actions recommended were to complete a further risk assessment and to discuss with the liaison consultant and liaison team members. Harry was noted as refusing his medication that day and a Mental Capacity Act assessment checklist indicated that he did not have capacity. The capacity assessment was not specific about the information which Harry did not have capacity to understand and there is no evidence that a formal mental health capacity act assessment was undertaken. It was noted that he would need a MHA assessment if he tried to leave the ward.

23 February 2015

On the 23 February Harry was seen by consultant physician 1 who found him to be a bit sleepy that day. She confirmed that the olanzapine should be restarted and some blood tests were arranged. A care plan dated the 23 February 2015 indicated that regular safety checks were needed to ensure Harry's safety whilst he was drowsy.

Harry was discussed during the liaison allocation meeting on the 23 February 2015 with the mental health team liaison consultant 1 (also a consultant in old age psychiatry) and the mental health liaison team registered nurse 1 present. The mental health liaison team registered nurse 1 that had assessed Harry the previous day fed back the review. The review was entered in the medical records and indicate that he was "very agitated on assessment, bad language", but the LYPT records did not reference the history of aggression when Harry did not have his medication as described by the stepdaughter. The records also indicate that Harry had a falls sensor installed due to his risk of falls. The impression was a likely delirium, possibly secondary to an infection or to olanzapine withdrawal plus, or minus, a relapse of his schizophrenia.

The plan was to prescribe olanzapine 2.5 mgs once a day regularly at night and 'as necessary' olanzapine 2.5 mgs, to encourage oral fluids and a fluid balance chart and review on the 24 February 2015 with blood results. The mental health liaison team consultant psychiatrist 1 stated that she noted the content of the FACE risk assessment, however this was not recorded or referred to in the notes she made.

As there were no previous psychiatric records for Harry on the LYPT system, the previous psychiatric notes for Harry were requested. The statement from the mental health liaison team consultant psychiatrist 1 indicates that historic records took a few days to be returned from storage and she noted that the notes were not received until after the incident had occurred.

The mental health liaison team consultant psychiatrist 1 spoke to the consultant physician 1. They noted that he had received one dose of olanzapine 2.5 mgs on 22 February at 4.50 PM and not the 'as necessary' 2.5 mgs olanzapine because the ward staff felt he was settled.

Harry was very drowsy and did not respond to the questions put to him. The liaison consultant stated that she would not have expected a relapse of schizophrenia to have caused him to be so drowsy and confused, although she was mindful that he had received a 2.5 mg dose of olanzapine at 4.50 PM on the 22 February 2015. The ward staff confirmed that there had not been any further episodes of challenging or inappropriate behaviour. The mental health liaison team liaison consultant psychiatrist 1 concluded that he was suffering from delirium with a possible relapse of his schizophrenia contributing to his presentation. The plan was to regularly re-introduce olanzapine.

Following the review undertaken by the mental health liaison team on the 23 February 2015 Harry experienced a seizure at 3 pm. Harry was given intravenous lorazepam and recovered well. The regular prescription chart indicated that olanzapine 2.5 mgs was prescribed on the 23 February 2015 at 6 pm however the omitted or delayed doses section of the prescription chart indicated that he was too drowsy to take any of his medication.

The ward rang the daughter to explain that Harry was due to transfer to ward J19 but this had not taken place. His stepdaughter relayed her concern that she felt that he was having seizures because his olanzapine had been omitted for a few days.

The specialist registrar for the gastroenterology oncology assessed Harry in the evening of the 23 February 2015 after being alerted to his admission by the oncology dietician. The record of the assessment state that the olanzapine had been omitted throughout his inpatient stay under oncology and stopped on discharge. The assessment said that Harry had remained stable with no evidence of psychosis and due to concern about his lowered seizure threshold on anti-psychotic medication the clinical decision was made to discontinue olanzapine. Following discussion with neurology it was thought appropriate to commence an anticonvulsant (lamotrigine). He was discharged from the oncology team as there was "no systemic anti-cancer treatment appropriate".

A statement by the ward J28 registered nurse 5 stated that during the night of the 23 February 2015 Harry was initially drowsy but then it was reported that he was getting in and out of bed. He did not suffer any further seizures that night.

24 February 2015

4.202 Harry was not reviewed by the mental health liaison team on the 24 February 2015. The statement from the mental health liaison team consultant psychiatrist states that the possible reasons for the lack of review on the 24 February 2015 were:

- Harry was not considered in need of urgent review on the 24 February 2015;

- that he could be managed on the ward in accordance with the current plan; and
- ward staff knew how to access the mental health liaison team if they had any concerns about Harry.

This explanation of the issues experienced by the liaison team was not included in the original investigation.

25 February 2015

Harry was transferred to ward J19 from J28 on the 25 February 2015. Before he left ward J28 a core medical trainee 4 spoke to the stepdaughter who was worried about the olanzapine and said that she thought he was hallucinating. The record asks for consideration of a psychiatric review and olanzapine when moved to ward J19. The care pathway for patients on the acute medical wards dictates that those who become medically fit for discharge within three days from admission remain on the floor. Those who require a longer admission are triaged to a 'downstream' medical ward within whichever specialty is deemed appropriate. Statements from staff indicated that Harry required a longer period of medical observation and investigation and he was therefore transferred to J19 which is a 29 bedded general male ward specialising in diabetes and endocrinology. We found that two staff statements refer to J19 as also caring for patients with drug and alcohol problems although this is not information provided in the official ward profile.

