# A summary of the key findings of the inquiry carried out into SIRI 30 STEIS 2013/ 21032

This Inquiry was commissioned by the Oxford Health NHS Foundation Trust Board and undertaken by:

Lead Investigators:

Dr Jason Jones, Consultant Clinical and Forensic Psychologist, Professional Lead for Psychology and Psychological Therapies, Specialised Services Division, Oxford Health NHS Foundation Trust

Dr Kevin Murray, Consultant Forensic Psychiatrist and Clinical Director, Broadmoor Hospital, West London Mental Health NHS Trust

Rebecca Kelly, Learning from Incidents Lead, Oxford Health NHS Foundation Trust

7th October 2013

Trust Headquarters
4000 John Smith Drive
Oxford Business Park South
Oxford
OX4 2GX

# 1 Purpose of this report

This report has been prepared to summarise the full investigation undertaken by Oxford Health NHS Foundation Trust into events that culminated in a patient going AWOL from our services. The event attracted public interest and this report has been prepared in recognition of that.

# 2 Account of Events

Mr I was a 44 year old man detained under Section 47/49 of the Mental Health Act 1983/2007. He had a complex past history and had been convicted of Wounding with Intent to Commit Grievous Bodily Harm in September 2004 and given a discretionary life sentence with a 4 year tariff.[1]

In July 2011 he was admitted from prison to a medium secure ward (in Milton Keynes) within Oxford Health NHS Foundation Trust. His mental disorder was successfully treated and he progressed from the medium secure ward to an open pre discharge forensic rehabilitation unit at Littlemore Mental Health Centre, Oxford, in April 2013. Mr I was subject to Section 47/49 throughout this time and was granted periods of leave. All changes to Mr I's care including security level and section 17 leave[2] were approved by the Ministry of Justice which is a legal requirement based on his section. These decisions were based on the good progress Mr I had made in services.

Mr I went absent without leave (AWOL) in the early hours of Monday 8 July 2013; two days after his unescorted leave had been suspended for returning 1 hour late and having consumed alcohol (breaching the conditions of his unescorted Section 17 leave) on the evening of Friday 5 July 2013. He had absconded from the pre-discharge unit during the night and prepared his bed to appear as though it was occupied. Police (later with the assistance of Interpol) were able to establish that Mr I had been picked up by taxi somewhere outside the unit, just after 01:00 hours on Monday 8 July 2013, taken by taxi to St Pancras Station where he boarded the 06:50 hours Eurostar train to Brussels. From there it appears he disembarked in Brussels, travelled to Berlin and on to Poland. Mr I was located in Poland and was arrested on a European Arrest warrant on the 15 July 2013.

A full and detailed report, prepared by Mr I's Responsible Clinician (Consultant Forensic Psychiatrist) summarising the relevant background, care needs and risks for Mr I was sent to the Ministry of Justice and a representative of Thames Valley Multi Agency Public Protection Arrangements (MAPPA) on the 10 July 2013. Mr I's Consultant Forensic Psychiatrist notes

[1] Section 47/49 is a section under the Mental Health Act that allows for a sentenced prisoner to transfer from prison to hospital with restrictions for the treatment of a mental disorder. After this the prisoner may either be returned to prison to serve the rest of their sentence or may be released from hospital on the same terms on which they would have been released from prison. In the case of Mr I this meant that he would have needed both discharge from a Mental Health Review Tribunal and approval from the Parole Board as he was on a discretionary life licence. Mr I was eligible for review and possible release via the Parole Board as early as December 2008.

[2] Section 17 leave of absence from hospital can be granted to allow a detained patient either escorted or unescorted leave from the hospital in which they are detained. This can only be approved by the Responsible Clinician (RC) and can be subject to any conditions deemed appropriate. Leave can be approved for short visits, multiple visits or extended periods of time. In the case of a sentenced prisoner the RC must apply to the Secretary of State for Justice for approval before agreeing and signing for leave.

in this letter that there had been a discussion with Thames Valley MAPPA after Mr I had gone AWOL. Mr I's Consultant Forensic Psychiatrist commented that he sent this letter on the understanding that it would then be shared with the police and in turn Interpol, who would share this information with the detaining authorities in Poland.

The victim of Mr I's Index Offence spoke with the press and made a complaint to the Trust. There has been significant press coverage.

Whilst AWOL, Mr I did not physically harm any other person, despite having opportunity to do so.

Before the extradition process could be completed, Mr I died, in detention in Poland, on 14 August 2013 from injuries, thought to be self-inflicted, sustained on the 8 August 2013.

As a result of both the AWOL and Mr I's death, a full analysis of the management of Mr I's care and treatment and the events both surrounding his absconding and subsequent events was commissioned by the Oxford Health NHS Foundation Trust Executive Team.

# 3 Key findings from the Inquiry

The inquiry concluded that Mr I was appropriately placed on the pre-discharge unit and that his move though services had been well thought out, planned and all actions taken had been with the full knowledge and support of the Ministry of Justice and Mr I's Probation Officer. He had made good progress whilst he was in services and there was no reason to believe that it would not have been possible for him to be successfully rehabilitated into the community and then lead a productive life. Mr I's motivation for his AWOL remains unclear.

The authors note that the pre-discharge unit (within which the majority of patients are not prisoners) offers an excellent opportunity for patients to experience greater degrees of liberty as they make progress towards the community. It offers greater therapeutic input than would be available in an open prison attempting similar rehabilitation. The authors also note that the pre-discharge unit has successfully discharged patients many times before with very few incidents of note. However, the service relies on relational security[3], not procedural or physical security, and central to effective relational security is a high level of understanding of the patient.

