Parliamentary and Health Service Ombudsman

# Matthew's Case

One of the final investigation reports from *Missed Opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust*

# Contents

# Background to the complaint

We are publishing the final investigation report of Ms Leahy who made a complaint to us about North Essex Partnership University NHS Trust with regards to the care and treatment her son received. This report was finalised in June 2019. We are publishing this now to inform the review that NHS England and NHS Improvement will shortly be carrying out into what happened at North Essex Partnership University NHS Trust.

We have redacted a small amount of information around the nature of Matthew's death in line with official Samaritans guidance to reduce risk that someone might imitate the methods used.

# Redacted final Investigation report

**Complaint about:**

North Essex Partnership University NHS Foundation Trust[1] (NEP)

## Case summary:

Ms Leahy's complaint is about the mental and physical health care provided to her late son, Mr Matthew Leahy. Mr Leahy died during an inpatient admission in NEP's Linden Centre in November 2012. Ms Leahy also complains about NEP's investigations into Mr Leahy's death, and how it responded to her concerns including the information it provided about safety improvements.

Our investigation found that some aspects of Mr Leahy's care and treatment were in line with relevant standards and guidance. However, we found significant failings in other areas including key elements of care. We also found that NEP's investigations were not robust enough and that NEP was not open and honest with Ms Leahy about the steps being taken to improve safety at the Linden Centre.

Knowing Mr Leahy did not receive adequate care has caused unimaginable distress to Ms Leahy. NEP had already acknowledged many problems following its own investigation. But at the time Ms Leahy complained to us, NEP had not taken sufficient and timely action to put things right. This added to Ms Leahy's distress and frustration as she had no assurance that things had changed for the better since Mr Leahy's tragic death. In light of this, we decided to uphold Ms Leahy's complaint and make recommendations to EPUT.

[1] In April 2017 North Essex Partnership University NHS Foundation Trust merged with another NHS organisation to form Essex Partnership University NHS Foundation Trust (EPUT).

## The complaint we investigated

Ms Leahy complains that NEP did not follow the correct procedure when it detained Mr Leahy, did not appropriately prescribe and monitor medication, did not provide information about the drugs he took, did not allocate a key worker to him, did not put an adequate care plan in place, did not observe him appropriately or properly engage with him, did not carry out an adequate patient risk assessment, did not adequately manage risks in the ward environment, did not assess his physical health and monitor his nutrition, did not provide psychological therapy, did not make adequate plans for his discharge, and did not take appropriate action when he reported being raped[2].

Ms Leahy also complains that the ward was short staffed, and that NEP did not keep proper records of the care provided to Mr Leahy. She is concerned about the attempted resuscitation and whether everything possible was done to save Mr Leahy's life. Finally, Ms Leahy complains that NEP did not carry out a robust investigation into Mr Leahy's death, did not respond adequately to her concerns, and did not provide accurate information about the extent of the safety changes made.

Ms Leahy says knowing that the care provided to Mr Leahy was 'substandard and wholly unacceptable' causes her and her family ongoing distress. She says she has to live with the guilt of knowing she supported Mr Leahy's detention at the Linden Centre, believing it was a place of safety. Ms Leahy says she has also suffered distress because NEP misled her about changes made to improve safety and forced her to spend months fighting for answers.

Ms Leahy is not reassured that NEP has taken appropriate action to prevent similar events from happening again. As an outcome to her complaint, she is seeking systemic improvements and an apology for the misleading information she has received about safety improvements in the past. Ms Leahy is also seeking compensation which she intends to donate to charity.

## Our decision

Based on the evidence we have seen, we find that the detention process, discharge planning, and the actions staff took to try to save Mr Leahy's life reflected applicable standards. In the circumstances of Mr Leahy's admission, it was appropriate not to provide psychological therapy. NEP has provided evidence that shows staffing requirements were met on the day Mr Leahy died although we do not know what interim ward management arrangements were in place. We find that overall, NEP responded adequately to Ms Leahy's concerns.

[2] The police attended after Mr Leahy contacted them to report being raped but took no further action.

On the whole the prescribing and administration of medication was in line with applicable standards. However, we find service failure specifically in respect of the use of rapid tranquilisation[3]: we saw no evidence that staff considered or used de-escalation techniques before resorting to rapid tranquilisation.

We also find that NEP failed to properly allocate a key worker to Mr Leahy, plan his care effectively, engage consistently with him, manage his observation level appropriately, assess or manage risk fully, do enough to look after his physical health, and take appropriate action when he reported being raped. Lastly, we find that NEP's record keeping and its investigation into Mr Leahy's death were not adequately robust, and that it was not open and honest about safety changes.

Ms Leahy has experienced significant distress at knowing Mr Leahy did not receive adequate care. NEP had already acknowledged many of the problems in Mr Leahy's care following its own investigation. But, at the time Ms Leahy came to us, it had not done enough to put things right. This added to Ms Leahy's distress and frustration.

In light of this, we have decided to uphold Ms Leahy's complaint and make recommendations to EPUT.

## Background

Mr Leahy (aged 20) had been under the care of NEP's Early Intervention in Psychosis (EIP) team since 2011 and had been diagnosed with a delusional disorder caused by cannabis use.

On 7 November 2012 the police detained Mr Leahy under section 136 of the Mental Health Act 1983 as amended in 2007 (the MHA). They brought him to NEP's Linden Centre where he had a formal assessment of his mental health and a mental state examination. Mr Leahy was detained for treatment under section 3[4] of the MHA and admitted to Galleywood Ward. The records show his psychiatrist was considering whether he had a drug-induced mental health disorder; but was also questioning whether his symptoms could be unrelated to drug use[5].

The day after admission, Mr Leahy told staff he would hang himself if they gave him injectable medication. On 9 November he alleged staff had raped him during the night. Mr Leahy had made a similar report during a previous inpatient admission at NEP in 2011.

On 15 November 2012 staff found Mr Leahy [unconscious in his room] [redacted]. They raised the alarm and tried to resuscitate him. Mr Leahy was taken by ambulance to Broomfield Hospital but

[3] Medication given to quickly calm a patient who is very agitated or behaving aggressively, in order to reduce risk to themselves or others, and allow them to receive the medical care they need.
[4] Under section 3 of the MHA, patients can be detained in hospital for treatment for up to 6 months.
[5] Studies have shown that around half of those with an initial diagnosis of cannabis induced psychosis (such as a delusional disorder) go on to be diagnosed with a non-drug induced psychotic condition.

was subsequently pronounced dead. The cause of death stated in his post mortem report was hanging. The post mortem report noted that Mr Leahy had a needle mark on the inside of his right elbow covered by surgical gauze, at least four needle marks in his right groin, and a possible needle mark in his left groin. Toxicology tests found evidence of prescribed medication in his system. GHB[6] was also present at a level *'consistent with post mortem production'*.

Following Mr Leahy's death, NEP wrote a *'Serious Incident 7 Day Report'*. The report concluded that all the agencies and staff involved in Mr Leahy's care had *'made every attempt to help and support him'*.

NEP went on to undertake a serious incident (SI) panel investigation. The report of the investigation concluded that overall the care and treatment provided to Mr Leahy was of a good standard, and largely met the requirements of the Care Programme Approach (CPA) and local policies. NEP said there were some areas of concern but it did not consider they had contributed to Mr Leahy's death. Recommendations were made around the management of observation levels, care planning, record keeping, the recruitment of permanent staff, and the management of environmental risks.

During its investigation, NEP found that Mr Leahy's care plan had been written after his death. NEP took disciplinary action against the staff involved, and referred the matter to the Nursing and Midwifery Council (NMC).

In January 2015 an inquest was held into the death of Mr Leahy. The inquest considered a report by an independent psychiatrist. The independent psychiatrist was critical of some aspects of Mr Leahy's care but concluded that on the whole, NEP had provided an acceptable level of care based on a well-structured assessment process.

A police report, prepared for the coroner, commented on the independent psychiatrist's findings. The police report said the findings showed that while there may have been administrative issues, Mr Leahy's care was appropriate at the time of his death. It also said the falsification of the care plan did not amount to a criminal offence and was not linked to Mr Leahy's death.

Solicitors acting for Ms Leahy commissioned a report by a second independent psychiatrist[7]. This report said the treatment provided to Mr Leahy *'fell below the standard of a reasonably competent practitioner*'. It said it was highly likely the combined failings in care materially contributed to Mr Leahy's death.

[6] Gamma-hydroxybutyrate. A substance which occurs naturally in the body but which can also be made artificially as a psychoactive drug.
[7] Ms Leahy told us this report was not considered as evidence during the inquest into Mr Leahy's death.

The coroner reached a narrative conclusion. The record of inquest said:

*'ML was subject to a series of multiple failings and missed opportunities over a prolonged period of time by those entrusted with his care. The jury found that relevant policies and procedures were not adhered to impacting on Matthew's overall care and well-being leading up to his death. The cause of death was 1a) hanging.'*

After the inquest, the coroner prepared a regulation 28 report[8] to help prevent future deaths. The coroner had concerns about staffing levels in the Linden Centre. She asked NEP to consider commissioning an independent inquiry into Mr Leahy's death.

NEP's response to the coroner said that 'staffing levels were 100%' during Mr Leahy's admission. Of those on duty, 44% were permanent members of staff. The remainder were bank[9] or agency staff. NEP said its board had considered the need for a 'public inquiry' into Mr Leahy's death but had decided not to pursue this because there had already been 'a comprehensive airing' through its own investigations, the police investigation, reports from independent psychiatrists, and the inquest. NEP said it would reconsider its decision if new information became available.

Contrary to what was stated in the police report for the coroner, the police recorded the falsification of Mr Leahy's care plan as a crime in April 2017; but took no further action. The same year the police began an investigation into a number of patient deaths at NEP, including Mr Leahy's. The investigation was undertaken jointly with the Health and Safety Executive (HSE). In November 2018 the police announced they would not be pursuing corporate manslaughter charges. HSE continues to investigate.

[8] A report made under regulation 28 of the Coroners (Investigations) Regulations 2013.
[9] A pool of staff employed by NEP to cover for temporary staffing shortfalls due to vacancies, staff absence etc.

## Evidence we considered

We use relevant law, policy, clinical guidance and standards[10] in place at the time of the events to inform our thinking. This allows us to consider what should have happened.

In this case, we also obtained clinical advice from:

- a Psychiatrist Adviser who is an experienced Consultant in General Adult Psychiatry.
- a Mental Health Nursing Adviser who is a senior NHS manager and registered mental health nurse with extensive experience of serious incident investigations; and
- a Paramedic Adviser with over 35 years experience in the NHS ambulance service including emergency medical dispatch centre working.

We also considered information provided by Ms Leahy, NEP and EPUT. This included NEP's investigation reports, reports prepared by two independent psychiatrists, staff statements and interview transcripts, NEP's policies and Mr Leahy's medical records. We also took account of records from the ambulance service that took Mr Leahy to Broomfield Hospital on 15 November 2012, reports of inspections by the Care Quality Commission (CQC), and information provided by the police. Last, we considered comments from all parties on our provisional view.

## Our findings

### Detention process

Ms Leahy is concerned about whether NEP followed the correct procedure when it detained Mr Leahy under the MHA. She wants to know whether staff explained his rights, including his right to an independent mental health advocate[11] and his right to request discharge through an appeal to a tribunal or to hospital managers. She also wants to know whether Mr Leahy's human rights were protected.

First, we consider the detention process and whether staff told Mr Leahy about his rights. Our Psychiatrist Adviser explained that section 136 of the MHA allows the police to detain someone in a public place if they have concerns about their mental health, and to transfer them to a designated place of safety[12]. An individual can be detained for up to 72 hours. During this time a formal mental

[10] These include our Principles. More detail about our Principles can be found at https://www.ombudsman.org.uk/about-us/our-principles

[11] An individual who supports a patient by explaining their options and rights, providing information, and attending meetings and appointments.

[12] A place designated by relevant interested authorities such as the police, local ambulance trust, local mental health trust, local authority etc. It may be the detainee's home (or the home of a friend or relative), a hospital or a police station.

health assessment should be undertaken. This usually leads to the individual being discharged or detained under section 2 or 3 of the MHA.

The person who makes the application for detention under the MHA is an Approved Mental Health Professional (AMHP)[13]. The AMHP identifies two doctors to attend the formal mental health assessment to make medical recommendations about detention. It is preferable for both doctors to be approved under section 12[14] of the MHA and for one of the doctors to have prior knowledge of the patient[15]. Both doctors must be registered with the General Medical Council (GMC).

In line with the MHA Code of Practice and guidance from the National Institute of Heath and Care Excellence (NICE)[16], patients who are being detained under the MHA should be given verbal and written information about their rights, including their right to appeal to a mental health tribunal. They should also be able to access an independent mental health advocate.

According to the records, the police were called when Mr Leahy 'trashed the caravan' he was living in which was owned by his father. An entry in the care records timed 12.04pm on 7 November says that a community psychiatric nurse (CPN) spoke with the police, who advised they were looking for Mr Leahy. The CPN suggested the police detain Mr Leahy and take him to a place of safety.

On arrival at the Linden Centre, staff prepared an initial care plan for Mr Leahy. The care plan shows that staff read Mr Leahy his rights under section 136 of the MHA and informed an AMHPS coordinator[17]. One to one nursing observations were started.

Following a formal mental health assessment later that day, Mr Leahy was detained for treatment under section 3 of the MHA. The doctors who assessed him were approved under section 12 of the MHA, and both are registered with the GMC. One of the doctors had prior knowledge of Mr Leahy.

Our Psychiatrist Adviser confirmed that the detention paperwork had been completed correctly and had been signed to confirm it was received by a hospital manager[18]. The medical recommendations of the two doctors clearly explained the rationale for admission for treatment.

---

[13] The AMHP is an employee of the local authority.
[14] Doctors who have specific training in the use of the MHA, and expertise in the management and treatment of mental disorders.
[15] If a doctor with prior knowledge of the patient is not available, two doctors without prior knowledge can attend but both should be approved under section 12 of the MHA. If that is not possible, at least one of the doctors should be section 12 approved. If that is not possible either, two doctors on the GMC register can attend. The AMHP has to set out in writing on the detention paperwork why the more ideal conditions cannot be met.
[16] CG136 Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services (NICE, 2011)
[17] The person who would allocate an AMHP to Mr Leahy's case.
[18] This is usually the senior nurse manager working on the ward or in the hospital at the time.

An entry in the care records at 8.00pm on 7 November notes that Mr Leahy was informed of his rights under the MHA. This is supported by the *'Patient Pathway Checklist'*. Item 15 on the checklist - *'Read and record MHA rights'* – has been signed by a member of nursing staff. A *'Section 132 – Patient's Rights Monitoring Form'* also confirms that staff explained Mr Leahy's rights. It is noted on this form that verbal and written information was provided. According to the form, Mr Leahy answered *'no'* when staff asked him if he wished to appeal to hospital managers or a mental health tribunal.

A referral form for independent mental health advocacy states that Mr Leahy refused to answer when staff asked him whether he wanted an advocate. He did not sign the form. Despite this, it is noted on the referral form and in the care records that Mr Leahy saw an advocate on 9 November.

Next we consider whether NEP acted in accordance with Mr Leahy's human rights when it detained him. In the UK, a person's human rights are protected by the Human Rights Act (HRA) 1998. The HRA is underpinned by the principles of fairness, respect, equality, dignity and autonomy (FREDA). NHS organisations should have regard for these principles in the provision of services.