The beds on ward J19 are separated into five bays which contain four beds each. Bed number 13 does not exist. Harry was placed in a bay area of the ward with beds numbered 10 – 14. Harry was in bed number 12 and not a side room. We examined the floor plan of ward J19 provided and found that there are two single rooms next to the nursing station and six (a staff statement said 9 single rooms altogether) other single rooms as well as five bays with four beds each. It is not known whether any single rooms were available during the time that Harry was a patient there. This aspect of care was not examined in the original investigation.

He was clerked into the ward by the core medical trainee 5 who found Harry to be hallucinating and pointing to the end of his bed stating his father was standing there and that everyone was talking about him. The core medical trainee 5 documented the issues from the information received from ward J28, which were that olanzapine was stopped during admission to J97 and that he had a new onset seizure disorder.

The core medical trainee 5 doctor was concerned to learn from a review of his notes that Harry had been on psychiatric medication which had been stopped. The doctor's impression was that he may have been hallucinating due to delirium. It was noted that the urine sample confirmed no growth, and that the recent blood tests indicated abnormal kidney function and anaemia. The plan was for a neurological referral, a fit chart, to prescribe lorazepam and a review by liaison psychiatry the next morning.

Harry was also reviewed on 25 February by core medical trainee 6 and the consultant physician 3. The consultant physician 3 noted that there was some uncertainty as to whether Harry was receiving olanzapine. On review, the consultant noted that Harry had a history of diarrhoea and had recently suffered a seizure. He questioned whether olanzapine may have been a contributory factor to the seizures.

The plan following review was for Harry to undergo a neurology review to review the anticonvulsant drug therapy, for the CT scan report, and to be reviewed by the dietician. Harry was sat out of bed, did not present as being agitated and his behaviour did not give any cause for concern. The consultant physician 3 stated that his focus was on Harry's physical health and he was aware that the mental health liaison team had reviewed Harry on the 22 February 2015 and were intending to review him again. On the 25 February 2015 Harry was seen for the third time by a clinical support worker from the mental health liaison team at 2.30 pm and this review was only recorded in the mental health liaison older people's assessment documentation. We were informed that as Harry had just transferred to J19, his notes were in transit and not accessible to her. She did however discuss Harry with a doctor on the ward.

On this occasion the stepdaughter was able to tell the mental health liaison team clinical support worker about her concerns. She said that she felt strongly that his olanzapine needed to be increased to get back up to the 15 mgs he had been on for about fifty years. She said there had been confusion about his olanzapine because he was getting mixed up with his dosette box meaning that he had not had his olanzapine for several weeks. He was hearing voices, she thought he had been hallucinating, and his "OCD" was getting worse.

The mental health liaison team clinical support worker noted that he was very preoccupied with his feet at the bottom of the bed "trying to get them through holes". The outcome of the review was discussed with the liaison team consultant and the plan was recorded as being to review again and consider increasing his olanzapine. The daughter noted in her diary that the "psychiatrist" would be contacting her after a meeting on the 27 February 2017 to "reintroduce olanzapine 5 mgs", however she did not receive the call.

We were informed that the mental health liaison team consultant psychiatrist was not aware of this being arranged by her or for any other team psychiatrist. She was not due in work on the 27 February, as she is part-time, so would not have made this arrangement personally.

26 February 2015

Harry was reviewed again for the fourth time on the 26 February 2015 by the mental health liaison team registered nurse 1 that had seen Harry on the 22 February 2015. The assessment was entered in the LTHT records and the mental health liaison older people's assessment document. The plan at this stage was to review Harry to see

whether he had tolerated the reintroduction of olanzapine and if he had, to increase the dose from 2.5 mgs to 5 mgs. On assessment the mental health liaison team registered nurse 1 found that Harry was able to report his history of schizophrenia and although he said he had been prescribed medication he could not remember what medication he had been prescribed. He denied any visual or auditory hallucinations and told the team that he used to experience these years ago.

The LYPT record indicates that he had not had olanzapine since the 22 February 2015 and noted that he had a seizure on 23 February 2015. They were considering whether or not the seizure was related to the olanzapine. The impression was that he had a delirium and also some post seizure confusion. The mental health liaison team registered nurse 1 discussed her review with the mental health liaison team consultant psychiatrist 1 and specifically the fact that Harry had suffered a further seizure on the afternoon of the 23 February 2015 and had not been administered his olanzapine. The mental health liaison team consultant psychiatrist 1 stated that in her view "it was entirely reasonable for the ward staff to withhold the olanzapine" in light of his further seizure. However, we were also informed that mental health liaison team consultant psychiatrist 1 agreed that Harry needed a psychiatric medical review of his anti-psychotic medication that day. As such the academic clinical lecturer and specialty trainee year 6 in Old Age Psychiatry was asked to complete this review as the mental health liaison team consultant psychiatrist 1 had pre-existing commitments at that point. The mental health liaison team registered nurse 1 discussed her assessment with the academic clinical lecturer and specialty psychiatry trainee year 6 in old age psychiatry as the mental health liaison consultant 1 was not available. The statement of the academic clinical lecturer and specialty psychiatry trainee year 6 in old age psychiatry indicated that he did not see Harry as the ward was engaged in a protected mealtime however he understood from either conversation in the psychiatry liaison morning meeting or from notes made by the mental health liaison team nurse that had assessed Harry that he was thought to be a low risk of violence towards and prior to his admission he had not been taking his olanzapine but it was restarted on the 22 February 2015 at a low dose of 2.5 mgs. The plan was to consider whether the olanzapine should be increased, however the mental health liaison team registered nurse told him that at around 11 am after commencing olanzapine 2.5 mgs Harry had a seizure and the medication had subsequently been withheld by the medical team.