## *3.1 The most Significant Influencing Factors associated with the AWOL event and over which Oxford Health had control are detailed below:*

- Correct observation procedures were not followed on the night the AWOL occurred.
- Mr I's interactions with an non-clinical member of staff only became apparent after the AWOL event. It is possible that this may have contributed to his desire to go AWOL. The member of staff had just gone on annual leave to Poland and it is possible that Mr I might have been attempting to locate them. The investigation did not find, however, that there was any inappropriate relationship on behalf of this member of staff other than some boundary issues/sharing of personal information.
- There was a lack of adequate understanding of Mr I's emotional, motivational and intentional disposition by nursing staff on the pre-discharge unit at and before the

[3] Relational security is one of three approaches to security in forensic settings (the other two being physical and procedural). Physical security pertains to the environment itself being physically robust to be safe and secure. Procedural security pertains to protocols, policies and procedures that are out in place to ensure safe and secure care. Relational security pertains the knowledge and understanding staff have of patients and of the environment, and the translation of that knowledge into appropriate responses and care.

AWOL. This was significantly affected by Mr I not disclosing his feelings to nursing staff despite having the opportunity to do so.

- There were some lack of processes to support proactive relational security on the pre-discharge unit, such as up to date risk assessment documentation. The pre-discharge unit relies on the ethos of the service and the relationships based on trust between staff and patients to maintain safety in the absence of physical and environmental security. The authors also noted that there was inadequate escalation of concerns about Mr I when he had had his leave suspended on 6 July 2013.
- The processes around transferring Mr I from medium secure to a pre-discharge environment were not optimal. Staff at Lambourn House had not been invited to a Care Programme Approach[4] (CPA) meeting to review Mr I's progress during the previous six months and handover between Responsible Clinicians did not take place until two weeks after admission. This may have created uncertainty over case management.
- The agreement to support Mr I's passport application and the retention of this by staff as part of restricted items for patients in medium security was not communicated clearly by staff from the medium secure unit to the pre-discharge staff at the point of transfer. There is, however, no national guideline or protocol on the management of passports for patients detained under the Mental Health Act. Within medium secure environments passports (and other personal possessions related to identity or banking) are considered to be restricted items and are held in safekeeping by the staff. The patient can access such items under supervision and only after this has been agreed by the multidisciplinary team. It is often the case that patients need access to these items as part of their rehabilitation programme for example, to open a bank account. Therefore, in medium secure services passports are managed within the restricted items procedures. This has not been the case in the pre-discharge unit where patients are allowed access to a range of items that would be considered restricted in medium security. However, patients admitted to Lambourn House are considered to have made significant progress in the treatment of their mental health problems. Staff are not empowered to prevent access to passports in the community, such as when on leave. Patients are not port flagged.

# 4 Positive areas of note

- CPA meetings were held regularly during Mr I's detention in hospital and they were well attended by the patient's multidisciplinary team members.
- The psychology handover between Psychologists at the medium secure unit and Pre-discharge unit responsible for Mr I's care was managed well.
- The Pre-discharge unit have a fully established Referrals and Admissions meeting. Staff on the pre-discharge unit commented on how this had assisted their thinking about referrals and admissions.

[4] The Care Programme Approach (CPA) is the national framework for mental health services assessment, care planning, review, care co-ordination, and service user and carer involvement focused on recovery.
The CPA framework includes arrangements for two types of support:

- **CPA** for people who have more complex needs, are at most risk or have mental health problems compounded by disadvantage, and need support from multiple agencies (as was the case for Mr I.
- **Lead Professional Care** for people who need secondary mental health services but have more straightforward needs involving contact with only one professional or one agency

- The Responsible Clinician (Consultant Forensic Psychiatrist) at the medium secure unit is to be commended for having established a good therapeutic relationship with Mr I. Mr I clearly trusted her and felt safe in her care.
- The Head of Service for low secure services is to be commended for maintaining good communication links within the Trust and with the Thames Valley Police following Mr I going AWOL.

## 5 Actions taken

Following this incident a number of actions have already been taken to improve practice. These are:

- Nursing observation charts have been amended within the forensic services to remind staff that by signing the form they are confirming that they have seen where the patient is and observed signs of life.
- Nursing staff across the forensic services have been reminded (through the clinical governance framework) of the importance of good practice around nursing observations with explicit guidance put in place to communicate precisely what is expected of staff undertaking observations.
- As part of a NHS Improvement and Innovation project, the Low Secure Service has initiated a project to introduce a competency tool for assessing observation practice.
- All pending admissions to and current patients on the pre-discharge unit subject to Section 47/49 have been reviewed by a senior clinical team.
- The forensic service induction process is being expanded to enable a re-induction for staff who have been absent from work for extended periods (such as long-term sickness or maternity leave) to refresh knowledge, competence and confidence.
- Legal advice has been sought about patient access to passports whilst detained and this has informed the development of local procedures.
- The Head of Mental Health Casework at the Ministry of Justice has been contacted to propose that the Ministry of Justice consider the development of national guidance to, for example, consider flagging the passports of all restricted patients with port authorities.

## 6 Key Recommendations

1. Recommendation 1: There should be a comprehensive review of the quality of nursing observations on the pre-discharge unit.
2. Recommendation 2: There should be a review of the induction, training, supervision and knowledge sharing undertaken with non-clinical staff across all inpatient areas within forensic services
3. Recommendation 3: There should be a comprehensive audit of the quality of risk assessment and management plans undertaken within the forensic services.
4. Recommendation 4: There should be a review of the transition process for patients within the forensic mental health service.