As noted above, we saw evidence that staff gave Mr Leahy information about his rights and ensured he had access to an advocate during his detention. This equipped him with the knowledge and support to pursue his discharge if he wished, and is therefore in line with the principles of fairness and autonomy. We also saw evidence that staff treated Mr Leahy with dignity during the detention process. The records show staff offered him food and drink regularly while he was in the section 136 suite, and went to the shop to buy tobacco for him.

In summary, we find that the process used to detain Mr Leahy was in line with applicable guidance. Staff provided information to Mr Leahy about his rights, and acted in accordance with the FREDA principles.

## Medication

Ms Leahy complains that staff overmedicated Mr Leahy, inappropriately administered a rapid tranquiliser, did not provide information about his medication, and did not monitor him for side effects. She wants to know whether medication prescribed to Mr Leahy caused him to *'pass out'* on 10 November 2012, and whether staff took appropriate action after this incident. She also wants to know whether the medication prescribed could have caused bleeding in Mr Leahy's stomach.

### Type of medication and dose

First we consider whether NEP prescribed and administered appropriate medication to Mr Leahy, including the use of a rapid tranquiliser.

Our Psychiatrist Adviser explained that doctors base their decision about which drugs to prescribe on the patient's diagnosis and needs. He noted that it is usual for patients experiencing symptoms of psychosis and agitation to be treated with

an antipsychotic drug with a calming effect. Mr Leahy was distressed by psychotic beliefs and was saying he was going to kill himself. Our Psychiatrist Adviser said drug management should have focused on reducing his psychotic thoughts, and providing tranquilisation to calm him.

On admission, doctors prescribed lorazepam (a tranquiliser), clonazepam[19] (another tranquiliser) and zopiclone (a sleeping tablet) to be taken *'as needed'*. Risperidone (an antipsychotic) was also prescribed, but Mr Leahy refused to take this drug so haloperidol (a tranquilising antipsychotic) was prescribed instead. Haloperidol is an older drug but our Psychiatrist Adviser noted that its use was appropriate, and that Mr Leahy had agreed to take it. Procyclidine was prescribed *'as needed'* to counter the side effects of haloperidol. Our psychiatrist Adviser confirmed all of the drugs administered were clinically appropriate.

Ms Leahy is concerned about the choice of haloperidol. She told us information available online says haloperidol is not suitable for people with thyroid problems and depression, and that patients should have an ECG before it is given. Ms Leahy said Mr Leahy was depressed, and blood tests carried out in July and August 2011 had shown he had an overactive thyroid gland. She also said Mr Leahy did not have an ECG before he started taking haloperidol, despite having an ECG during a previous admission in 2011 which showed abnormal findings.

The British National Formulary (BNF)[20] says haloperidol should be used with caution in patients with a severely overactive thyroid gland. This means that doctors should weigh up the risks and benefits before deciding whether to prescribe it. Our Psychiatrist Adviser said Mr Leahy's blood test results from 2011 show he had a slightly raised thyroxine level and a normal TSH[21] level. He explained that patients can sometimes have either a slightly abnormal level of either thyroxine or TSH, but this is not necessarily clinically significant.

Mr Leahy refused a physical examination on admission so it would not have been possible to do blood tests to check his thyroxine levels. Consequently, doctors had to take a risk based approach when deciding whether to prescribe haloperidol. Our Psychiatrist Adviser noted that Mr Leahy was a fit, young person. There is no evidence that he was showing symptoms of an overactive thyroid gland, and his test results from the previous year were only slightly abnormal. He considered that it was appropriate in the circumstances to prescribe haloperidol to Mr Leahy.

In respect of depression, our Psychiatrist Adviser said doctors use clinical judgement when deciding whether to prescribe haloperidol to patients with a severe depressive disorder and psychotic symptoms. He noted that there are risks with other antipsychotic drugs too, and that in every case doctors have to weigh the risks of prescribing against the risks of leaving psychosis untreated. While Mr Leahy was distressed at times, the records do not indicate he was clinically depressed with severe and continuous low mood. There was no reason therefore

[19] No clonazepam was administered to Mr Leahy during his admission.
[20] A reference guide for clinical staff about the use, dose, risks and side effects of medication.
[21] Thyroxine stimulating hormone. A hormone that tells the thyroid gland to produce thyroxine.

for doctors to have considered depression as a risk when prescribing haloperidol to him.

Our Psychiatrist Adviser said an ECG is '*recommended*' before patients start taking haloperidol and other psychiatric drugs although it is not mandatory. He explained that there is a risk that patients taking haloperidol may develop a severely abnormal heart rhythm. Our Psychiatrist Adviser said the most important consideration is the QTc[22] interval. A prolonged QTc interval can indicate a risk of seriously abnormal heart rhythm.

Doing an ECG provides baseline data, although it can sometimes also identify risks of serious cardiac problems. As muscular movements interfere with the heart trace, patients must be relaxed and calm. In practice, it may not be practicable to carry out an ECG. Our Psychiatrist Adviser said that with a young, physically fit patient, doctors will balance the risk of prescribing before an ECG has been carried out, with the risk of not prescribing drugs to a psychotic, agitated patient.

A plan to carry out an ECG is documented in Mr Leahy's clinical records. While there is no evidence this happened, the ECG carried out in 2011 reports that Mr Leahy's QTc interval was within the normal range. However, the ECG did show a 'possible partial RBBB[23]'. While acknowledging this finding, our Psychiatrist Adviser said Mr Leahy was otherwise a fit, young person who was acutely disturbed. He did not have cardiac symptoms or a family history of cardiovascular disease. Our Psychiatrist Adviser said it was appropriate in the circumstances to prescribe haloperidol without first carrying out a further ECG.

Next, we consider the dose of medication prescribed. In line with the BNF, the maximum total daily oral dose of haloperidol in 2012 was 30mg[24]. The maximum daily dose of procyclidine is 30mg in divided doses. The maximum total daily oral dose of lorazepam is 4mg in divided doses. The maximum daily dose of zopiclone is 7.5mg.

[22] Part of the ECG trace.
[23] Partial right bundle branch block. An abnormality which can affect how well the heart pumps blood.
[24] The maximum daily dose was reduced to 20mg in 2014.

The table below shows the doses of the drugs administered on each day of Mr Leahy's admission. Our Psychiatrist Adviser confirmed that the doses taken were all within BNF limits.

| | Haloperidol | Lorazepam | Procyclidine | Zopiclone |
|---|---|---|---|---|
| 8 November[25] | 10mg | 2mg | | |
| 9 November | 1x10mg<br>1x5mg | 2mg | | |
| 10 November | 3x5mg | | 3x5mg | |
| 11 November | 3x5mg | | 5mg | |
| 12 November | 3x5mg | | 5mg | |
| 13 November | 3x5mg | 1mg | | 7.5mg |
| 14 November | 3x5mg | | | 7.5mg |
| 15 November | 1x5mg[26] | | | |

Ms Leahy has specifically complained about the use of rapid tranquilisation on 8 November 2012. Our Psychiatrist Adviser said staff should avoid giving patients rapid tranquilisation unless it is absolutely necessary. NEP's rapid tranquilisation policy reflects this advice. Section 9.3.1 sets out the following '*non-drug de-escalation approaches*' which should be tried before staff resort to rapid tranquilisation:

- 'Maintain adequate distance
- Moving the patient to a quiet place
- Maintaining a calm approach throughout
- Maintaining the safety of patient and staff members
- Use of non-threatening communication both verbal and non verbal
- Attempting to establish the patient's trust
- Explanation and reassurance
- Offering oral medication only if necessary'

[25] The haloperidol and lorazepam given on this date were for the purpose of rapid tranquilisation.
[26] In addition to the oral haloperidol, doctors prescribed a haloperidol depot [medication given by injection which is slowly released into the body over a number of weeks] on 15 November 2012 at a test dose. The drug charts show the depot was not administered.

NEP's policy states that staff should consider giving oral medication before an injection, and use the lowest dose necessary to address the patient's behaviour. The policy gives doctors discretion to either administer tranquilising medication (such as lorazepam) on its own or in combination with an antipsychotic.

The records show that a psychiatrist requested the rapid tranquiliser because Mr Leahy was '*very agitated and distressed about being under mental health act was abusive verbally...'*. Nursing staff documented in the care records that Mr Leahy '*... continued to present as unsettled in presentation, reports feeling suicidal at present reports that he would use a means of hanging if he were to kill himself. Continues to present with paranoid and suspicious thoughts re: being raped by medical staff'*.

According to the drug charts, Mr Leahy was given 10mg of haloperidol and 2mg of lorazepam. Our Psychiatrist Adviser said it would be common practice to administer this combination of drugs to a patient who was both agitated and psychotic.

Nursing staff completed an incident form and a rapid tranquilisation monitoring tool. It is documented in the care records that Mr Leahy accepted the medication orally and that it had *'good effect'*.

There is nothing documented in any of the records to indicate that de-escalation techniques were considered or used. On the relevant section of the rapid tranquilisation monitoring tool, a nurse has written *'N/a'*.

Taking all of this together, we find no failings in respect of the type and dose of medication prescribed to Mr Leahy. We find service failure only in respect of the lack of consideration or use of de-escalation techniques before rapid tranquilisation was given.

### Information provided to Mr Leahy about his medication

Next, we consider Ms Leahy's complaint that staff did not give Mr Leahy adequate information about his medication. Our Psychiatrist Adviser explained that Mr Leahy's doctors should have tried to provide him with some choice about which drug he took. They should have also provided written information to help him decide, and discussed the medication with him.

As noted above, the records show that doctors initially prescribed risperidone to Mr Leahy. This drug was never administered because he did not want to take it. On 9 November a psychiatrist documented in the notes that haloperidol had been chosen as an oral antipsychotic because Mr Leahy was *'willing to take* [it] *regularly'*. This indicates that Mr Leahy was afforded choice about which antipsychotic drug he was to take.

The notes for a ward round on 15 November state: *'Matthew requested a haloperidol depot injection and also an information leaflet'*. When one of the psychiatrists present at the review was interviewed as part of NEP's investigation, they recalled that Mr Leahy had asked about the dose, how the depot was administered, and whether it could be injected into his arm.

A CPN who attended the ward round documented the discussion about medication in Mr Leahy's records. The CPN's notes state there was a review of the medication Mr Leahy had taken since his admission to the Linden Centre. Mr Leahy asked if haloperidol was available as a depot injection and there was a discussion about the difference between a haloperidol depot and another type of depot antipsychotic.

The records do not indicate what, if any, written information Mr Leahy was given about his medication. During the ward round on 15 November, a plan was made to give him a leaflet about haloperidol depots. There is nothing documented to confirm this happened.

We saw no evidence that Mr Leahy was given written information about any of the other drugs prescribed. The section of the *'ward stay care pathway checklist'* which asks if written advice about medication has been given to the patient, has been left blank. Our Psychiatrist Adviser noted that it may not have been essential to provide information to Mr Leahy about drugs he had taken during previous admissions as he may already have been aware of their purpose and likely effects. We saw evidence that Mr Leahy had taken zopiclone during a previous admission in 2011, but not lorazepam or procyclidine.

Nevertheless, our Psychiatrist Adviser said the records indicate that Mr Leahy understood the effect of both lorazepam and zopiclone, as he had asked to use both drugs during his admission in 2012. The CPN's notes of the ward review on 15 November provide further evidence of Mr Leahy's understanding. It is documented that Mr Leahy said he needed zopiclone because of his sleep pattern, and reported that procyclidine had worked well for him.

Ms Leahy has also queried whether Mr Leahy should have been given information about the rapid tranquiliser. Our Psychiatrist Adviser said that patients who require rapid tranquilisation are likely to be distressed and agitated. These circumstances do not lend themselves to discussions about drugs. He also pointed out that patients are unlikely to have capacity to make an informed choice, and that if they were able to have a considered discussion about rapid tranquilisation, it probably would not be necessary in the first place. In light of our Psychiatrist Adviser's comments, we would not have expected doctors to have provided information to Mr Leahy about rapid tranquilisation.

Based on what we have seen, we find no failings in respect of the provision of information about medication.

### Monitoring of medication

Now, we consider Ms Leahy's complaint that staff did not monitor the effects of Mr Leahy's medication.

Guidance from the NMC on the management of medication[27] states that nurses must contact the prescriber without delay where contra indications to prescribed medicine are found, or where a medicine causes an adverse reaction or is found to be unsuitable.

Our Mental Health Nursing Adviser reviewed the medication records. He confirmed the records were properly completed and show staff administered Mr Leahy's prescribed medication correctly. Mr Leahy accepted all his medication. Our Psychiatrist Adviser confirmed there were no specific monitoring requirements in respect of haloperidol, lorazepam, procyclidine and zopiclone. He could see no evidence that Mr Leahy developed an adverse reaction to any of the drugs prescribed, or any indication they were not suitable for him.

Ms Leahy is concerned that Mr Leahy experienced side effects including sedation, dizziness/faintness/a racing heart and pain in his legs. She also said the police noted Mr Leahy's speech was slurred when they saw him on 9 November about his allegation of rape.

According to the records, Mr Leahy was noted to be sleepy on more than one occasion. Our Psychiatrist Adviser explained that sedation can happen when a patient first starts taking tranquilising medication while the appropriate dose is still being determined. He noted that temporary sedation may be impossible to avoid and does not indicate poor prescribing practice.

It is documented in the electronic care records that Mr Leahy had an episode of dizziness on 10 November. His post mortem report states that he told the police his legs hurt on waking one morning, and that was why he suspected he had been raped. Our Psychiatrist Adviser said that if medication was responsible, there is likely to have been a recurring pattern of symptoms as the drugs reached their peak dose in Mr Leahy's body. As only single episodes of dizziness and leg pain are noted, it is difficult to attach any significance to them.

We saw no reference in the care records to Mr Leahy having slurred speech. However, his post mortem report says that the police officers who saw him on 9 November described him as being '*in a drug-induced state*' and '*not very coherent*'. Our Psychiatrist Adviser noted that it is unclear what the police officers meant by these comments. They may indicate that Mr Leahy was sleepy or that he was showing signs of psychosis.

The only occasion when specific medication monitoring was needed was on 8 November when staff administered rapid tranquilisation. NEP's rapid tranquilisation policy states that staff should monitor the patient's pulse, temperature, respiratory rate and oxygen saturations at least every 15 minutes

[27] Standards for medicines management (NMC, 2007).

for the first two hours, then every 30 minutes until the patient is able to walk around. The policy states that the patient's blood pressure should be measured 30 and 60 minutes after each dose/injection.

According to the drug charts, the rapid tranquiliser was administered at 11.25am. The observation records do not indicate that Mr Leahy was incapable of moving around after he took the medication.

The records show staff checked and recorded Mr Leahy's blood pressure, pulse and oxygen saturations at 11.30am, 11.50am and 12.30pm. At the 12.30pm check, Mr Leahy's temperature was also recorded. His oxygen saturation level and temperature were recorded at 12.14pm, and his pulse and temperature were recorded at 12.58pm and 1.00pm.

Based on the data recorded, the monitoring of Mr Leahy's blood pressure was broadly in line with the policy. But his pulse, temperature and oxygen saturations were not monitored every fifteen minutes for two hours, and there was no monitoring of his respiratory rate.