He was not at that time or in the past 24 hours displaying any psychotic symptoms and was not distressed or agitated or showing any signs of aggression or distress. The academic clinical lecturer and specialty psychiatry trainee year 6 in old age psychiatry discussed this with the core medical trainee 6 who explained that they were increasing the antiepileptic medication (lamotrigine) and they were unsure whether olanzapine was a contributory factor to the seizures. The academic clinical lecturer and specialty psychiatry trainee year 6 in old age psychiatry felt that the risk of restarting olanzapine and potentially causing a further seizure outweighed the risk posed by any current disturbance to his mental state.

The academic clinical lecturer and specialty psychiatry trainee year 6 in old age psychiatry therefore advised that olanzapine should be withheld until the lamotrigine was at therapeutic levels. He was aware that without olanzapine (or at such a low dose) that there was a risk of relapse of symptoms, however he did not wish to cause harm by unnecessarily exposing Harry to a risk of further seizures or other side effects caused by the prescription of antipsychotic drugs given his age and the risk of falls, over sedation or stroke.

He advised that if Harry was to become distressed by psychotic symptoms that they should use olanzapine 2.5 mgs as required plus lorazepam (a benzodiazepine anxiolytic medication often used for sedation) and advised that the liaison team would review Harry daily to assess his mental state, risk and the point at which regular antipsychotic medication should be reintroduced regularly so action could be taken if and when required. The plan was to discuss his medication regime with the liaison consultant psychiatrist. The review and plan were entered in the medical notes.

An LTHT adult specialist nursing assessment was undertaken on the 26 February 2015. This assessment is undertaken at admission, when there is any change in the condition of the patient and at discharge. The assessment documented that Harry was agitated, anxious, worried, confused, disorientated and had schizophrenia.

A template care plan for Harry's inability to maintain own safety dated the 26 February 2015 was completed for Harry indicated that he was experiencing an increase in his confusion. The care plan had the aim of monitoring the patient and reducing the risks of self-harm and injury. Twelve nursing actions formed part of the template were associated with the safety of the environment and reassurance.

A further template care plan for confusion and disorientation was completed for Harry on the 26 February 2015 with the aim of maintaining his safety, preventing complications and reducing anxiety. Nine nursing actions formed part of the template and were associated with observation, assistance, supervised mobility, administering of medication and the use of bedrails if necessary. Both template care plans indicated that on the 26 February 2015 Harry was "pleasantly confused" and "orientated when needed".

A level two pharmacy review was undertaken on the 26 February 2015. We understand a level two review to include all of the level one actions to make sure the prescription is reasonable, legal and safe, and medicines are being administered and available plus an additional review of the patients' medical records and consideration as to whether the medicines are appropriate to their medical conditions taking into account any tests or results that have occurred whilst they have been an inpatient. We have not found evidence that this review commented on the current medication regime.

27 February 2015

A further level two pharmacy review was undertaken on the 27 February 2015.

The mental health liaison team consultant psychiatrist 1 was not working on the 27 February 2015 so she had asked the mental health liaison team specialty doctor 1 to undertake the review of Harry. The mental health liaison team specialty doctor reviewed Harry at 11.45 am with the mental health liaison registered nurse 2 who had assessed Harry previously on the 22 February 2015. A brief summary of their review was entered in the medical records, and in the mental health liaison team older people's assessment document in with the plan to review daily.

The mental health liaison team registered nurse 2 reviewed Harry found him to be very drowsy. He briefly engaged and said "You're wasting your time. I'm going to die". The plan was recorded as review daily and withhold the olanzapine. He was in a bay area of ward J19 – no recommendation was made to move him to a side room near to the nursing office. This was an area of care not explored in the original investigation. Harry was very drowsy and physically frail and agitated in a "wandersome" rather than an aggressive manner. He had not displayed any aggressive behaviour in the 24-hour period prior to this review. Harry was very quiet and it was difficult to make out what he was saying. He was mumbling rather than not being cooperative in the review. The seizures were noted, in the Psychiatric Doctors review the previous day, as probably not olanzapine related but as he appeared not too distressed by his psychotic symptoms the plan was continued to withhold the olanzapine until his anti-seizure medication (lamotrigine) was back to the therapeutic dose and to consider restarting the olanzapine. Harry was to be reviewed daily and if he was distressed by psychotic symptoms the plan was to use 'as necessary' lorazepam (for short term use in anxiety) and olanzapine.