Our Psychiatrist Adviser said that the physical observations which were recorded gave no reason for concern. Mr Leahy's temperature and oxygen saturation levels[28] were normal and his pulse remained below 100. His blood pressure was slightly raised; but this was unsurprising given that he was distressed and agitated at the time. There is no evidence that Mr Leahy came to any harm as a result of the rapid tranquiliser.

Our Psychiatrist Adviser noted that it could be challenging for staff to carry out all of the checks at the intervals specified in NEP's policy, for example if patients are agitated or resistant. Our Mental Health Nursing Adviser agreed and said that staff have to use their judgement.

In summary, while staff did not monitor all of Mr Leahy's physical observations at the intervals specified in NEP's policy, the records show he was checked six times after the rapid tranquiliser was given. None of the observations recorded gave rise to alarm. Consequently, we find that NEP's actions did not fall so far short here that they amount to service failure. We also note there is no evidence that the rapid tranquiliser caused any harm to Mr Leahy.

[28] The oxygen saturation level recorded at 12.14 was abnormal. Our Psychiatrist Adviser suspected that it had not been recorded correctly as it was out of line with the other measurements recorded.

### Events of 10 November 2012

Ms Leahy is concerned that medication may have caused Mr Leahy to 'pass out' on 10 November 2012, and that staff did not take appropriate action in response.

The incident is documented in the care records at 5.40pm. According to the records, a member of nursing staff saw Mr Leahy sitting on the floor in the corridor. Mr Leahy told the staff member he had sat down because he was feeling dizzy.

Our Psychiatrist Adviser explained that some psychiatric drugs can cause postural hypotension[29]. However, if Mr Leahy had been experiencing postural hypotension as a side effect of his medication, it would be likely to occur every time he stood up. As there is only one episode of dizziness documented in Mr Leahy's care records, it is unlikely to have been caused by his medication.

Our Mental Health Nursing Adviser said that following an episode of dizziness, it would be good practice for a member of the nursing team to check the patient's physical observations. There would be no requirement to contact a doctor or arrange a medical review unless there were specific concerns about the patient's condition.

It is documented in the care records that Mr Leahy's physical observations were checked. Our Psychiatrist Adviser said his blood pressure was slightly raised and his heart rate was slightly fast; but his other observations were normal. The care records state that a doctor would review Mr Leahy. We saw no evidence this happened. But there is also nothing documented to indicate that it was necessary in the circumstances. We saw no evidence that Mr Leahy lost consciousness, or that he fell and hit his head. There is also no evidence that the staff member who found Mr Leahy had any ongoing concerns that would point to the need for a medical review. We find no failings in respect of this incident.

### Whether medication caused gastric bleeding

Last, we consider Ms Leahy's complaint that the medication prescribed to Mr Leahy caused gastric bleeding. Ms Leahy told us blood was found in Mr Leahy's stomach at post mortem.

Mr Leahy's post mortem report refers to the presence of dark fluid in his stomach. It does not mention blood. Ms Leahy has provided an audio recording of the pathologist giving evidence at Mr Leahy's inquest in 2015. The pathologist states there was a small amount of fluid, and that because Mr Leahy died by hanging, some blood may have leaked out of the lining of his stomach to make the fluid look dark.

[29] Where blood pressure falls when a person stands up after sitting or lying down. Postural hypotension can cause momentary dizziness or faintness. It is harmless unless the faintness causes the person to fall over and hurt themselves.

Ms Leahy has also sent us information provided by a second pathologist who reviewed Mr Leahy's post mortem report in 2018. The second pathologist said that if blood stays in the stomach for more than a few minutes, the acid present causes it to turn black. He also said that the findings of Mr Leahy's post mortem had shown he had died very rapidly. Consequently, he did not think that the small amount of altered blood in his stomach was associated with the manner of his death. Instead, he thought Mr Leahy's stomach had been bleeding either as a result of stress or due to mild irritation caused by his medication.

Our Psychiatrist Adviser agreed the dark fluid in Mr Leahy's stomach could have been altered blood. However, he confirmed that the BNF does not list gastric bleeding as a recognised side effect of any of the drugs Mr Leahy took. In the absence of such a link, we find that on the balance of probabilities, Mr Leahy's medication did not cause gastric bleeding.

### Summary of our findings about medication

We find that on the whole, NEP's actions in respect of Mr Leahy's medication reflected applicable standards. Doctors prescribed medication which was appropriate for Mr Leahy's symptoms at an appropriate dose. Although there is no evidence that Mr Leahy was given any written information, staff discussed his medication with him and gave him choice about the drugs he took. We do not find that Mr Leahy experienced side effects to his medication which staff failed to monitor. After Mr Leahy was given a rapid tranquiliser on 8 November, staff monitored his physical observations albeit not to the full extent of the standards set out in NEP's policy. Based on what we have seen, it is unlikely that Mr Leahy's medication caused gastric bleeding or the episode of dizziness he had on 10 November.

The only area where we find that NEP's actions fell so short that they amount to service failure is in relation to what happened before the rapid tranquiliser was given. We saw no evidence to show staff considered or used de-escalation techniques before resorting to rapid tranquilisation.

## Allocation of key worker

Ms Leahy complains that NEP did not allocate a key worker to Mr Leahy.

Our Mental Health Nursing Adviser said that identifying a nurse with overall responsibility for a patient's care helps to provide consistency and build an effective therapeutic relationship with the patient. According to NEP's admissions policy, patients must be allocated a key worker/named nurse within 24 hours

A '*patient pathway checklist*' in Mr Leahy's clinical records indicates that he was allocated a key worker on 7 November, the day he arrived at the Linden Centre. However, the records show that when Mr Leahy was seen by hospital managers on 12 November, he was aware of his appeal rights but did not know who his keyworker was.

NEP's SI panel investigation found there was confusion about who was to be Mr Leahy's keyworker. The report states that the role was given to a nurse who was not on duty for the first two days of Mr Leahy's admission. The nurse was interviewed as part of the SI panel investigation. The transcript of the interview indicates the nurse had no clear memory of being told they were Mr Leahy's keyworker. At the inquest into Mr Leahy's death, the nurse said they found out they were Mr Leahy's key worker on the evening of 13 November by reading a whiteboard. The nurse acknowledged going on annual leave shortly afterwards without taking any action.

Based on what we have seen, Mr Leahy was not properly allocated a key worker/named nurse. Our Mental Health Nursing Adviser noted that the matter was not picked up at the time by a senior nurse. He said this was poor practice which demonstrated a lack of coordinated care for Mr Leahy. What happened here fell so far short of NEP's policy that it amounts to service failure.

## Care planning

Ms Leahy complains that NEP did not put an adequate care plan in place for Mr Leahy. She also complains that staff falsified a care plan after Mr Leahy's death.

Our Mental Health Nursing Adviser said the importance of sound care planning cannot be overstated. He noted that care planning is fundamental to how nurses (and other health care professionals) are able to assess, identify, and meet a patient's needs.

In line with NICE guidance[30], Mr Leahy should have had an appropriate care plan based on a comprehensive assessment of his needs. The care plan should have set out how staff were going to treat his mental health condition and reduce the risk of harm.

A *'CPA Clinical/Specialist Care Plan'* in Mr Leahy's records states that he had been admitted to Galleywood Ward for a full assessment of his mental health and physical needs. The *'plan/goal'* set out was for staff to complete a full and detailed assessment. The *'actions required'* were for staff to observe and assess Mr Leahy's mood, behaviour, diet/fluid intake, continence, sleep, communications and interactions, thought processes, mobility and dexterity, and his ability to carry out activities of daily living.

Our Mental Health Nursing Adviser said this was sufficient for an initial care plan focusing on the immediate care priorities. However, there is no evidence of meaningful and effective care planning subsequently. Mr Leahy's initial care plan was not developed to reflect the full range of his needs and address all the

[30] NICE CG136 Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services (NICE, 2011), and Quality Standard QS14 Service user experience in adult mental health services (NICE, 2011).

relevant risk issues such as his reports of rape, substance abuse, aggression, family relationships, and non-compliance with prescribed medication. Care planning was not detailed or structured enough to meet NICE standards. In particular, there was no evidence staff had planned, implemented, reviewed and evaluated Mr Leahy's care.

NEP's SI panel investigation report acknowledged that Mr Leahy's initial care plan covering his first 72 hours in the Linden Centre did not address all of the risks present and was not updated. It also acknowledged that a more comprehensive care plan was written after Mr Leahy's death.

In light of the evidence, we find that NEP did not ensure Mr Leahy's care was adequately planned. Care planning fell so far short of applicable standards that it amounts to service failure. The failings were compounded by staff preparing a care plan after Mr Leahy's death, seemingly to cover up deficiencies in the documentation. NEP addressed this matter appropriately through its disciplinary procedures, and by referring the matter to the NMC.

## Observation and engagement

Ms Leahy complains staff did not observe Mr Leahy appropriately during his admission, including on the day of his death. She also complains that staff did not engage with him.

Our Mental Health Nursing Adviser noted that the aim of close observation is to maintain meaningful engagement with the patient in order to secure their safety and wellbeing, and avoid harm. NEP's *'Inpatient observation and engagement'* policy describes four levels of observation:

- Level 1 – General observations[31]
- Level 2 – Defined observations[32]
- Level 3 - Within eyesight[33]
- Level 4 - Within arm's length[34]

The policy states that a patient's observation level may be lowered by the nurse in charge after discussion with the multidisciplinary team (MDT). The responsible clinician's opinion must be sought prior to reducing the observation level of patients detained under the MHA. The policy also states that observation should be seen as an opportunity to engage and support the service user in a positive manner, and for one-to-one interaction.

[31] General observation of patients' whereabouts at least once per hour.
[32] A specified number of checks per hour (minimum 4 and maximum 6).
[33] Continuous observation of the patient. Clinicians must be in the same area as the patient, keeping them within eyesight.
[34] Continuous observation of the patient. Clinicians should be close enough (within arm's length) to intervene immediately if/when necessary.

The records show Mr Leahy arrived at the Linden Centre at 3:55pm on 7 November. He was placed on one to one nursing observations. On admission to Galleywood ward, level 2 observations were started (4 checks per hour). A doctor who saw Mr Leahy at 11:45pm recommended level 2 observations but stated that nursing staff could increase the observation level if necessary. The doctor's notes do not specify how many checks were to be made each hour; but the observation records show Mr Leahy was generally observed four times per hour. On 8 November Mr Leahy reported feeling suicidal and spoke about hanging himself. He was placed on level 3 observation.

Our Mental Health Nursing Adviser confirmed the observations levels in place on 7 and 8 November were appropriate. The records show that staff carried out the required level of observation[35].

The care notes for 9 November say Mr Leahy was '... *calm in mood and fairly settled in behaviour'*. During a ward round later that day, it was agreed that his level of observation could be either level 2 (with six checks per hour) or level 3, at the discretion of nursing staff. Mr Leahy was nursed on level two observation; but was only checked four times per hour rather than six. Level 2 observations continued until 12 November[36].

On 13 November Mr Leahy was nursed on level 1 observation. NEP's SI panel investigation report acknowledged there was no recorded rationale for reducing Mr Leahy's observation level on this date. It said the records do not show who made the decision, and that it happened without the involvement of the MDT. At the inquest, Mr Leahy's psychiatrist indicated that a member of the night staff lowered Mr Leahy's observation level overnight on 12/13 November without consulting him.

According to the SI report and the psychiatrist's evidence to the inquest, the lowering of Mr Leahy's observation level was discussed and agreed within the ward team later on 13 November, but the paper record of that discussion was subsequently lost. We have seen no documented evidence of the rationale for lowering Mr Leahy's observation level. NEP's SI report indicated that Mr Leahy's mental health had improved quickly during his admission and that there was nothing to suggest that a higher level of observation should have been in place at that time. Nevertheless, it seems that the lowering of Mr Leahy's observation was not in line with NEP's own policy. NEP's SI report acknowledged this was *'unsafe and poor practice'*.

EPUT told us that the level one observation sheets for 13 and 14 November have been missing since the time of Mr Leahy's inquest. Consequently, we do not know whether Mr Leahy was properly observed on these dates.

[35] There are two level 3/4 observation sheets for 8 November 2012 providing different information. On examination, one of the observation sheets had been misdated and actually relates to 9 November 2012.
[36] An entry in the electronic care notes for 3.00pm on 12 November 2012 says Mr Leahy was nursed on level one observations. This appears to be an error as the observation records show he was nursed on level 2 observations.

The level 1 observation sheet for 15 November has been provided. It consists of hourly timeslots which are initialled when patients are sighted. Staff have initialled the timeslots when Mr Leahy was observed. As the exact time he was seen is not recorded, we cannot tell how often he was observed: he could have been seen twice in 10 minutes and then not been observed for up to two hours.

The last timeslot initialled for Mr Leahy on 15 November was 10.00–11.00am. The Health Care Assistant (HCA) carrying out general observation that morning did not initial the 11.00-noon timeslot. According to NEP's SI panel investigation report, the HCA was told Mr Leahy was in a review meeting. The HCA looked into a room and established that a review was taking place but did not actually see Mr Leahy. The report indicates that the last time anyone recalled seeing Mr Leahy on the ward was around 11.00am. Mr Leahy was found in his room at 12.04pm. The records do not show Mr Leahy was observed hourly on 15 November, in line with NEP's *'Inpatient observation and engagement'* policy.

Next we consider Ms Leahy's complaint about how staff engaged with Mr Leahy. Ms Leahy told us there was *'next to no evidence'* in the care records of any engagement with him.

NEP's *'Inpatient observation and engagement'* policy states that there should be positive engagement with patients twice per shift by the nurse/clinician allocated to them for that shift.

Our Mental Health Nursing Adviser said that the daily entries in the electronic care records provide detailed accounts of the interaction and engagement staff (including nurses, doctors and HCAs) had with Mr Leahy on each day of his admission. The records describe Mr Leahy's presenting mental state and his behaviour in detail, and demonstrate frequent engagement with him.

However, the observation records often only state Mr Leahy's location or observed behaviour, and do not demonstrate meaningful engagement. Our Mental Health Nursing Adviser said that observation is not merely an exercise in watching a patient and making a record of where they are. He added that using a minimum of words that do not describe engagement with the patient or their mental or physical status is poor practice. For example, where the observation records state *'asleep'*, our Mental Health Nursing Adviser said that detailed and accurate information should have been recorded such as '*asleep in bed, breathing noted*', or *'verbal response elicited, says he is ok'*.

In summary, although the care records provide some evidence that staff engaged positively with Mr Leahy, the observation records we have seen do not demonstrate adequate engagement. In addition, the evidence shows staff did not complete Mr Leahy's observations in line with the level prescribed on 9 November, and his observation level was reduced on 13 November without discussion with the MDT. The way staff carried out level 1 observation on 15 November did not ensure Mr Leahy was checked every hour. The standard of care in respect of observation

and engagement fell so far below the requirements of NEP's *'Inpatient observation and engagement'* policy that it amounts to service failure.

## Risk assessment and management

Ms Leahy complains staff did not carry out a full and appropriate risk assessment which took Mr Leahy's history and all the relevant risk factors into account.

Guidance from the Royal College of Nursing (RCN)[37] says that nursing staff should manage risk, be vigilant about risk, and help to keep everyone safe in the places they receive health care. Guidance from the Royal College of Psychiatrists (RCP)[38] states psychiatrists must '*be competent in evaluating and documenting an assessment of clinical risk, considering harm to self, harm to others, harm from others, self-neglect and vulnerability'*. Our Psychiatrist Adviser said both medical and nursing staff should contribute to patients' risk management plans.