The statement of the mental health liaison team specialty doctor indicated that following the assessment the ward was advised to continue his one-to-one nursing special and to contact the on-call mental health liaison team should they have any concerns or need advice out of hours. However, the information regarding the one-to -one special was not evidenced in either the LTHT or the LYPT records for Harry and the stepdaughter cannot recall Harry ever being on one-to-one observations. We understand that the mental health liaison team specialty doctor believed that Harry was already on one-to-one observation, erred on the side of caution and advised that these should continue. This information was not included in the original investigation.

Ward J19 registered nurse 6 spoke to the LYPT discharge facilitator on the 26 February 2015 who said that Harry had been removed from his nursing home for being aggressive. The registered nurse had not been made aware of this on his admission, however he started to complete the NHS continuing care checklist on the 27 February 2015, requested a joint care manager to organise a care planning meeting and completed a night assessment to detail Harry's care needs.

The ward J19 registered nurse 6 updated Harry's care plan that day at about 6.30pm and described him as being pleasantly confused and not aggressive. Harry was wandering around the ward, not speaking, but compliant with directions and taking his prescribed medication. Harry did not have bed rails attached as he was sat out.

Regular safety checks were undertaken which comprised of asking him if would like a drink or to be accompanied to go to the toilet, and checking that the environment was safe. Registered nurse 6 knew the mental health team liaison team had reviewed Harry but it was not usual practice to accompany them in the assessment process, and the notes are checked afterwards.

The ward J19 day shift nursing handover to the night staff of the 27 February 2015 indicated that Harry had been wandering around the ward and he had locked himself in the toilet for a period of time between 9.30 and 10 am. He refused to take all his medication that day. He was confused, shouting and difficult to manage but had not displayed any violent behaviour.

We understand the use of handover sheets to be routine practice in general hospitals and are confidentially disposed of after the shift has ended. As a result we have not been able to examine evidence of the handover note to the night shift of the 27 February 2015.

However, we found discrepancies in that statements from staff also indicate that Harry was non-compliant with his care and at one point he was found lying under his chair and when helped up and onto the bed he tried to hit out at the care support worker whilst she helped him with a drink.

Harry became more confused in the evening and was getting difficult to manage. At 19.15 Harry was reported as being very aggressive, abusive and hitting and kicking out at staff. He was mobile and able to attend the toilet however a little unsteady on his feet. Ward J19 registered nurse 7 discussed with the doctor and handed over to the night shift the fact that Harry was not taking his medication and required a doctor to review him.

Ward J19 registered nurse 7 stated that she did not think Harry required one-to-one care because he would settle down for short periods and was not aggressive towards other patients. Although she handed over to the night staff that they should “keep an eye on him” she did not request more formal observations or one -o-one care. She reported in her statement that nursing staff can implement “hourly rounding” of patients who are a falls risk, at risk of absconding or because of mental health conditions. Ward J19 registered nurse 7 stated that Harry was not, at that time, on “hourly rounding” as he was thought to be manageable on the ward with standard staffing levels. However, we found the records associated with this to be inconsistent. A falls care plan commenced on the 19 February 2015 indicated that Harry “required hourly rounding” however a cross was entered in the record from the 19 until the 27 February 2015 rather than a tick, however the separate hourly checks form had the checks signed as being undertaken every hour from 8 pm until 7 am during this time period. This area of care was not explored in the original investigation.

The statement from ward J19 registered nurse 7 indicated that generally, patients are observed by all members of staff as they undertake their duties. There is always a member of staff moving about the ward as a result. After midnight patients are checked

to see that they are safe every 15 minutes. It was reported that due to his behaviour Harry was on “extra rounding” where staff document at least every hour that they have seen the patient. This was thought to be adequate for Harry as he became more agitated when someone was close to him.

The patient in the single room opposite the four bedded bay in which Harry was being cared for had an external agency worker sitting with them on a one-to-one basis because of their particular needs. She was sat outside of this patient’s room as he could become aggressive and he preferred this.

This agency nurse worked regularly three nights per week on ward J19 and was a designated “safety guardian” which meant that she had received training through the employing agency called “Ensign”, to work with patients who had dementia or minor mental health problems.

The agency nurse stated that as soon as she started the night shift Harry was constantly swearing and shouting “Nurse, nurse get here we’re going to get killed” and other obscenities, including racial slurs, that appeared to be directed at people unknown.

Ward J19 registered nurse 8 went to see Harry once handover had been completed. Harry was in the bay with beds 10 - 14 and was allocated bed 12. His behaviour was challenging and he shouted and swore at her. Registered nurse 8 checked his medication chart and noted that he had been prescribed lorazepam, however he refused the offer of an oral dose and threw a cup of water at her.

Registered nurse 8 asked the on call foundation year doctor 2 (FY2) if he could review Harry and change the prescription of oral lorazepam to intramuscular which he did. The FY2 doctor started his shift at 4.30 pm and was covering wards J19, J20 and J21 which are all on the same ninth floor of the hospital. The FY2 doctor stated that Harry was shouting and wouldn’t answer any questions put to him. He did not write anything in Harry’s notes in relation to his review and did not hear anything else about Harry that night.