NICE guidelines on the management of self harm[39] say health professionals should undertake an integrated and comprehensive assessment of a patient's needs and risks. The factors that should be considered when assessing patient risk include:

- any psychiatric illness and its relationship to self-harm,
- unpleasant affective states or emotions,
- changes in significant relationships, and
- co-existing risk-taking or destructive behaviours such as exposure to unnecessary physical risks, drug misuse or engaging in harmful or hazardous drinking.

All of these risk factors were present in Mr Leahy's case, so they should have been fully considered. In order to reduce the risk of harm to Mr Leahy, staff should have developed a risk management plan to address each of the risks identified.

Our Mental Health Nursing Adviser said there was some evidence of risk assessment and risk management planning in Mr Leahy's records, but how complete and comprehensive it was varied. Entries in the electronic risk assessment records for 7, 8 and 9 November identify the key risks of neglect, suicide, aggression/violence, and the risk of Mr Leahy making allegations of rape. There is little in the way of subsequent risk management to address the risks identified. Our Mental Health Nursing Adviser said he would have expected to have seen a more detailed analysis of each risk, together with actions to reduce the risk.

Our Psychiatrist Adviser was also critical of risk assessment and risk management. He noted that while the risk of *'suicidal ideas'* was recorded, this was not explored with Mr Leahy in any detail, and no plan was put forward to manage the risk.

[37] Principles of Nursing Practice (RCN, 2010).
[38] Good Psychiatric Practice, 3rd Edition (RCP, 2009).
[39] CG133 Self-harm in over 8s: long-term management (NICE, 2011).

Our Psychiatrist Adviser said there were particular points when risk should have been considered including when staff decided to administer rapid tranquilisation, when Mr Leahy indicated he may harm himself, and when he was granted ward leave. A rapid tranquilisation form completed on 8 November does not mention risk. On 9 November, it is documented that Mr Leahy was threatening to kill himself *'if injected'*. There is no evidence to suggest staff took this threat seriously. The management plan noted on this date was for Mr Leahy to be given a depot injection (risperidone). On 15 November Mr Leahy's psychiatrist granted escorted ward leave. There is nothing documented to show that the psychiatrist asked Mr Leahy about suicidal thoughts or explored any other risks before this happened.

Ms Leahy has specific complaints about risk management on 15 November, the day Mr Leahy died. She complains about staff's response when Mr Leahy was reported to be in a distressed and agitated state after his ward review. She also complains about staff's failure to escalate an incident when Mr Leahy spat on the floor, to a charge nurse.

First, we consider what happened after Mr Leahy left his ward review. Ms Leahy told us about a witness who came forward in 2018. The witness reported seeing Mr Leahy in an agitated state, threatening to harm himself. Ms Leahy told us the witness alerted nursing staff who failed to respond.

When we interviewed the witness, they told us they saw Mr Leahy leaving his ward review on the morning of 15 November. They could not remember the exact time. They said Mr Leahy left the room where the review had taken place, walked a short distance down the corridor to the staff office, hit the wall outside with his hand and stated *'I'm going to kill myself'*, before moving down the corridor towards his bedroom. The witness said they were in an area where Mr Leahy would have had to pass by again to access the garden. The witness said they were in that area for one and half hours but did not see Mr Leahy pass.

The witness told us they were alarmed by the tone of Mr Leahy's voice. Shortly after the incident, they went to the staff office and spoke to a nurse about what they had seen. According to the witness, the nurse replied: *'He's all talk'*. To the witness' knowledge, no-one went to check on Mr Leahy. The witness said other staff members were in the office at the time. The witness could not remember who was there but recalled that they were talking about the decision to grant ward leave to Mr Leahy.

The witness also told us about a conversation they had with a manager later that day after Mr Leahy had been found [unconscious in his room] [redacted]. They said they told the manager about what they had seen Mr Leahy do, and their subsequent conversation with the nurse. The witness told us the manager stated: *'Shut your mouth and don't say anything'*.

We interviewed the nurse and the manager to whom the witness referred. The nurse told us they did not recall anyone raising concerns about Mr Leahy on 15

November. The nurse said the information the witness gave about the conversation with them was untrue. The nurse said that if such a concern had been raised about Mr Leahy, action would have been taken: the incident would have been documented, Mr Leahy's risk assessment would have been updated, his observations levels would have been reviewed, and his case would have been discussed with a doctor with a view to admitting him to the Psychiatric Intensive Care Unit (PICU). The nurse did not recall having the conversation reported by the witness on any other day during Mr Leahy's admission.

The nurse also told us they were away from Galleywood Ward for part of the morning on 15 November attending a medicines management meeting. The nurse could not remember what time the meeting started, but recalled the alarm had sounded a few minutes after they returned to the ward office. In a written statement dated 15 November 2012, the nurse indicated they were at the meeting from around 10.00am to around 11.55am.

The manager told us he had no direct involvement in routine patient care. The first time the manager became involved in Mr Leahy's case was when the alarm sounded on 15 November 2012. The manager was not based at the Linden Centre but was there to attend a meeting. The transcript of an interview conducted in January 2013[40] indicates this was the medicines management meeting that the nurse had also attended. The transcript says the meeting began at 9.30am and finished at 11.45am.

The manager told us they were not aware of any incident involving Mr Leahy outside the staff office, or of any concern being reported to the nurse about his mental state, on 15 November or on any other day during his admission. The manager explained that in such circumstances, they would have expected the nurse to check on Mr Leahy, complete a risk assessment and mental state examination, and ask a doctor to review him.

The manager said the conversation the witness reported having with them – about the nurse's failure to act - never happened. The manager said that if such a conversation had taken place, they would have made a note of it and addressed it with the nurse as part of a debrief, to identify learning. The manager was shocked by the witness's account of the conversation and told us they would not have responded in that way or used that language.

During the interview, the manager's representative expressed concern that the witness may have wrongly identified the person to whom they spoke. We asked the witness to describe the individuals they spoke to. The witness gave descriptions which matched the manager and the nurse and confirmed their names.

Faced with differing accounts from those involved, we considered other evidence to help us to establish what happened on 15 November, including Mr Leahy's

[40] The interview with the manager was conducted as part of NEP's internal investigation.

clinical records, interviews with other staff members and the electronic door entry data for the Linden Centre.

It is unclear from Mr Leahy's clinical records when the ward review on 15 November started. While the electronic care notes[41] say *'Matthew was seen in care review at 10.00am this morning ...'*, the handwritten record of the ward review is untimed. At the inquest, Mr Leahy's psychiatrist indicated that the ward review may have started around 9.45am and that it lasted for around 30 minutes. The transcript of an interview[42] with a junior doctor who also attended the ward review says they spoke with Mr Leahy, his CPN and a student nurse from 9.30am. A transcript of an interview[43] with Mr Leahy's CPN says Mr Leahy was *'... first up on the review due to start at 10 o clock'*. However, the CPN told us that he estimated that the ward review started at 9.30am and lasted around 30 minutes. The CPN said they spoke to Mr Leahy on his own for 20-30 minutes before the ward review began. The CPN said Mr Leahy then indicated he may go outside to smoke. In the event he did not do this and the review started.

So, there is a lack of clarity about when the ward review started: we have varying accounts of it starting at 9.30am, 9.45am or 10am. Neither do we have a clear account of how long it lasted or when it ended. The psychiatrists and the CPN indicate it lasted around 30 minutes, but we also know that two of the doctors who were present at the review were moving around the Linden Centre between 9.48am and 9.55am[44]. This could be due to the meeting not yet having started, it having started and ended, or them having left the meeting early.

The records for Mr Leahy's ward review on 15 November refer to medication, housing issues, escorted ward leave, his sleeping pattern and his wish to give up cannabis. It is documented that Mr Leahy still believed he had been raped, but that he did not seem to be distressed by his *'delusional thoughts'*. Nothing is documented to indicate Mr Leahy left the ward review in an agitated or distressed state.

Notes made by the CPN at the time say Mr Leahy's mood seemed slightly flat, but he appeared 'devoid of anger' during the review and was *'composed throughout'* the time they spent together. The witness' account – of Mr Leahy hitting the wall and stating that he was going to kill himself - does not fit with the CPN's recollection of Mr Leahy's manner during, or on leaving, the ward review. However, the CPN also told us that he would not have been surprised if Mr Leahy had acted in this way.

The CPN told us that when the ward review ended, Mr Leahy left the room stating that he was going to the garden to smoke. The CPN said they joined Mr Leahy a few minutes (and no longer than ten minutes) later. Planning to escort Mr Leahy on ward leave the next day, the CPN took Mr Leahy's mobile phone number and called

[41] Written in retrospect at 3.57pm.
[42] Conducted in 2013 as part of NEP's investigation.
[43] Conducted in 2013 as part of NEP's investigation.
[44] Based on electronic door entry data.

him at 10.19am to check he had entered it in his phone correctly. The CPN could not be sure at what point during the conversation the call was made but thought it may have been two thirds to three quarters of the way through. The CPN estimated that the conversation in the garden lasted ten minutes, however it could have been as short as five minutes. This suggests Mr Leahy left the ward review a few minutes after 10am. The CPN told us they left Galleywood Ward directly after this conversation[45].

We also interviewed a student nurse and a second nurse who had attended Mr Leahy's ward review on 15 November. The student nurse told us Mr Leahy appeared happy and in agreement with the matters discussed during the ward review. However, she described him as having a *'poker face'*, suggesting that he may not have been showing his true thoughts and feelings. The student nurse recalled that Mr Leahy was smiling and laughing at times when this was not appropriate. The second nurse told us Mr Leahy was calm and cooperative during the review and agreed to have a depot. Neither nurse indicated that Mr Leahy showed any signs of agitation during the review, nor were they aware of any concerns about his mental state that morning.

Data from the electronic door entry system provides further evidence about staff's whereabouts in the Linden Centre on 15 November. It shows the nurse entered the staff room on Galleywood Ward at 9.47am. We do not know how long the nurse remained there but they used their access card to exit a door from a corridor at 10.00am before returning through the same door at 10.02am and leaving the ward via the main entrance less than a minute later. The nurse returned to Galleywood Ward at 11.35am. This is consistent with their account of being off the ward for part of the morning attending the medicines management meeting.

Door entry data for the manager shows his access card was not used between 9.53am and 11.30am. This fits with his attendance at the medicines management meeting. The manager last used his access card in the Linden Centre at 4.38pm. The manager told us he had stayed at the Linden Centre that afternoon, helping to arrange support for patients and staff, and contacting Mr Leahy's father.

We have not been able to obtain door entry data for Mr Leahy or his CPN to provide any further clarification about the timing of the events on 15 November. Based on what EPUT told us, the CPN did not have a personalised access card and may have used a visitor or temporary card. There is evidence that visitor and temporary cards were used on 15 November. EPUT was unable to tell us who these cards were assigned to as records are only retained for three years.

EPUT told us there was a separate access system for patient bedrooms. Unless data was downloaded, the system only retained records of around 100 transactions. EPUT could not locate any data for Mr Leahy's bedroom door, and was unable to tell us whether data had ever been downloaded.

[45] The notes the CPN made at the time say this was at approximately 10.25am.

Having considered all the available evidence, we do not have a clear picture of what happened on 15 November in respect of the specific conversations the witness reports. We have differing accounts from the individuals who came into contact with Mr Leahy that day. The witness' account[46] of Mr Leahy's demeanour and movements is not consistent with the accounts of staff present during the ward review, including Mr Leahy's CPN who was with him before, during and after the review. The witness indicates Mr Leahy left his ward review in an agitated state, before heading to his bedroom. The CPN's account indicates Mr Leahy left his ward review in a calm state and went to the garden where he was seen in a similarly calm state minutes later. The timing of the CPN's meeting with Mr Leahy is based on objective data from their mobile phone call log.

Significantly, as we do not know when the ward review started and ended, we cannot establish whether the nurse was on the ward at the time the witness says they spoke to them. If Mr Leahy left the ward review before 10.00am, there was opportunity for that conversation to have taken place. From 10.02am onwards, the nurse would not have been on Galleywood Ward so could not have spoken with the witness. The manager was present at the Linden Centre on the afternoon of 15 November. Therefore, there was opportunity for the witness to speak to the manager. However, we have conflicting accounts from the witness and the manager about whether this conversation took place, and no additional evidence to support either version of events.

Taking all of this together, we cannot reconcile the various accounts of what happened on 15 November and the conversations reported by the witness. Consequently, we cannot say, even on the balance of probabilities, that Mr Leahy was in an agitated state on the day of his death and that staff failed to respond.

Turning to the spitting incident, Ms Leahy complains that no-one informed a charge nurse when Mr Leahy spat on the floor in front of a second CPN around an hour before he was found in his bedroom. Our Mental Health Nursing Adviser said the incident should have been formally reported in line with NEP's incident reporting procedure. It could then have fed into Mr Leahy's patient risk assessment.

The second CPN's interview[47] transcript indicates that the incident happened around 11.00am on 15 November. According to the transcript, Mr Leahy approached the entrance to the room where the second CPN was speaking with another patient and, without speaking, spat on the floor between them. The transcript says the second CPN perceived Mr Leahy's actions to be a *'gesture of contempt'* and reported the incident to a staff nurse.

[46] Despite repeated attempts, we have been unable to speak to the witness to clarify some aspects of their account.
[47] Conducted in 2013 as part of NEP's investigation.

The staff nurse's interview[48] transcript states that they intended to pass the information on. The staff nurse recalled speaking to someone[49] but could not remember who, or the outcome of the conversation. The staff nurse was newly qualified and the incident took place during her first week on the ward. The staff nurse did not have access to NEP's electronic records system at the time and had not been trained how to use it.

Our Mental Health Nursing Adviser said it is not possible to say whether the incident had any significance to Mr Leahy's clinical presentation, his mental state at the time, or the risks presented. He noted that Mr Leahy could have spat on the floor because he was feeling angry. Alternatively, it could have been a cultural behaviour, or it could indicate that he was experiencing excessive salivation as a side effect of the medication he was taking.

Given that the second CPN perceived Mr Leahy's behaviour as a hostile act, we consider they should have properly documented and reported the incident. Instead of doing this, the second CPN relayed the details to another nurse, who was unable to access the electronic system to record the incident in Mr Leahy's care notes.

In summary, based on the evidence we have seen, we are unable to say that Mr Leahy was in an agitated state on the day of his death and staff failed to act. While we are unable to say NEP failed Mr Leahy in respect of this specific point, we find that the overall assessment and management of risk during his admission was not sufficiently rigorous in that staff did not fully consider all the known risks to him, and did not develop an adequately robust risk management plan. We also find that staff failed to take appropriate action in response to the spitting incident that occurred around an hour before Mr Leahy was found on 15 November. The failings in respect of the assessment and management of risk are all the more significant since Mr Leahy was at the Linden Centre due to concerns about his welfare and the risks he posed to himself and others. Those risks should have been properly assessed and managed. What happened in terms of risk assessment and risk management fell far short of applicable guidance. That was significant and serious service failure.

[48] Conducted in 2013 as part of NEP's investigation.

[49] At the inquest into Mr Leahy's death, the staff nurse said they had informed a charge nurse about the spitting incident after Mr Leahy had been discovered in his bedroom.

## Management of environmental risks

Ms Leahy complains the fittings and fixtures in Mr Leahy's room were not *'fit for purpose'*, particularly [possible ligature points] [redacted].

Our Mental Health Nursing Adviser said risks present in the ward environment should be reduced through health and safety risk assessments, safe systems of work, and patient risk assessments/risk management plans. However, he noted that ligature points can never be entirely eliminated.

Information that NEP provided to Ms Leahy indicates that the last annual patient safety environment audit before Mr Leahy's death, took place on 2 February 2011. The next audit took place on 19 November 2012. The timing of this audit – four days after Mr Leahy's death - suggests it was a response to the incident rather than part of a planned programme of safety auditing. The 21 month interval between the two audits does not demonstrate that adequate attention was being given to the management of environmental risks at the time.

The audit in February 2011 found a [high risk was posed by specific ligature points] [redacted]. The audit in November 2012 found a medium risk [posed by the same specific ligature points] [redacted]. We saw nothing to account for the reduction in the risk rating between the two audits.

Taking all of this into account, we find that NEP failed to adequately manage environmental risks. Mr Leahy had threatened to hang himself. [redacted]. The risk associated with [the ligature points] could have been mitigated through a thorough risk assessment and risk management plan, but as noted in paragraphs 125-127, these were not adequate in Mr Leahy's case. We find that what happened in relation to environmental risk assessment and management fell so far short of established good practice that it amounts to service failure.

## Mr Leahy's physical health and nutrition

Ms Leahy complains that NEP did not assess Mr Leahy's physical health or adhere to its physical health care policy. She also complains that NEP did not monitor Mr Leahy's nutrition.

First, we consider what NEP should have done to look after Mr Leahy's physical health. Our Mental Health Nursing Adviser said that patients' physical health should be monitored as part of the provision of effective, holistic health care.

In line with NEP's policy on physical health care, Mr Leahy should have had a full medical assessment and examination on admission, or as soon as possible following admission. If this did not happen, staff should have documented the reason and reviewed the situation on a shift by shift basis. Staff should have made at least one attempt to undertake a physical health assessment in each 24 hour period until it was complete. The assessment should have included details of past and present illnesses, a comprehensive review of symptoms, appropriate

blood tests, documentation of known allergies, a medication review, and a review of Mr Leahy's health status including smoking, substance use, diet and exercise.

NEP's admissions procedure also refers to the need for a physical examination including a baseline ECG, body mass index (BMI) measurement, venous thromboembolism screening, smoking status and any allergies. Staff should also have recorded a full physical description of Mr Leahy.

A *'patient pathway checklist'* completed on 7 November indicates that a physical examination was completed. However, elsewhere in Mr Leahy's records, it is documented that Mr Leahy refused a physical examination on admission, and there is no evidence of such an examination having been carried out. According to the records, Mr Leahy also refused to have his physical observations checked on admission.

Our Mental Health Nursing Adviser considered that in light of Mr Leahy's mental health, it would have been counter-productive for staff to have persisted with attempts to carry out a physical examination at this stage in his care. He noted that this may have distressed Mr Leahy further, and potentially worsened his mental state and/or increased the risk of aggression and self-harm.

We agree that it would not have been appropriate to press the issue in the face of continued refusal from Mr Leahy. However, the records show that he allowed staff to check his physical observations on 8 November after the rapid tranquiliser had been administered. Staff checked Mr Leahy's physical observations again on 10 November after he had an episode of dizziness. There is no evidence that staff took the opportunity to see whether Mr Leahy would also agree to a physical health examination on either of these dates. We saw no evidence that staff returned to the issue at any point during Mr Leahy's admission, including when he reported bleeding from the anal area on 9 November. We also saw no evidence that blood tests or an ECG were carried out, despite a plan to do them being documented in Mr Leahy's records.

Ms Leahy is specifically concerned about a lack of action by staff after Mr Leahy reported having cysts when he was admitted. Our Psychiatrist Adviser explained that within a multi-disciplinary inpatient team, the psychiatrist is primarily responsible for patients' physical health care. While Mr Leahy was detained under the MHA (and therefore unable to access his own GP), his psychiatrists should have managed his physical health problems and referred him for specialist care if necessary.

On 9 November a psychiatrist wrote in Mr Leahy's records: *'... told me that he has developed cysts that would need assessment at the GUM [genitourinary medicine] clinic*'. Our Psychiatrist Adviser said the records do not make it clear whether the psychiatrist felt Mr Leahy's report of cysts were real or a symptom of his mental illness. To explore this, the psychiatrist should have asked Mr Leahy to show him the cysts and suggested a full physical examination. There is no evidence to show the psychiatrist did this. We do not know how Mr Leahy would have responded if this had happened. But, we do know that that his concerns were real. His post mortem report says there was an inflamed epidermoid cyst to the right side of his scrotum.

Now, we turn to the monitoring of Mr Leahy's nutrition. Ms Leahy complains staff did not check Mr Leahy was eating properly during his admission despite a psychiatrist commenting that he had lost weight. She told us the report of Mr Leahy's post mortem examination said there was no food in his stomach.

NICE guidance[50] recommends that all hospital inpatients should be screened on admission to see if they need nutritional support. NEP's nutritional guidelines for mental health patients reflect NICE guidance. They say that an assessment of nutritional status should be undertaken to collect baseline data and identify patients who are 'at risk'. The assessment should include the patient's height, weight, waist circumference and BMI.

NEP's nutritional guidelines also contain a risk scoring card which takes account of the patient's current weight and BMI, weight loss in the last three months, appetite, ability to eat and retain food, and stress factors. A score of 4-5 indicates that staff should monitor the patient's nutrition. The guidelines say that a nutrition risk score should be calculated **'...ON ADMISSION and WEEKLY if service user's condition has changed'** (original emphasis). The guidelines also include a 'nutritional care flowchart' which indicates that staff should monitor food and fluid intake for patients with a BMI of less than 20, poor nutritional intake, or weight loss over the last 3 months.

The records indicate that Mr Leahy refused to have his height and weight measured on the day of admission. His height (1.73m), weight (73.70kg) and BMI (24.60)[51] are documented the next day. Mr Leahy's BMI was well within the normal range.

Despite this, there are several references in the records to Mr Leahy not eating regularly and looking like he had lost weight. The *'Discharge Summary Part 1'* states: '*On admission Matthew reported a very erratic eating and sleeping pattern'*. It is noted in the electronic risk management records for 7 November that Mr Leahy had been neglecting his personal hygiene and dietary requirements and was believed to have lost a significant amount of weight. A CPA assessment dated 8 November states: *'Matt has not been attending to his overall dietary and hygiene needs independently he appears gaunt and thin in appearance, ... he looked like he had hoist [sic] a significant amount of weight of late'*. In addition, the transcript of an interview with one of Mr Leahy's psychiatrists states '*... he would have lost at least a stone of weight since I had seen him previously, which was three or four months ago. There was so much evidence of self-neglect.'*

Our Mental Health Nursing Adviser said clinical assessment had not indicated that Mr Leahy's physical health status was compromised because of poor diet or a lack of nutrition, and that nutrition was not a priority clinical need in the first week of admission because the focus was on assessing and treating his psychosis. But, as staff had identified self-neglect as a problem, they should have monitored Mr Leahy's weight and nutrition during his admission.

[50] CG 32 Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition (NICE, 2006).
[51] In Mr Leahy's post mortem report, his weight is noted as 78.5kg (12st5) and height as 176cm (5'9").

While we acknowledge our Mental Health Nursing Adviser's view, there is clear evidence in the records of concern about Mr Leahy's nutrition and weight. Staff should have acted on these concerns in line with NEP's policy. In particular, staff should have completed a nutrition risk score for Mr Leahy. Based on the information noted above, it is likely that Mr Leahy would have scored one for unintentional weight loss in the last month, two for poor appetite, and one for having a mental illness. With a total risk score of four, his weight should have been checked every week and his food intake should have been monitored and documented.

In summary, we find that NEP did not take adequate care of Mr Leahy's physical health. There is no evidence that staff made further attempts to carry out a physical examination after Mr Leahy's initial refusal, despite opportunities arising on 8 and 10 November. We also saw no evidence that staff acted on Mr Leahy's reports of cysts. Despite signs of weight loss and Mr Leahy's report of erratic eating patterns, NEP did not adequately monitor his nutrition. Together, we find that this represents care which fell so far below the requirements of NEP's own policies that it amounts to service failure.

## Provision of psychological therapy

Ms Leahy complains Mr Leahy did not have any psychological therapy during his admission.

Our Mental Health Nursing Adviser noted that Mr Leahy was acutely mentally unwell when he was admitted, and that the focus of his care during the early days should have been on managing risk and establishing a therapeutic relationship with him. He explained that if psychological therapy had been provided too soon, it was unlikely to have been effective and could potentially have been counterproductive and worsened Mr Leahy's mental state. Psychological therapy should have been provided once his mental state had improved.

Having considered our Mental Health Nursing Adviser's comments, we do not find any omissions by NEP here. It was too early in Mr Leahy's admission to provide psychological therapy.

## Discharge planning

Ms Leahy complains discharge planning was inadequate.

In line with NICE guidance[52], changes in care (especially discharge) should be structured and phased and discussed and planned carefully with patients. Discharge plan should include actions to take in the event of problems arising after patients have left hospital. Family members and/or carers should be involved in discharge arrangements.

Our Mental Health Nursing Adviser said the process of planning for a patient's discharge and aftercare should start as soon as they are admitted to hospital. However, he noted that in light of how unsettled Mr Leahy was and because he

[52] NICE CG136 Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services (NICE, 2011).

had not been at the Linden Centre long, discharge planning would not have been the clinical team's priority.

Despite this, there is evidence that staff had started to complete the discharge planning paperwork. A psychiatrist had completed a comprehensive *'Discharge Summary Part 1'* form, and staff had also started to complete an *'Inpatient Leave Plan'*. This demonstrates they were thinking about Mr Leahy's eventual discharge.

Based on what we have seen, there is evidence of discharge planning which was commensurate with Mr Leahy's clinical presentation and the stage of his admission.

## Response to rape allegation

Ms Leahy complains that NEP dismissed Mr Leahy's rape allegation as part of his delusions and did not follow its *'Promoting Sexual Wellbeing with Service Users'* policy. She told us staff did not contact the police or carry out a capacity assessment when Mr Leahy reported being drugged and raped by staff.

NEP's policy states that all allegations of sexual abuse/sexual assault/rape by a professional, another service user or a third party should be reported under its incident reporting procedure and that the police should be informed.

The policy contains a flow chart setting out the procedure to follow, including a list of 'essential actions'. These include contacting the police and carrying out a capacity assessment relating to *'the nature of the alleged incident'*.

Mr Leahy's report of rape is documented in the care records on 9 November. This was not the first time he had reported being raped. On the day of admission, he said police were trying to rape him when they brought him to the Linden Centre. He had also said that staff had raped him during a previous admission.

The notes of the ward round (timed at 1.15pm) on 9 November state: *'He also believes that he has been raped in the last 2 nights!. When I tried to tell Matthew that its* [sic] *very unlikely as he has been on level 3 obs, he seemed fixated on this belief'*.

An entry in the electronic care notes timed at 8.11pm says: *'He then made an allegation that staff had raped him during night shift and he was bleeding from the anal area. He was challenged about this as he had not expressed this idea in the morning. He reports that she* [sic] *had not realised this until he started bleeding ... Matthew was seen by the advocate* [redacted] *as he had called the police and reported that he was raped'*.

NEP told us that the police attended the Linden Centre and spoke to Mr Leahy and staff but took no further action. No charges were ever brought against any member of staff.

From the records, it is unclear whether or how staff considered the application of NEP's policy. NEP told us it was unable to identify the precise reasons why staff

did not contact the police in line with its policy. But it referred us to extracts from the clinical records relating to Mr Leahy's delusions.

The fact that the care records say staff *'challenged'* Mr Leahy about the allegations, indicates that they felt his reports of rape were a symptom of his delusional disorder. Our Mental Health Nursing Adviser said in view of Mr Leahy's longstanding history, it was reasonable for staff to consider this. However, the wording of NEP's policy does not point to there being any discretion in this situation. Our Psychiatrist Adviser said that given what was stated in the policy, there was no justifiable reason why staff had not followed it.

EPUT told us subsequently that NEP's policy was followed, in that the police had been called, albeit by Mr Leahy rather than staff. While we acknowledge EPUT's view, it is unclear whether staff intended to contact the police but were pre-empted by Mr Leahy. The ward round where Mr Leahy first reported being raped is timed at 1.15pm. EPUT told us the police attended at 4.30pm. Without knowing the time of Mr Leahy's phone call, it is difficult to say whether staff would have called the police, had Mr Leahy not already done so himself.

We do know that Mr Leahy was challenged about his report of rape and told that it was unlikely that he had been raped. We saw no evidence that staff completed an incident form or a capacity assessment which were also requirements of NEP's policy. In addition, our Mental Health Nursing Adviser noted that it would have been important to address the issue of Mr Leahy's reports of rape through effective care planning and risk management. As noted in paragraphs 103 and 125, this did not happen.

In summary, we find that NEP did not take appropriate action in response to Mr Leahy's reports of rape. NEP's failure to follow its own policy, without any explanation, amounts to service failure.

## Resuscitation

Ms Leahy is concerned about the emergency response when Mr Leahy was found on 15 November. She told us a document from the ambulance service shows there was a delay before paramedics were able to enter the Linden Centre to reach him.

Our Metal Health Nursing Adviser explained that staff in an acute mental health setting would be expected to apply basic life support techniques and use a defibrillator, if available. In line with guidance from the Resuscitation Council[53], when Mr Leahy was found not breathing, staff should have called an ambulance, performed continuous CPR until the ambulance arrived, and used the defibrillator on the ward, following any instructions given by the device.

According to NEP's SI panel investigation report, Mr Leahy was discovered at 12.04pm when a student nurse who was carrying out general observations tried to

[53] Adult Basic Life Support (Resuscitation Council, 2010); The Use of Automated External Defibrillators (Resuscitation Council, 2010)

enter his bedroom. The student nurse provided a witness statement on the day of the incident. The statement says the student nurse was unable to open the bedroom door with their access key. The student nurse tried again and was able to open the door slightly but it felt heavy. The student nurse asked two HCAs for assistance. The HCAs managed to open the door, found Mr Leahy and raised the alarm.

The transcript of an interview with one of the HCAs states they opened the door to Mr Leahy's room, found him [unconscious] [redacted] and raised the alarm. It goes on to say that the HCA *'assisted'* Mr Leahy [redacted] and nursing staff arrived within seconds with scissors and oxygen. NEP did not interview the other HCA.

Our Mental Health Nursing Adviser has reviewed NEP's resuscitation policy, staff statements/interview transcripts and Mr Leahy's clinical records. He was satisfied that the emergency response was appropriate. When staff arrived on the scene they alerted their colleagues by activating their alarms. Other members of nursing staff and a doctor attended. Emergency resuscitation was commenced and an emergency ambulance was called. The records show staff used a defibrillator which advised them not to administer a shock. Attempts to resuscitate Mr Leahy continued until ward staff handed over care to the paramedics.

The ambulance service has confirmed that one unit was despatched to the Linden Centre, consisting of a paramedic and a senior emergency medical technician. The HCA's interview transcript says '... *We cleared the corridors, waited for the ambulance, the ambulance arrived, I took the green bag off the paramedic, straight down to the ward, gave the green bag there* ...'. This indicates that the ambulance crew were taken to Mr Leahy's ward without delay.