At about 9 pm, when registered nurse 8 approached Harry to administer the injection of lorazepam he was shouting and appeared to be hallucinating. The security team were called to assist, and they held his arms and legs. Registered nurse 8 kept Harry calm by talking to him and registered nurse 9 stated that she administered the injection. There are discrepancies in the records for when the lorazepam was administered. Registered nurse 8 stated it was administered at about 8.30 pm, registered nurse 9 stated it was administered at about 9.40 pm although it is recorded on the medicines prescription and administration sheet as being administered at 9 pm. The original investigation indicates that this was administered at 1.30 am.

The status of this intervention was not explored further in the original investigation, however we could not find evidence that the five points of the MCA 2005 had been

considered to justify the administration of lorazepam or that a Mental Health Act (MHA) assessment had been considered.

We also note that at some point during the night, clinical support worker 1 recalled a patient whose bed was located close to Harry in bed 11 complained to the nursing staff about his behaviour and he was subsequently moved to another bed, away from Harry at his request. A further staff statement recalled that this patient was not happy to be close to Harry. We also know from a further staff statement that the patient in the side room opposite Harry's bay complained about his shouting. However, we have not found evidence that Ken or Roger located in the same bay as Harry complained, whether they had the capacity to do so, or that their safety was considered.

It was reported that Harry slept on and off for the following four hours. Records indicate that Harry "remained verbally abusive but in bed all night with side rails up all night".

The agency nurse assigned to one-to-one care for the patient in the single room opposite stated that Harry was "rattling his bedrails all night" and that "during the night the nurses even shut the doors to the bay because of the shouting".

A night time assessment chart was commenced on the 27 February 2015. This chart documents preparation for bed, behaviour during the night, mental state, continence, medication, times in and out of bed and requires a summary. On the 27 February 2015 Harry was described as wandering around for most of the night, that he was incontinent and was assisted back to bed twice.

At around 3 am on the 28 February 2015 Harry became loud and was shouting. Registered nurse 8 approached him with oral lorazepam which he appeared to take with a drink. He appeared to be calmer after taking this although his mood appeared to be "up and down". Records indicate that registered nurse 8 was "doing rounding" to check and reassure Harry through the night which helped quieten his shouting and decrease confusion.

The statement from registered nurse 8 said that she had entered the bay at 6.30 am because Harry was banging on the wall behind his bed with his walking stick. She removed this from him, placed it at the end of his bed and then left the bay. We also note that a statement from registered nurse 11 indicated that although she cared for Harry only on a couple of occasions she recalled that he was very possessive about his stick as he needed this for walking.

The agency worker assigned to one-to-one care for another patient in a side room opposite the bay in which Harry was being cared for heard banging and Harry shouting "Die you bastard die" at 7.10 am. She knew it was this time because she saw the clock on the wall. She was aware that there were two other patients in the bay, and stated that all the registered nurses and health care support workers were at the "top of the ward".

Although she was assigned one-to-one care for another patient she felt duty bound to find out what was going on. The bay had double doors with glass windows but because she was short in stature she couldn't see what was going on through the windows so went into the room. When she entered the room she saw Harry standing naked and with a walking stick in his hand. She saw Roger on the floor and Ken was in bed with blood coming out of his nose and with two lumps on his head. She observed that both patients appeared to have had their cannulas and catheters pulled out. However, we understand from Roger's family that he had neither a cannula or a catheter as far as she was aware, and Ken's family told us that he only had a catheter in situ.

As she tried to calm Harry down, he responded by saying "You don't understand, you don't understand. I had to do it love. We'd all have been dead". She took hold of the walking stick (described as a wooden one with a normal hooked top), threw it across the floor so that it was out of reach, took hold of Harry and shouted for help from a clinical support worker that was passing by the bay, and said "I really need your help, he's attacked two patients and we need back up". The clinical support worker 1 came into the room, pressed the panic alarm button to alert staff and then left the bay.

The statement from clinical support worker 2 indicated that at 6.30 am, whilst she was working in the bay with beds 15 - 18 she heard a shout for help from clinical support worker 1. As registered nurse 8 was carrying out personal care for another patient she heard shouting in another part of the ward and clinical support worker 2 came and told her that urgent help was needed.

We note that the timings of when the incident was discovered do not correlate and understand that this may be due to human factors and the tragic incident itself. To summarise these discrepancies, registered nurse 8 said she entered and left the bay with beds 10 – 14 (where Harry was) at 6.30am, however clinical support worker 2 said she heard a shout for help from clinical support worker 1 at 6.30 am. Registered nurse 9 said that at 6.40 am she was undertaking a wash of patient inside room 19 and the agency worker told her that help was needed in bed 12. The agency worker said she looked at the clock when she entered the bay and it was 7.10 am.

Registered nurse 8 ran to the bay beds 10-14, found the door open and Roger from bed 14 on the floor at an angle between bed 10 and 14. Clinical support worker 1 was holding Harry down by the arms.

Clinical support worker 2 could see Harry's walking stick next to him and so she picked it up and put it out of the way on the windowsill behind the curtain. She then picked patient 1 up "from the back" and pulled him along the floor so that he was between bed 12 and 14. Roger apparently said "Harry attacked me. Pulled me off the bed and attacked me". This account was disputed by the Roger's family who said that he had got out of bed himself to intervene.

Registered nurse 8 saw Ken in bed 10 on the floor with his face covered in blood. She placed a pillow under his head and with the assistance of the clinical support worker 2

she put Harry back in his bed and pulled the curtains around him. Registered nurse 8 left the area to call security, the on call doctor and the site matron.

The security officer received a call at about 7.12 am to say that there was a violent patient on ward J19. Three members of security attended the ward and when they arrived Harry was shouting with clenched fists and was repeating "I got three of them". And "Watch out for these nurses they're dangerous" They escorted him to the television room of the ward by holding his arms. He continued to mumble saying that he got three of them but the others got away. He said something to the effect of "I was in my house. I saw three men in my room. I thought they were going to rob me, take something, I got my stick out and I went to attack them to save myself".

According to the security staff Harry kept looking towards the door when the nurses were passing and on occasions said "Look at them. Be careful of them". It was agreed with the day site manager that Harry would be accompanied by two security guards whilst he was in the television room. Harry later calmed down and took medication from the staff. He was checked for any obvious injuries to himself.

Roger was returned to his bed, and although his observations were normal he was complaining of pain in his hip. Roger's family dispute this account, and indicate that when she arrived on the ward later that afternoon, he was in bed and only complained of pain at that point when the staff tried to move him onto a trolley. We note the NICE⁴² quality statement (4) on checks for an injury after an inpatient fall indicates that "older people who fall during a hospital stay are checked for signs or symptoms of fracture and potential for spinal injury before they are moved".

Registered nurse 12 from the oncoming ward J19 day shift noticed that Ken had a 2 cm cut to his forehead, a 1.5 cm cut to the middle of his scalp and dried blood on his nose possibly from a nose bleed. He had a low blood pressure and his respirations had increased. He was assigned hourly observations.

At about 7.30 am registered nurse 13 tried to contact Ken's relatives without success and left an answerphone message for them to call the ward. Ken's relatives arrived at 8.30 am. At about 9 am registered nurse 13 escorted Ken for a CT scan. His son and daughter were informed by the on call consultant that he had deteriorated, and his prognosis was poor, due to his previous condition and the fact that he was on end of life care, which may or may not have been exacerbated by the attack. Ken's family raised a number of concerns which were taken as a formal complaint by the day site manager. At about 7pm the family were updated about Ken's condition which was poor. He was transferred to Leeds General Infirmary later in the evening.

We heard from Roger's family that she had contacted the ward about 7.435 am to be told that there had been an incident. The ward rang back about 8.30 am to say that he

⁴²NICE; Falls in older people Falls in older people, Quality standard Published: 25 March 2015

[nice.org.uk/guidance/qs86](https://www.nice.org.uk/guidance/qs86)

<https://www.nice.org.uk/guidance/qs86/chapter/quality-statement-4-checks-for-injury-after-an-inpatient-fall>

didn't appear badly injured. She set off immediately to visit Roger but was a five-hour journey away and so arrived in the afternoon. Roger was later diagnosed with a laceration to the back of his left hand showing the tendons, an oblique fracture across the neck of the little finger metacarpal bone on his right hand and a fracture of the right hip. His relative arrived on ward J19 about 2.30pm. When his family visited the ward they were provided with the opportunity to complain but declined, however we heard from the family that it was not that they declined, but that they were in a state of shock at the time.

Harry's stepdaughter was contacted about 11 am and arrived on the ward about 12.30 pm. She was provided time with the day site manager to make a complaint. Security staff said that Harry's stepdaughter told them that she was unhappy with the care her father had received and that his medication which he had been on for 40-50 years had been stopped even though she had warned them. His stepdaughter later raised concern about Harry being provided with soup and a roll, potatoes and a pie to eat whilst he was in the television room with the security guards, and told them he required a pureed diet. Registered nurse 13 contacted the LTHT site manager (clinical matron) who said she would hand over to the day matron who would come to the ward. A registered nurse from ward J21 came on to ward J19 by chance and registered nurse 14 asked him if the police should be called. The registered nurse from ward J21 asked the night staff to bleep the site manager to ask if the police should be called. The day site manager attended the ward at about 8.15 am. She was asked directly by the registered nurse 13 if the police should be contacted and she said no and that it was up to the families to decide if they wanted the police to be involved.

Ken's family told us that they had contacted the police whilst they were on the way to the hospital, and staff statements indicated that at some point a police constable 1 arrived on the ward who said that he had been contacted by security and had come to find out what had happened. The statement from the security guard indicated that the police had attended the hospital to investigate a break in and wanted to view CCTV footage in respect of this.

Police have confirmed that the CCTV footage was of the ward doors from outside the ward and only shows people attending and leaving the ward.

The security guard stated that he was "pretty sure that the police had not been contacted" and so he informed the police about the incident on ward J19. Registered nurse 13 felt relieved and told the police constable 1 that they had been advised not to call the police. Police constable 1 alerted his seniors of this and not long afterwards detective sergeant 1 and detective constables 1 and 2 arrived on the ward.