Ms Leahy is concerned about information in the ambulance service's CAD (Computer Aided Despatch) report. At 12.14pm, it is documented: '*PAT [patient] STOPPED BREATHING COULD NOT GET TO THE PAT, THERE WAS A TEAM OF DOCTORS DOING CPR I ASKED TO GET TO PAT 3 TIMES AND WAS UNABLE AND ADVISED A HCP* [Health Care Professional] *WAS DOING CPR'*. Ms Leahy fears this indicates the ambulance crew was refused entry to the Linden Centre, meaning that vital time was lost.

The CAD report shows the call from the Linden Centre was received at 12:08pm. Our Paramedic Adviser said that the despatch code assigned was a *'red 1'* response. This meant that an ambulance should have been on scene within 8 minutes. According to the CAD report, an ambulance was despatched at 12:10 and noted to be mobile at 12:11. It arrived on scene half a minute later. The overall time from the 999 call to the arrival of the ambulance was 2 minutes and 54 seconds.

Our Paramedic Adviser explained that while the ambulance was on its way, the call handler from the ambulance service would remain on the line taking further details from the caller and giving instructions, for example on how to administer CPR. The notes on the CAD report indicate that the call handler asked the caller to

get near to the patient so that the caller could provide updates about Mr Leahy's condition to the call handler, and so the call handler could give advice to the caller. The notes indicate that the caller was telling the call handler that health care professionals were already administering CPR so they were unable to get to the patient.

CCTV footage from the Linden Centre shows the ambulance crew arriving. There is no evidence of any delay before the crew access the building. At 12.13pm the crew can be seen entering the Linden Centre. They go through the reception and are met by staff who take them to the ward.

The ambulance crew have documented on the *'patient care record'* (PCR) that they were on the scene [at the Linden Centre] at 12.13pm and with Mr Leahy at 12.14pm. The first recording of Mr Leahy's vital signs is also documented at 12.14pm. The crew noted on the patient care record that ward staff were performing *'good effective CPR'* when they arrived.

Our Paramedic Adviser explained that the timings on the CAD report are generated automatically. The time on-scene is also generated automatically when the ambulance is within 200 metres of the scene, and then written on the PCR by the ambulance crew. The ambulance crew manually record the time they reach the patient on the PCR. This is likely to account for the slight discrepancies between the timings on the CAD report and those recorded on the PCR.

In summary, while Ms Leahy's concern about the information on the CAD report is understandable, the evidence we have seen does not indicate that the ambulance crew was delayed. An ambulance was despatched promptly and arrived within 3 minutes of the 999 call. The crew were with Mr Leahy within a minute of their arrival at the scene and started assessing him immediately.

Ms Leahy is also concerned that NEP has been unable to provide a 'print out' from the defibrillator that ward staff used during the attempted resuscitation of Mr Leahy. She told us that without a print out, there is no evidence the defibrillator was working.

Our Mental Health Nursing Adviser explained that defibrillators used in psychiatric units are usually completely automated. They give instructions to the operator about whether to administer a shock. EPUT has confirmed that the defibrillator on Galleywood Ward at the time was a *'Medtronic Lifepak 500'*. This type of defibrillator digitally records patient data including their heart rhythm and any shocks advised or delivered. The defibrillator can be connected to a printer, computer or modem to transfer the data and print a report.

There is no print out from the defibrillator in Mr Leahy's records. EPUT told us that the staff who carried out the SI panel investigation did not request a print out at the time. It also told us that the defibrillator was no longer in service and would have been destroyed. Therefore, it has not been possible for EPUT to obtain a print out now for the purpose of our investigation.

EPUT spoke to one of the investigators involved in the SI panel investigation who confirmed there was no indication that the defibrillator was not working. The evidence we have seen supports this. There is nothing noted in any of the staff interview transcripts to indicate there was a problem with the defibrillator. A psychiatrist who took part in the resuscitation wrote in Mr Leahy's records: *'Defib attached shock not advised, so we continued with CPR till ambulance arrived'*. This indicates that the defibrillator was working as it diagnosed Mr Leahy's heart rhythm and provided instruction not to administer a shock.

Finally, Ms Leahy has sent us papers from a meeting of NEP's board on 27 February 2013. She told us the papers show there was a problem with defibrillators on the mental health wards at the time of Mr Leahy's death. The papers state: *'CAS alerts – one alert relating to batteries for Heartstart defibrillators and EMBE*[54] *are checking these. These machines are to be replaced in the new financial year*.'

The information in the board papers relates to the Department of Health's Central Alerting System, which is used to issue patient safety alerts and send safety critical information to the NHS and independent health care providers. In this case, the CAS alert was to notify NEP of a potential problem with *'Heartstart'* defibrillators. NEP evidently had units of this type as the board papers state they were being checked and were due to be replaced soon. However, the alert does not necessarily mean that a problem had occurred with NEP's defibrillators. In any event, the defibrillator on Galleywood Ward was not the type that was the subject of the CAS alert.

In summary, the evidence we have seen indicates that ward staff responded correctly to the emergency situation and took all appropriate actions to try to save Mr Leahy's life. We saw no evidence that the defibrillator was not working properly.

## Staffing

Ms Leahy complains that Galleywood Ward was short-staffed, and that no senior member of staff was on duty on the day of Mr Leahy's death.

Our Mental Health Nursing Adviser explained that now, NHS organisations have to publish details about their staffing levels in advance. Staffing levels are monitored through contract review arrangements. This was not the case in 2012.

In guidance[55] in place at the time of Mr Leahy's admission, the RCN said it did not advocate a *'universal nurse-to-patient ratio'*, because the number and mix of nursing staff needed depended on a range of factors which had to be considered locally. However, it noted that national staffing recommendations existed for some specialist areas, such as intensive care and neonatal nursing. In respect of acute adult mental health wards, the RCN referred to a recommendation made in 1998 by the Royal College of Psychiatrists (RCP) which states: *'It is unlikely that a ward*

[54] EMBE is an external company NEP used to check and maintain its defibrillators.
[55] Guidance on safe nurse staffing levels in the UK (RCN, 2011).

*of 15 acute patients could be safely managed with less than three registered nurses per shift during the day and two at night, irrespective of other staff available*.' The RCP's recommendation was made 14 years before Mr Leahy's admission. We found no updated recommendation applicable at the time.

The CQC standard[56] that was applicable at the time did not set minimum staffing levels. Instead, it stated that care providers had to ensure that '*...at all times, there are sufficient numbers of suitably qualified, skilled, and experienced persons employed for the purposes of carrying on the regulated activity*'. The standard required care providers to show they had systems in place to determine and maintain adequate staffing levels.

EPUT has sent us a NEP board report which explains the criteria used to calculate the minimum number of staff and the skill mix required on NEP's mental health wards at the time of Mr Leahy's admission. These are:

- *'Number of beds on the ward or unit*
- *Clinical specialism*
- *Whether or not the unit was isolated or part of a larger centre with other wards and services on site*
- *The level of acuity/demand and turnover*
- *Volume of MHA activity*
- *The clinical perspective of professional leads and ward managers.*
- *Physical workload*
- *Complexity and severity of presenting patient group*
- *Senior nursing staff clinical judgement and experience of the care settings.'*

The report said that guidance had been produced to help staff to manage increased activity or acuity levels on the ward, and to determine whether more staff were needed to meet the clinical needs of the patient group. Our Mental Health Nursing Adviser confirmed that the information in the board papers showed that NEP had used appropriate factors to determine its staffing requirements.

NEP told us that the required skill mix for Galleywood Ward was one band 6 nurse, three band 5 nurses and 2 HCAs. EPUT told us NEP's records indicate that Galleywood Ward was one HCA short for the morning shift on 12 November and for the afternoon shift on 13 November. It told us staffing had been increased on other shifts possibly due to high activity levels or increased observations.

There is no evidence the ward was short staffed on the day of Mr Leahy's death. NEP said it had the full complement of staff plus an additional HCA, meaning the ward was overstaffed by one. NEP provided a copy of the roster for Galleywood Ward for 15 November 2012 which confirms the required staffing numbers were met. One of the band five nurses and two of the HCAs were agency workers. There was no ward manager in post at the time, but NEP told us the ward manager was not counted in the staffing numbers.

[56] Essential standards of quality and safety (CQC, 2010).

NEP's SI panel investigation report said staffing levels were adequate during Mr Leahy's admission; but it noted concern amongst nursing staff about the number of bank and agency staff employed and the variable quality of these individuals. The report said this, together with having two newly qualified nurses undergoing preceptorships[57], had led to nursing staff '*feeling stretched*'. Similarly, NEP's response to the coroner's regulation 28 report indicated no problem with staffing numbers[58]; but acknowledged that a significant percentage of the nurses working at the time were agency or bank staff.

In respect of Ms Leahy's concern about a lack of senior staff on duty, NEP told us that when a ward manager post is vacant, its usual practice was for a deputy ward manager to act up. If there was no-one suitable to do this, a member of staff would be transferred from a different ward. NEP was unable to provide any information about the ward management arrangements in place at the time of Mr Leahy's admission.

In summary, while we acknowledge the coroner's concerns and recognise NEP had identified issues about reliance on bank and agency staff, the evidence we have seen during our investigation does not indicate that Galleywood Ward was short staffed at the time of Mr Leahy's death. The records show staffing levels were met on 15 November 2012, albeit with some agency staff. That said, there is insufficient evidence for us to say whether or not appropriate interim arrangements were in place while the ward manager post was vacant.

## Record keeping

Ms Leahy complains staff did not keep full and accurate records of Mr Leahy's care during his admission at the Linden Centre.

NMC guidance[59] in place at the time sets out the principles of good record keeping. It says records should be clear, relevant, accurate and factual. Information should be documented about assessments and reviews undertaken, any risks or problems that have arisen and the action taken to deal with them, and the arrangements made for ongoing and future care. The guidance also states that records must not be falsified.

Our Mental Health Nursing Adviser reviewed the records relating to Mr Leahy's admission in November 2012. Much of the paperwork was in line with the NMC guidance including the '*patient pathway checklist'*, CPA referral form, the paperwork relating to Mr Leahy's detention under the MHA, and psychiatrists' assessments of his mental health.

Our Mental Health Nursing Adviser said the narrative entries in the electronic care records provided a good account of the day to day care provided to Mr Leahy including his clinical presentation and some information about the risks and issues

[57] A structured period of transition for newly qualified nurses.
[58] The information NEP reported at the time does not include what EPUT told us (based on its review of NEP's staffing records in 2018) about Galleywood Ward being one HCA short for two shifts.
[59] Record Keeping Guidance for Nurses and Midwives (NMC, 2010).

he presented with. An allocated bed space form and patient property form had been completed. A consent to treatment form had also been completed but Mr Leahy had refused to sign it. Similarly an *'agreement to treatment plan'* and an acceptable behaviour form had been created but not signed by Mr Leahy.

An initial care plan had been documented, and records relating to risk assessment/management were present. However, our Mental Health Nursing Adviser noted that the 'risk' section on some of the paperwork had either been left blank or was not fully completed, including on the inpatient leave form and the section of the electronic records relating to risk *('risk repository'*). Our Psychiatrist Adviser was also critical of the recording of risk assessment and risk management. He noted that Mr Leahy's psychiatrists had not used the electronic risk records, and the recording of risk in their hand written notes was superficial.

The clinical records include sections labelled *'HONOS*[60] *Assessments'* and '*PHQ9*[61] *Assessments'*; but both were left blank. An '*Essence of Care Assessment'* had also been left blank. The physical examination form had not been completed, but as discussed in paragraph 168, this was because the physical examination was not completed. There was no record of a mental capacity assessment.

NEP has acknowledged that one component of the records – Mr Leahy's care plan - was falsified. This is contrary to the NMC guidance and the matter has been considered by the NMC. EPUT has confirmed that some of NEP's records are missing, namely the paperwork setting out the rationale for lowering Mr Leahy's observation level on 13 November, and the general observation records for 13 and 14 November 2012.

Ms Leahy has specific concerns about the records relating to the PRN (as needed) medication Mr Leahy took. She told us that nothing is documented in his records about his response to the medication or possible side effects.

NMC guidance[62] in place at the time says that nurses must make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring the signature is clear and legible.

NEP's policy on PRN medication says that the behaviour which has led to the use of PRN medication and the effect must be clearly described in the patient's clinical notes/electronic care records. It also says that any side effects of PRN medication must be monitored.

Our Psychiatrist Adviser noted that some of the drugs Mr Leahy took such as lorazepam can be a drug of abuse so nursing staff should not give PRN medication to patients when they ask for it, without discussing this with the patient and documenting the reason for their request.

[60] Health of the Nation Outcomes Scales (HoNOS). A tool used to measure change in a person's mental health, well-being and social functioning.
[61] Patient Health Questionnaire. A tool used to assess patients' mood.
[62] Standards for medicines management (NMC, 2010).

Our Mental Health Nursing Adviser confirmed the records show nursing staff documented the rationale for giving PRN medication to Mr Leahy, and its effect, on some occasions but not on others. Mr Leahy was given PRN lorazepam on 8[63], 9 and 13 November. The rationale for administering lorazepam and its effect is recorded for 8 November. The records for 9 November say a psychiatrist requested PRN medication to help Mr Leahy calm down. During the evening shift, it is noted that Mr Leahy was settled. There is no rationale or effect documented for the PRN lorazepam given to Mr Leahy on 13 November. The records say *'Asked and was given PRN'*.

Mr Leahy also took PRN procyclidine and zopiclone. Procyclidine is used to counter the side effects of antipsychotic medication such as tremor and excessive salivation. Zopiclone is a sleeping tablet given on a short-term basis to help patients whose sleep is disturbed. As these drugs are routinely and commonly prescribed, and the reason for administration is self-evident, our Mental Health Nursing Adviser was not critical that the rationale and effect was not specifically noted in the records on every occasion they were given to Mr Leahy.

In summary, we find that some of NEP's records were completed to an adequate standard. In other areas, record keeping was not as robust as it should have been. Some paperwork was lost and Mr Leahy's care plan was falsified. Nursing staff did not record rationale and effect on each occasion when PRN lorazepam was given. In these respects, record keeping fell so far short of applicable guidance and NEP's policy that it amounts to maladministration.

## NEP's investigations

Ms Leahy complains that NEP did not carry out a robust investigation into Mr Leahy's death. She told us that NEP's 7 day report[64] was written by a member of staff who was involved in the falsisfication of Mr Leahy's care plan. She told us the subsequent SI Panel investigation report was inadequate and not fit for purpose.

The 7 day report was written by a manager, who was later found to have been involved in creating a care plan for Mr Leahy after his death. While we recognise knowledge of the falsification came about after the report was written, we can see why Ms Leahy questions the credibility of the report.

In respect of care planning, the 7 day report states: '*Throughout ML's contact with EIP services and in-patient care, care plans were done and reviewed regularly*'. This statement is factually incorrect. During Mr Leahy's final admission, his care plan was not updated until after his death. The 7 day report does not demonstrate that NEP was working in line with guidance from the NPSA[65] which emphasises the importance of NHS organisations being open and truthful when things go wrong.

[63] For the purpose of rapid tranquilisation.
[64] An initial report prepared within 7 days of an incident which is used to decide whether further investigation is needed.
[65] Being Open (NPSA, 2009).

Turning to the SI panel investigation, Ms Leahy has a number of concerns. These include whether appropriate staff were involved and whether they were trained for the role, the methodology used, and whether the family were sufficiently involved. She also has concerns about the SI panel report itself: she said it was not sufficiently comprehensive, it took too long to complete, and it was not signed.