The LTHT Procedure for the Reporting and Management of Serious Incidents November 2013 states that the recognised protocol must be followed for liaison and effective communication between the NHS, the Health & Safety Executive (HSE) and the Association of Chief Police Officers with regards to investigating patient safety incidents resulting in unexpected death or serious harm. This is set out in the Memorandum of Understanding: Investigating Patient Safety Incidents Involving Unexpected Deaths or Serious Harm, (the MoU) published by the Department of Health

in February 2006. The Memorandum is further supported by Guidelines for the NHS, published in November 2006. We understand that this MoU has since been withdrawn, and NHS England are in the process of reviewing this. However, the Police College have issued guidance on investigating deaths and serious harms in health care settings⁴³ which states that “The MOU has now been withdrawn although it is acknowledged that much of the content is still relevant for conducting investigating in Healthcare settings and has been included within this guide.” We found that this guidance was not followed.

On the 2 March 2015, the night shift senior house officer doctor (SHO) was asked to complete a document entitled “care of the dying person” for patient 2 at 9.45 pm on ward J19. It was noted that on assessment that Ken had suffered a right sided maxillary fracture following the assault by Harry. He was calm and comfortable and his family were with him. The SHO documented that all of his regular medications were stopped apart from medication for symptom relief. At 4.15 am on the 3 March 2015 Ken was certified dead.

On the 3 March 2015 a statement from the night shift foundation year doctor March 2015 saw Roger on ward L50 after having had an operation to insert a right hip screw to treat a femur neck fracture. He had a very low blood pressure and a low body temperature with a full bladder. He was given a “bear hugger” which is a device used to warm someone up if they are cold and catheterisation was attempted twice. On 4 March at 11.40 the night shift foundation year doctor certified his death at 12.40 am.

On the 28 February 2015 the mental health liaison team reviewed Harry after they had been asked to see him following the incident. He refused all medication. Harry remained with security in the day area of ward J19 until the night of 28 February 2015 and according to the security staff his transport arrived at about 11 pm to midnight to take him to the LTHT psychiatric intensive care unit (PICU) at the Newsome Centre in Leeds. The stepdaughter noted that she had “told the psych’s of my battle to get his medication reinstated”.

A risk assessment was undertaken on the 1 March 2015 in the PICU indicated that Harry thought what he did was right as other men were attacking him. He said that he had schizophrenia and although he said that he took olanzapine he appeared to have limited insight into his mental health as he did not think his actions were in response to those delusional ideas. We do not entirely understand this and whether Harry meant that he didn't think his actions were in response to delusional ideas, or he thought they were reasonable and in response to being attacked.

On the 24 March 2015 when Harry was in PICU, the Approved Mental Health Practitioner (AMHP) report prepared for a Mental Health Act (MHA) application for

⁴³ An SIO’s Guide to Investigating Unexpected Death and Serious Harm in Healthcare Settings – Revised 2015 (v10.6) <http://library.college.police.uk/docs/NPCC/2015-SIO-Guide-Investigating-Deaths-and-Serious-Harm-in-Healthcare-Settings-v10-6.pdf>

detention stated that that the diagnosis of schizophrenia and not chronic delirium was confirmed by the Consultant Psychiatrist on the PICU.

Whilst on the PICU Harry was reported as being erratic with his compliance with medication requiring this to be administered intramuscularly. Initially, he was actively 'psychotic' and misidentifying staff as the police or others.

By the 24 March 2015 Harry was beginning to accept oral medication and by 30 April 2015 although he still had some paranoid and suspicious thoughts these were reducing. By the 22 May 2015 it was reported that violence and harm was no longer an issue. His physical health was deteriorating and he needed a blood transfusion as a day patient on the 30 March 2015 and to be transferred to LTHT St James University Hospital for several days in February and May 2015.

An end of life care plan was put in place on the 15 May 2015. On the 18 May 2015 Harry was seen by the St Gemma's Hospice community palliative care team due to his deteriorating condition and right sided weakness secondary to brain metastases. Pain management medication was reviewed and prescribed. He was discharged from his section on the 2 June 2015 and was reported to be in terminal decline on the 8 June 2015. Harry died peacefully on the 9 June 2015.

Appendix D – Terms of Reference for the internal investigation

The Terms of Reference agreed between the two NHS Trusts, the respective families and the Review Team are as follows:

Leeds Teaching Hospitals NHS Trust (LTHT) and Leeds and York Partnership NHS Foundation Trust (LYPT) have commissioned this independent investigation into the care and treatment of patient HB. The purpose of this investigation is to learn any lessons that might help to prevent any further incidents of this nature and to help improve the reporting and investigation of serious events in the future. The investigation will consider the physical and mental health input from both LTHT and LYPT and will specifically review the communication between the clinical teams from different organisations.