## Make up of the panel, methodology and family involvement

NEP's incident reporting policy states that SI investigation panels should be chaired by a senior clinician and include at least two other clinicians or social care professionals, all of whom should be trained in root cause analysis (RCA).

EPUT has confirmed that the panel that investigated Mr Leahy's death consisted of a chair and a panel member. Both had received training in RCA. EPUT told us a third panel member had been identified; but this person had been unable to *'commit to the investigation'*. Based on this information, NEP did not follow its policy in respect of the make-up of the panel.

In terms of the methodology used, the SI panel investigation report states that the investigation was based on the '*principles of root cause analysis'*. The report does not explicitly refer to any root causes or contributory factors. But, its content indicates that NEP attempted to identify care and service delivery problems, and the possible underlying causes such as high activity levels on the ward and a shortage of permanent staff. The overdue environmental audit is not mentioned in the report. This is a further possible contributory factor so it should have been considered. In addition, the section of the report which explores how Mr Leahy died states that the family raised concern about [a specific ligature point] [redacted]. This wording gives the impression that the concern about [the ligature point] [redacted] originated from the family rather than through the process of RCA. NEP requires SI panel members to be trained in RCA, but the report indicates that insufficient regard was had for identifying root causes and contributory factors.

Ms Leahy is also concerned that the investigators did not visit the room at the Linden Centre where the incident occurred, or interview all of the staff who found Mr Leahy.

Guidance from the National Patient Safety Agency (NPSA)[66] indicates that a site visit *'may'* help the investigation team to establish whether the physical environment contributed to an incident. NEP's SI panel investigation report does not indicate whether a site visit took place. But, it is evident from the content of the report that the investigators knew how Mr Leahy was found, and that [a known ligature point] [redacted] had been used. Given what the guidance says and what the investigators already knew, we do not regard any failure to do a site visit as a significant flaw in the investigative process.

[66] Independent investigation of serious patient safety incidents in mental health services: Good practice guidance (NPSA, 2008).

Online resources from the NPSA[67] indicate that information should be sought from personnel involved in an incident and other witnesses. Three members of staff witnessed the discovery of Mr Leahy: a student nurse and two HCAs. The student nurse provided a witness statement on the day Mr Leahy was found. NEP interviewed the student nurse and one of the HCAs as part of its SI panel investigation. The HCA's interview transcript indicates that they took the lead role in raising the alarm and obtaining assistance for Mr Leahy. For completeness, the second HCA should also have been interviewed. NEP was unable to tell us why this did not happen.

With regard to family involvement, Ms Leahy told us she was not able to contribute to the terms of reference for the SI panel investigation. There is nothing in NEP's policy or the NPSA guidance in place at the time that indicates family members should contribute to the terms of reference for investigations into patient safety incidents. Nevertheless, it would have been helpful if NEP had discussed the terms of reference with Ms Leahy to ensure she knew which issues would be covered by the SI panel investigation, so that she could explore alternative avenues for addressing any concerns which would not be addressed through this process. Such action would have been *'customer focused'* in line with our Principles of Good Administration.

NEP's policy does state that service users and carers should be encouraged to participate in investigations, and that they should be offered meetings to discuss draft and final reports. EPUT told us that Ms Leahy was involved in the SI panel investigation and that this was noted in the report. Besides the concern about [ligature points] [redacted], the evidence we have seen does not show what, if any, information Ms Leahy contributed to the investigation or how that had been taken into account.

Neither is it clear what opportunities Ms Leahy had to discuss the draft report. The report states that the panel met with her on 16 January 2013 (when the report should have been in draft). We know from correspondence provided by Ms Leahy's solicitors that a second meeting took place in May 2013. That correspondence shows the purpose of the second meeting was to allow Ms Leahy to ask questions about the report, which by that point would have been finalised. The solicitor's letter documents Ms Leahy's concerns about inaccuracies in the report including what is said about how old Mr Leahy was when his parents separated, whether he had texted or phoned his uncle on the day he was admitted to the Linden Centre, and the time he was last seen before his death. The solicitor's letter indicates that Ms Leahy was also unhappy about the *'hypotheses'* for Mr Leahy's death that were presented in the report. The wording of the solicitor's letter indicates that this was the first time concerns were being raised, and that Ms Leahy had not seen a draft version of the report.

[67] https://improvement.nhs.uk/resources/learning-from-patient-safety-incidents/

### The SI panel investigation report

Ms Leahy told us that the SI panel investigation report did not cover all the relevant issues including the attempted resuscitation of Mr Leahy, and staff's actions when he reported being raped. She also told us that MHA discharge planning and Mr Leahy's physical health needs were not covered even though these points were specifically noted in the terms of reference. Because of these omissions, Ms Leahy believes the report's recommendations were ill-informed, flawed, and insufficient to address problems at NEP. In particular, she noted that the report did not include a recommendation to address the issue of new staff being unable to log incidents on NEP's electronic records system.

The SI panel investigation report begins by setting out the terms of reference:

> *'1. To investigate the involvement of NHS Services in the care and treatment of*
>
> *Matthew Leahy following his death from hanging at the Linden Centre, on*
>
> *15 November 2012 in Chelmsford, Essex.*
>
> *2. To review the scope of Mathew Leahy* [sic] *involvement with Mental Health Services and the quality of his health and risk assessments.*
>
> *3. To consider the appropriateness of any care, treatment or supervision that may have been provided, planned or offered having regard to:*
>
> *i. His health and social needs*
> *ii. His risk assessment of potential harm to himself*
> *iii. Any previous psychiatric history*
> *iv. Any previous criminal involvement and relevant convictions*
>
> *4. The extent to which his care met statutory obligations considering in particular*
>
> *i. The Mental Health Act 1983 amended under MHA 2007*
> *ii. HSG (94) 27 Discharge planning guidance*
> *iii. CPA application*
>
> *5. To provide a written confidential report to the Executive Scrutiny Group citing the findings of the panel by 16 January 2012 making appropriate recommendations in the attached pro forma. Verbatim commentary from interviews of the panel, are not to be included in the final report.*
>
> *6. To investigate the facts of the case from the point of view of learning, and of ensuring best practice.'*

The report's findings include sections on Mr Leahy's diagnosis and medical treatment, his engagement with mental health services, risk assessments, risk and care plans (which also covers the allocation of a key worker), and observation levels. There are also sections on Mr Leahy's lifestyle, the manner in which he died, activity and staffing levels on the ward, problems with records storage, and staff support following the incident.

The report does not explore the administration of the rapid tranquiliser or how Mr Leahy's physical health needs were met during his admission in November 2012 (although it does refer to his physical health during a previous admission). As such, NEP does not seem to have done what it said it would do in terms of considering '*the appropriateness of any care, treatment or supervision that may have been provided, planned or offered having regard to... i. His health and social needs; ii His risk assessment of potential harm to himself*.'

Discharge planning is also not covered, despite being specifically included in the terms of reference. Mr Leahy was at an early stage in his care and treatment. It is understandable therefore why the investigators might not have considered the adequacy of discharge planning. But, NEP should have tailored the terms of reference to reflect the circumstances of Mr Leahy's case. Instead, it seems they were taken directly from an example in NEP's incident reporting policy.

The report does not cover the attempted resuscitation of Mr Leahy or the adequacy of staff's response to his reports of rape. Neither of these issues are explicitly mentioned in the terms of reference. But, as Mr Leahy had complained about bleeding from the anal area, this should arguably have been considered in relation to the care he received with *'regard to his health and social needs'*.

Although the report identifies many of the problems we found during our investigation, its conclusions do not reflect its findings. The report identifies failings in fundamental elements of care, including care planning, observation, the allocation of a key worker, and environmental risk management. Yet, it still concludes that overall the care and treatment provided to Mr Leahy was of a good standard. NEP has not shown that it acted fairly and proportionately here in line with our Principles of Good Administration: its conclusion was not proportionate, appropriate or fair.

The report makes a number of recommendations which were developed into an action plan. Our Mental Health Nursing Adviser said the actions described were positive steps which would help to prevent similar events in the future. However, he considered that many of the actions (such as those in respect of patient observation) were not SMART[68], and did not go far enough in terms of including specific actions for auditing operational practice, and for the training and supervision of staff. As the report did not fully meet its terms of reference in respect of considering the administration of the rapid tranquiliser or how Mr

[68] Specific, measureable, achievable, realistic and time bound.

Leahy's physical health needs were met during his final admission, no recommendations were made in these areas. NEP did not do enough to put things right or seek continuous improvement.

Ms Leahy is also unhappy about the timescale for producing the report. She told us NEP should have completed the report within 45 days but it actually took 70 days.

The 45 day timescale Ms Leahy refers to relates to NEP's minimum reporting standards to its lead commissioner. NEP's incident reporting policy states that within this timescale, NEP must provide its RCA and accompanying action plan to the lead commissioner.

At the time of Mr Leahy's death, the Mid Essex Primary Care Trust (the PCT) was the lead commissioner. Ms Leahy sent us a copy of an email which shows the PCT was notified of Mr Leahy's death on 16 November 2012. The PCT received the SI panel investigation report in January 2013 but requested *'additional information and assurance'* from NEP. When the PCT was disbanded at the end of March 2013, North Essex Clinical Commissioning Group (the CCG) continued to seek further assurance that NEP had learnt lessons and made improvements. The SI was not closed until 6 June 2014.

EPUT told us that NEP's SI panel investigation was scheduled to be completed by 16 January 2013; the report was finalised on 22 January; and received by the PCT by the deadline of 23 January.

Based on NEP notifying the PCT about Mr Leahy's death on 16 November and sending the report by 23 January, at face value NEP met the reporting timescale of 45 working days. However, the report and action plan were not sufficient to satisfy the PCT, and subsequently the CCG, that NEP had learnt from Mr Leahy's death and put adequate measures in place to prevent similar incidents in the future. The purpose of carrying out an SI investigation is to show learning and improve patient safety. NEP did not accomplish this within an appropriate timeframe.

Ms Leahy is also unhappy that NEP sent her an unsigned version of the SI panel investigation report. NEP's incident reporting policy does not specify that a signed copy of the report should be sent to families. EPUT told us that the report was not signed because it had been sent electronically. Ms Leahy told us she received the report by post and not by email.

We have conflicting information about how the SI report was sent. Even if Ms Leahy was sent an unsigned copy, we do not consider that would amount to maladministration, given that there was no specific requirement for a signed copy to be sent.

In summary, the evidence we have seen shows NEP took some steps to investigate Mr Leahy's death and that it identified many of the failings our investigation has found. However, overall we find that NEP's investigation was not adequate. Because of what has since been learned about its author, the 7 day report lacks credibility. The SI panel investigation did not fully meet its terms of reference.

NEP did not follow its policy in respect of the composition of the SI investigation panel, have sufficient regard for RCA or interview all the staff members present when Mr Leahy was found in his bedroom. The evidence we have seen does not demonstrate Ms Leahy was as involved as she should have been.

The conclusion of the SI panel investigation report (which stated that overall the care was of a good standard) does not reflect its findings, which identified problems in key areas of nursing practice during Mr Leahy's final admission, including problems with the management of his observations, a fabricated care plan, and confusion about his keyworker. The recommendations of the SI panel investigation were not sufficiently robust and comprehensive. While at face value NEP met its reporting timescales for the investigation, it failed to assure the PCT and CCG about learning and improve patient safety within an appropriate timeframe. We find that NEP's actions in respect of its investigations fell so far short of the applicable standards and its own policy that they amount to maladministration.

## NEP's responses to Ms Leahy's concerns

Ms Leahy complains that NEP did not provide adequate answers to her concerns about Mr Leahy's care. She told us that NEP continually promised answers to her questions, but none were forthcoming.

NEP told us that Ms Leahy did not lodge *'a formal complaint'*. However, it provided copies of correspondence from Ms Leahy which clearly set out her concerns about the circumstances of Mr Leahy's death and the adequacy of NEP's investigation. NEP should have considered the concerns Ms Leahy raised in line with our Principles of Good Complaint Handling.

Many of Ms Leahy's letters asked NEP to commission an independent inquiry into the circumstances surrounding Mr Leahy's death. In its responses to Ms Leahy, NEP said Mr Leahy's death had already been thoroughly investigated through its SI panel investigation, the police investigation, and the coroner's inquest. In these circumstances, it did not think an inquiry was warranted. NEP therefore gave reasons for its decision, in line with our Principles of Good Complaint Handling.

NEP told Ms Leahy it would reconsider her request for further investigation if any new evidence came to light. Ms Leahy wrote to NEP setting out what she saw as new information. She pointed to a number of issues including factual errors in the SI panel investigation report. On the whole, these seem to be minor discrepancies in the report's *'background'* section that would not, by themselves, draw into question the report's findings about the care Mr Leahy received.

Ms Leahy also referred to Mr Leahy's reports of being drugged and raped, and the fact that he had needle marks on his body and GHB in his system at the time of his death. The pathologist had already commented on the presence of GHB in Mr Leahy's post mortem report, which would have formed part of the evidence

considered during the coroner's inquest. There was no further explanation NEP could offer on this issue.

Ms Leahy's correspondence with NEP about the allegation of rape, the needle marks and the GHB implies that criminal harm had been done to Mr Leahy while he was under its care. In a letter to NEP dated 7 August 2015, Ms Leahy explicitly stated that she believed serious crimes had been committed. We can fully understand Ms Leahy telling NEP's Board, as she did in September 2015, that she wanted to know *'what really happened'* to Mr Leahy. But, her suspicion that Mr Leahy had been the victim of a criminal act was a matter for the police to investigate rather than NEP.

Similarly, Ms Leahy referred to issues such as evidence being destroyed by the police in error, and witnesses not being present at the inquest. These were also matters for the police and the coroner to address rather than NEP. NEP explained to Ms Leahy that it would co-operate and share information with the police and would make its records available should there be a criminal investigation in the future. NEP also offered to meet with Ms Leahy. We can understand Ms Leahy's frustration at feeling her suspicions were not being heeded, but NEP seems to have adequately explained that the issues being raised were about the decisions and actions of other agencies.

Other concerns that Ms Leahy raised related to forensic matters such as how Mr Leahy was found hanging [as well as other factors related to the ligature] [redacted]. Ms Leahy told NEP that she understood [specific details about the ligature] from the evidence given at the inquest [redacted]. She wanted to know how this could be, when the police had indicated [contradictory details about the ligature] [redacted]. As there are no details in the staff interview transcripts about [these specific details] [redacted], we can see that it would have been difficult for NEP to answer this question. However, it would have been helpful if NEP had explained the difficulty in responding to Ms Leahy.

Ms Leahy also expressed concern that NEP had not told her a second HCA had been present when Mr Leahy was found. She also said NEP had not interviewed or disclosed the name of one of the nurses involved in the fabrication of Mr Leahy's care plan, and had led her to believe this nurse was an agency worker when they were actually employed by NEP.

We have seen no evidence to suggest NEP sought to mislead Ms Leahy about the staff present at the time Mr Leahy was found, or whether they were permanent or agency staff. But, we have also seen no evidence that it provided any reassurance to her about this when she expressed concern. As noted in paragraph 254, NEP should have interviewed the second HCA as part of its internal investigation.

We would not have expected NEP to disclose the names of staff involved in the fabricated care plan to Ms Leahy. However, it should have taken appropriate action to address their actions. It did this. In a letter to Ms Leahy's MP dated February 2015, NEP confirmed it had taken disciplinary action against the staff members involved and referred them to the NMC.

In May 2015 Ms Leahy met NEP to discuss her concerns. NEP wrote to Ms Leahy a few weeks later to respond to seven questions she had asked during the meeting. NEP said that questions Ms Leahy asked about staffing levels on the day of Mr Leahy's death and criminal records checks had been covered in a separate letter to her MP. It enclosed a copy of this letter, which provided a full response to her questions. In response to a question about the availability of CCTV, NEP explained that CCTV was in operation in public areas, and that the footage was only kept for 30 days. In 2018, EPUT located some CCTV footage showing the ambulance crew taking Mr Leahy from the Linden Centre on 15 November 2012. The CCTV footage did not provide any new information about the circumstances of Mr Leahy's death. Nevertheless, NEP should have told Ms Leahy that CCTV footage existed for that day.

During the meeting in May 2015 Ms Leahy also asked NEP for more information about what happened on the day of Mr Leahy's death. First, she wanted NEP to ask the two HCAs to clarify how they found Mr Leahy and how they removed him from the ligature point. NEP told her it had asked one of the HCAs to review his statement, but he had nothing further to add. It enclosed a copy of the HCA's statement. NEP did not mention the second HCA. NEP told us it did not interview the second HCA as part of the SI panel investigation. NEP should have acknowledged this to Ms Leahy. Doing so would have been open and honest in line with our Principles of Good Complaint Handling. NEP should also have explained what efforts, if any, were made to trace the second HCA in response to the questions Ms Leahy asked in 2015.

Second, Ms Leahy wanted the CPN involved in the spitting incident and a student nurse who was also present, to clarify what happened. NEP told Ms Leahy it had contacted the CPN. The CPN had reviewed their witness statement but was unable to add any further detail. NEP enclosed a copy of the CPN's statement. NEP said the student nurse confirmed they had no further detail to add.

Ms Leahy also asked why two doctors who were on duty at the time of Mr Leahy's death did not attend the inquest. NEP's response confirmed that the two doctors no longer worked at NEP. A witness statement from one of the doctors was enclosed with the response. NEP said it had written to both doctors to let them know an inquest was to be held into Mr Leahy's death but it received no response. NEP said it held a telephone number for one of the doctors but the number was not in operation. NEP noted that in any event, the coroner decided who should be called as a witness.

Finally, Ms Leahy asked whether any of the patients on the ward at the time had a *'forensic background'*. She asked NEP to notify the police if this was the case. In

response, NEP said it had contacted Essex Police and offered to assist with any further enquiries.

Ms Leahy sent us an audio recording of the meeting which indicates that NEP also gave an undertaking to carry out a wider review of incidents where patients had died or been harmed. We saw no evidence that this review happened.

It is clear from Ms Leahy's subsequent letter to NEP that she did not accept there was no more it could tell her about what happened to Mr Leahy. Ms Leahy also described how a former senior manager had [demonstrated how Mr Leahy may have died] [redacted]. The former senior manager told us they recalled that Ms Leahy wanted to understand the issue of patient safety [as well as management of specific environmental factors] [redacted]. They explained [this was not done to give a graphic demonstration of Mr Leahy's death] [redacted]. We accept that there was no intent to cause distress or offence. However, in light of the circumstances of Mr Leahy's death, we can see that this inappropriate and highly insensitive approach would have been extremely distressing for Ms Leahy. NEP apologised for this matter in August 2016.

In summary, while NEP could have provided fuller explanations in places and ensured that all agreed actions were followed up, we find that overall it made reasonable attempts to answer Ms Leahy's questions. NEP sent timely replies to her letters, explaining why it had decided not to commission a further investigation. Although the response about the HCA could have been more robust, we do not find that NEP refused to answer Ms Leahy's questions. The information she sought was primarily about the circumstances of Mr Leahy's death: many of the issues she raised were questions that could only have been properly explored by a police or forensic investigation. NEP explained this and offered to co-operate with any investigation the police decided to carry out. While NEP apparently provided inaccurate information about the availability of CCTV footage in 2015, we have seen nothing to indicate that it sought to deliberately mislead Ms Leahy. The CCTV footage located in 2018 provides no new information about what happened to Mr Leahy.

## What NEP said about safety improvements

Ms Leahy's final complaint is that NEP told her, her MP and the CQC that it had implemented all the recommendations in the SI panel investigation report, when this was not the case.

Ms Leahy sent us copies of letters NEP sent to her and her MP in February 2015. The letters state that NEP had made changes since Mr Leahy's death to improve patient safety and prevent similar events in the future. One of the letters says that the recommendations of the SI panel investigation had been fully accepted by NEP and fully implemented.

Guidance from the NPSA[69] sets out expectations about learning and follow up after serious incidents. It states that action plans arising from RCA should be implemented and monitored, and that arrangements should be in place for evaluating improvements in practice. Our Principles for Remedy note the importance of putting things right quickly and effectively.

NEP's SI panel investigation recommended a number of reviews including a review of the observation policy and the way level 1 observations were carried out, the way key workers were allocated to patients, how paper records were stored, and a review of [specific] equipment [redacted] in order to reduce the risk of hanging. Other recommendations included formulating a recruitment plan to address substantive staff vacancies, action to ensure that care plans were updated and used at handover and care reviews, and action to ensure observation levels were only lowered after discussion with the multidisciplinary team. We note that some of the recommendations NEP made after Mr Leahy's death were similar to some of those made in response to another patient death that occurred four years earlier.

NEP's action plan largely focused on reviewing written policies. As noted by our Mental Health Nursing Adviser (paragraph 265), it did not go far enough in terms of highlighting specific actions to be taken. In relation to the safety of the ward environment, the action plan referred to a review of [specific ligature points relevant to Mr Leahy's death] [redacted], but did not include any specific actions about how the findings of that review would be taken forward, other than to briefly state that a report would be submitted *'as to next steps'*. NEP's action plan did not include the review of [a specific item] [redacted] mentioned in the recommendations of the SI panel investigation report. EPUT told us it holds no information about why NEP did not carry this recommendation forward.

The records show NEP completed the majority of the actions on the plan by the end of April 2013. It did not make the substantive physical improvements to the Linden Centre until August 2015 (but as noted above, the action plan did not require it to). NEP told us that it then replaced [several ligature points] [redacted].

NEP explained to us that the delay in carrying out the work was due to the need to find a solution to reduce risks from [potential ligature points] [redacted], the limited number of such safety devices available at the time, and the time taken to trial different options and carry out the necessary work on an occupied ward. It told us that [relevant alarms] [redacted] became available in early 2015, and funding was secured in March of that year.

The timeliness of NEP's actions to address ligature points has been the subject of concern by the CQC. The report of an inspection in February 2015 (published May 2015) referred to Mr Leahy's case. The CQC said NEP had trialled options but had

[69] National framework for reporting and learning from serious incidents requiring investigation, NPSA, 2009.

not fully addressed the issue, although it had designated bedrooms as *'high dependency'* to mitigate risk. The CQC said its inspection found a number of high risk ligature points around the wards, which had not been identified by NEP's own safety audits. During the same inspection, the CQC also found a lack of detail in risk assessments and care plans. It required NEP to make improvements in these areas.

Similar issues came up again during the next inspection in August 2015, when the CQC rated NEP's acute psychiatric wards as '*inadequate*'. Among its findings, the CQC said:

- There was an unacceptable number of ligature risks on its wards. Risks were not being properly managed even though they had been highlighted during previous inspections.
- There had been 25 incidents involving the use of a ligature attached to a fixed object on the acute admission wards, with one incident occurring during its inspection. Self-ligature had caused two deaths during the last 12 months and similar deaths in previous years. The CQC said NEP had given assurances that changes would be made but it had not addressed concerns fully even though patients had died from self-ligature.
- There was an overreliance on bank and agency staff.
- Overall patient risk assessments were adequate; but those reviewed on one of the wards in the Linden Centre lacked detail.
- The majority of care plans were not personalised or holistic, and did not include patients' views.

The findings of the CQC's inspections in 2015 reflect some of our findings. NEP did complete reviews of its processes and the ward environment after Mr Leahy's death. But, it told Ms Leahy and her MP in February 2015 that it had made changes to improve patient safety and prevent similar events in future. The fact that the CQC was still finding problems that year indicates that the reviews had not led to timely, tangible and sustained improvements. What NEP told Ms Leahy was not evidence-based.

While NEP was right when it said the recommendations in the SI panel investigation report had been actioned, it should have been explicit that the actions taken had identified a need for further work which was still ongoing. Significant physical improvements were yet to be made; it was disingenuous for NEP to omit this information.

In summary, the evidence we have seen, including the findings of CQC inspections almost three years after Mr Leahy's death, does not demonstrate that NEP addressed all of the safety problems at the Linden Centre in a timely way. In this respect, NEP's actions fell so far short of applicable standards that they amount to maladministration.

## Summary of our findings

The evidence we have seen indicates that some elements of Mr Leahy's care and treatment, and NEP's responses to Ms Leahy's concerns reflected applicable standards:

- NEP followed the correct process when Mr Leahy was detained under the MHA.
- Medication was appropriately prescribed.
- It was appropriate in the circumstances not to provide psychological therapy.
- Discharge planning was adequate and commensurate with the stage of Mr Leahy's care.
- Staffing numbers were adequate at the time of Mr Leahy's death.
- Staff responded appropriately when Mr Leahy was found in his bedroom on 15 November 2012.
- NEP responded adequately to Ms Leahy's correspondence.

In other areas, we find NEP's actions fell so far short of applicable standards that they amount to service failure or maladministration. Specifically:

- De-escalation techniques were not considered or used before rapid tranquilisation was administered on 8 November 2012.
- Mr Leahy was not properly allocated a key worker, nor was his care adequately planned.
- Mr Leahy's physical health needs were not adequately looked after, including his nutrition.
- Staff did not always engage with Mr Leahy adequately.
- Mr Leahy's observations were not properly managed.
- The assessment and management of risk, including environmental risk, was not rigorous enough.
- Adequate action was not taken when Mr Leahy reported being raped.
- Clinical record keeping was not robust enough.
- Overall, NEP's investigation of Mr Leahy's death was not adequate.
- The conclusion of the SI panel report is at odds with its findings, and the recommendations are not sufficiently robust or comprehensive.

- The SI panel investigation failed to provide assurance that NEP had learnt from Mr Leahy's death and improved patient safety.
- NEP did not fully address all the safety problems at the Linden Centre in a timely way, despite indicating otherwise in correspondence to Ms Leahy and her MP in February 2015.

## The injustice to Ms Leahy

We have found service failure in many key areas of Mr Leahy's care. Knowing that Mr Leahy did not receive an adequate standard of care has caused significant and ongoing distress to Ms Leahy. At the point Ms Leahy came to us, she had no confidence that things had changed for the better because CQC inspections were still finding some of the same problems. This added to her distress and frustration.

We have found maladministration in respect of NEP's recordkeeping, its investigations into Mr Leahy's death, and the information provided to Ms Leahy about the extent of the safety improvements made. These issues have caused Ms Leahy further distress and frustration.

## Our recommendations

Ms Leahy is seeking an apology and financial redress in respect of the misleading information about safety improvements. She is also seeking assurance about action taken to help prevent a recurrence of what happened in Mr Leahy's case.

We have considered our recommendations in light of our Principles for Remedy. These state that where maladministration or poor service has led to injustice or hardship, the organisation responsible should take steps to provide an appropriate and proportionate remedy. It should also ensure complainants receive assurance that lessons have been learned, and an explanation of changes made to prevent maladministration or poor service being repeated.

We recommend that within two months of the date of our final report, EPUT should:

- write to Ms Leahy to provide a full and final acknowledgement of the failings identified in this report (see paragraph 307) and the distress this caused her;
- apologise for the distress caused by the information NEP sent in February 2015 about the extent of the safety changes made; and
- make a payment of £500 to Ms Leahy in recognition of the distress caused by the receipt of the inaccurate information.

In making recommendations to help prevent a recurrence of the failings we have identified, we have considered what actions have already been taken since the events. Although NEP had taken action since Mr Leahy's death to address some of the failings, the findings of CQC inspections indicate that they have not led to the tangible and sustained improvements Ms Leahy was seeking throughout the organisation. A CQC inspection of NEP's mental health wards, including the Linden Centre, in September 2016 found that the majority of patients had comprehensive and detailed risk assessments, and that NEP was using regular agency and bank staff to ensure consistency in patient care. However, the CQC still had concerns about safety on some wards. Matters specifically mentioned included the assessment and management of environmental risks, how NEP shared learning from incidents with staff, staffing levels, and record keeping.

A subsequent CQC inspection of EPUT's acute wards for adults of working age (not including the wards in the Linden Centre) in August 2017 found that the number of potential ligature points had reduced since 2015. But, problems were still being found with the recording of patient observations and risk assessment.

The most recent CQC inspection, and the first comprehensive inspection of EPUT following the merger, took place in May 2018[70]. The CQC rated EPUT as *'good'* overall, although it rated the safety[71] element as *'requires improvement'*. The inspection report said EPUT had *'increased the pace'* of patient safety improvements and had a robust governance framework in place. EPUT's acute psychiatric wards for adults of working age received an overall rating of *'requires improvement'*. The CQC found:

- The management of environmental risks had improved significantly, but safety risks including ligature points were still found on some wards.
- Not all patients had a detailed risk assessment.
- Lessons from incidents were not always identified or shared.
- While the vast majority of patient records contained an adequate care plan and physical health assessment, care plans did not always address patients' physical health needs.

The CQC required EPUT to make improvements to ensure all environmental risks were identified and mitigated against, and that staff complete detailed risk assessments for all patients. The CQC's findings suggest that while progress has been made over the years, further improvements still need to be made in some areas.

We recommend that, within two months of our final report, EPUT should:

- write to Ms Leahy to provide a detailed summary of the action that has or will be taken to help prevent a recurrence of the failings we have identified, together with any further action planned to address the ongoing concerns noted in the most recent CQC inspection in respect of its acute psychiatric wards. EPUT should also explain how it will measure and report on the effectiveness of these changes.
- send a copy of the above information to us.
- send a copy of our investigation report and the information sent to Ms Leahy to **NHS Improvement** and **CQC.**

[70] The CQC carried out a focused inspection of some of EPUT's services in November 2017. It did not rate the services but asked EPUT to make improvements in respect of ward ligature assessments, reducing ligature points, reducing the number of unfilled staff shifts, reviewing systems for sharing learning from SIs with ward staff, and reviewing processes for checking patient care plans and risk assessments were completed. At the time of the inspection in May 2018, EPUT had completed some but not all of these actions.
[71] When inspecting services, the CQC considers whether they are safe, effective, caring, responsive to people's needs, and well-led.

## Conclusion

This report sets out our findings on Ms Leahy's complaint. Based on the evidence we have seen; we have decided to uphold her complaint about NEP's actions and make recommendations to EPUT.

**Parliamentary and Health Service Ombudsman**

Citygate
Mosley Street
Manchester
M2 3HQ
United Kingdom

Telephone: 0345 015 4033

Textphone: 0300 061 4298

Fax: 0300 061 4000

Email: phso.enquiries@ombudsman.org.uk

www.ombudsman.org.uk

Follow us on:

If you would like this document in a different format, such as Daisy or large print, please contact us.

Published 10 January 2020