- Review all relevant clinical records from January 2015, including clinical assessments and care plans, demonstrating the reason for admission, assessment and treatment plans and outcomes for patient HB; providing a clear chronological time line of patient HB's journey through services following the treatment of complications associated with his diagnosis of oesophageal cancer in Jan/Feb 2015 to his transfer to the Leeds and York Partnership Foundation Trust following the incident on 28 February 2015; the review of records will include GP records, LYPT records, Corinthian House records and LTHT records to inform the investigation into the care and treatment provided in January/February 2015; make all records available for the investigation and review earlier records where these may be relevant to the investigation.
- Interview staff/clinicians involved in patient HB's care during this period to provide a factual account of the patient's care prior to his transfer on 28th February 2015 with a particular focus on the suitability of the environment he was in; whether sufficient attention was given to information from patient HB's family and GP; management of his medications and the rationale for decisions made in this regard.
- Interview the families affected by the incident on Ward J19 in February 2015, ensuring their voices are heard. The investigation team will involve all the patient's families in the investigation as fully as possible to ensure their comments and concerns are heard and addressed.
- Review the appropriateness and effectiveness of the care and treatment plans of patient HB in light of any identified health and social care needs, identifying both areas of good practice and potential areas of concern.

- Review the adequacy of any risk assessments and risk management, including specifically the risk of patient HB harming him-self or others and review any related issues for safeguarding vulnerable adults.
- Review the interface, communication and joint working between all those involved in providing care to patient HB to meet his mental and physical health needs.
- Review the management, actions and communications in the period following the incident on ward J19 to identify areas of good practice and any issues of concern.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Review leadership and management on ward J19, especially in regard to patient care, quality and safety.
- Establish whether there are any underlying issues that may impact on how the team on ward J19 functions and consequently affect patient care. This could involve reviewing audit data, including ward health-check, incidents and complaints data. The investigation team should also review the layout of the ward location of patients, staff and equipment.
- Consider if this incident was either predictable or preventable.
- Provide a written report to the Trust that includes realistic, measurable and sustainable recommendations for action to address the learning points to improve systems and services.
- Consider and comment on any incidental findings that arise from the investigation.
- The investigation team will ensure there is regular (at least monthly) communication with the Trust on the progress of the investigation and report. Any specific issues of concern that are identified during the investigation that could have a significant impact on the care or safety of existing patients should be raised with the senior managers of the Trust without delay, so that immediate action can be taken.
- The Independent Reviewer will be responsible for updating the families on the progress of the investigation as required by the families.

Appendix E- Internal Recommendations

The Review Team believes there are lessons to be learnt from their investigation and have made the following recommendations:

Recommendation 1

Where patients admitted to acute medical wards have a diagnosed serious mental illness or are prescribed antipsychotic medication, acute medical staff should, as part of the care pathway, access the early opinion of a Consultant Psychiatrist or liaison team to consider the impact of planned physical health treatment regimes as they would from a Consultant specialising in physical health problems.

Niche evaluation- this recommendation has been completed

Recommendation 2

All mental health assessments and in particular risk assessments undertaken by LYPT older peoples liaison team should be shared with and available for the respective acute medical team and ensure that historical and current risks are being consistently documented and appropriately assessed.

Niche evaluation- this recommendation has been completed

Recommendation 3

Primarily for LTHT but also LYPT should review how families are involved in the care and treatment of their family members; how they can support the care processes; inform both risk assessments and support plans and how services can respond to their needs.

Niche evaluation- this recommendation has been completed

Recommendation 4

Overall clinical leadership and accountability for patients in the Acute Hospital beds lies with the responsible Consultant. Mental health services providing input to the care and treatment of medical patients also hold that same responsibility for their actions. Therefore the Trust's should review how a more integrated approach could be developed between the two specialties.

Niche evaluation- this recommendation has been completed

Recommendation 5

Acute Hospital based Staff would benefit from further training in mental health issues including assessment and appropriate responses. LTHT should review its current post-

graduate training for all staff to include this additional mental health training, with the local mental health services being commissioned in delivering that training.

Niche evaluation- this recommendation has been completed

Recommendation 6

The mental health liaison service currently operated by LTHT and LYPT reflects national best practice guidelines that was planned and introduced many years ago. Since that time there has been a change in the dynamics/ presentation of people into acute settings and the demands placed upon both Trusts that has not been reflected by a change in the commissioning of liaison services.

Both Trust's, together with NHS commissioners should undertake a collaborative review of the Hospital Mental Health For Older People Service to ensure that it is responding to the changing needs of patients, is in line with current practice and builds on the aims and objectives described in the LYPT Liaison Psychiatry for Older People Hospital Mental Health Team for Older People 2014.

Niche evaluation- this recommendation has been completed and embedded

Recommendation 7

Currently communications between the two clinical teams is not well defined. Both Trusts should review with the respective clinicians how effective communications can be pragmatically managed and improved.

Niche evaluation- this recommendation has been completed

Recommendation 8

The current physical and mental health assessment documentation reflects a separate approach to care. The Trusts should review these assessments to enable a more integrated physical and mental health assessment process.

Recommendation 9

The review has identified multiple patient clinical information formats and systems. The Trusts should agree a collaborative approach to information recording and sharing that is in an accessible and single format.

Niche evaluation- this recommendation has been completed

Recommendation 10

The review has identified a number of issues in relation to case mix and the environment of ward J19. Both Trusts should jointly review the suitability of caring for patients with primary mental health issues on an acute medical ward.

APPENDIX F - FISHBONE DIAGRAM

