

BOARD PAPER HA06/037

Report of the Independent Inquiry into the Treatment and Care of Geoffrey Hodgkins

Executive summary:

On November 20th 2004 Geoffrey Hodgkins, a 37 year old long term mental health patient in the care of Portsmouth City Teaching Primary Care Trust, died after experiencing breathing difficulties during a period of restraint.

In accordance with HSG94(97) Hampshire and Isle of Wight Strategic Health Authority commissioned an independent inquiry into the care and treatment received by Geoffrey Hodgkins. The report of this Inquiry is attached.

In response Portsmouth City Teaching primary Care Trust has prepared a Strategic Action Plan (attached) through which its Board expects to be held accountable for implementing changes to its corporate governance, clinical governance, management arrangements and the involvement of patients and the public. This is supported by a detailed operational working schedule to assist implementation.

Actions requested:

1. The Board is asked to receive the Report of the Inquiry and its recommendations
2. The Board is asked to note the content of the Action Plan and ask the Executive Team to ensure that there are satisfactory processes in place to monitor progress against this and to identify and escalate exception reports

Aim(s)/objective(s) supported by this paper:

To publish the findings of an independent inquiry into the care and treatment received by a patient of the mental health services who died following a significant untoward event

To identify the lessons to be learnt from this incident and propose ways to reduce the risk of such events occurring in the future

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Date of paper:

October 2006

**Independent Mental
Health Enquiry
into
the Care and Treatment
received by
the late Geoffrey
Hodgkins**

Report commissioned by:

**Hampshire and Isle of Wight Strategic
Health Authority**

September 2006

Acknowledgement

The External Enquiry Panel would like to thank the family of Geoffrey Hodgkins and all members of staff from the Portsmouth City Teaching Primary Care Trust who gave their time to meet with the Panel. The External Enquiry Panel especially appreciated the openness with which individuals shared their views on the issues under debate as well as their personal and professional concerns relating to the tragic death of Geoffrey Hodgkins and their aspirations for generating organisational learning to reduce the risks of such an incident occurring in the future.

We highly value the welcome for the Panel which was expressed not only by representatives of the Senior Management Team but also by all members of staff whom we met.

The Panel is grateful for the full commitment given by all members of staff and the representative of the family to these interviews and the openness and frankness with which they shared their perspectives.

In order to carry out the review in an efficient and effective manner the Panel reviewed a number of documents which are identified in this report. To collect and organise comprehensive and changing sets of documentation and information as well as to liaise with a number of different individuals both within and outside the organisation is a task which can be unfamiliar and challenging. In this case the assistance was provided by the Director of Service and the PCT Facilities Receptionist, who most politely responded to all our requests for information, did all the preliminary work behind the scenes and organised the whole visit in a professional and courteous manner.

September 2006

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<i>Index:</i>	<i>Page</i>
Terms of Reference	6
Executive Summary	7 – 8
1. Portsmouth City Teaching Primary Care Trust	9 – 12
2. Geoffrey Hodgkins – The Service User	13 – 22
2.1 The period leading up to 19 th November 2004 inc. medical history	13 – 16
2.2 Chronological sequence of events on the 19 th and 20 th November 2004	16 – 20
2.3 The chronology of actions taken after the 20 th November 2004	20 - 22
3. Methodology	23 – 26
3.1 Documentation	23 – 24
3.2 Interviews	24 – 25
3.3 Report structure	26
4. Review of the policies, protocols, care pathways and procedures relating to the care of Geoffrey Hodgkins at the time leading up to and of the incident and assessment of:	27 – 34
• Their adequacy from a clinical perspective	
• The approaches taken to implementing them and assuring their implementation	
4.1 Review and assessment of the adequacy of policies, protocols, care pathways and procedures from a clinical perspective	27
4.2 Observation Policy	27 – 28
4.3 Substance Misuse/Mental Health Services Supervision Policy	28 – 29
4.4 Resuscitation Policy	29 – 30
4.5 Restraint and Rapid Tranquilisation Policy	30 – 31
4.6 Emergency Response Procedure etc.	31 – 33
4.7 The approaches taken to implementing policies, protocols, care pathways and procedures and assuring their implementation	33 - 34
5. Examination of the quality and suitability of Geoffrey Hodgkins' overall treatment, care and supervision in the context of:	35 - 41
• His actual and assessed health and social care needs	
• The actual and assessed risk of potential harm to himself or others	
• His previous psychiatric history including alcohol and drug misuse	
• Any previous forensic history	
• The appropriateness of the decisions made by the practitioners involved and the subsequent treatment and care provided	
5.1 Overall quality and suitability of treatment, care and supervision	35 – 36

5.2 Actual and assessed health and social care needs	36 – 37
5.3 Actual and assessed risk of potential harm to self and others	37 – 38
5.4 Previous psychiatric history including alcohol and drug misuse	38
5.5 Previous forensic history	38
5.6 Appropriateness of the decisions made by the practitioners involved	39 – 41
6. Examination of the extent to which Geoffrey Hodgkins’ Prescribed Treatment and Care Plans were relevant, adequate, documented, agreed with the patient, carried out, monitored and complied with at all times.	42 - 44
6.1 Examination of prescribed treatment and care plans	42 – 44
7. Examination of the extent to which the overall management of Geoffrey Hodgkins’ care, in the period leading up to the incident, and the incident itself complied with statutory obligations, the Mental Health Act Code of Practice, local operational policies and practice guidance and relevant guidance from the Department of Health including the Care Programme Approach and other relevant sources of best practice, including a review of:	45 - 50
• The policy and protocols of restraint used by the Trust	
• The extent to which the policies and protocols of restraint were followed	
7.1 Overall management of care	45
7.2 The PCT’s policy and protocols of restraint	45 – 46
7.3 Adherence to PCT policies and protocols on restraint	46 – 48
7.4 Risk management procedures and incident reporting	48 – 50
8. Examination of the overall quality of the collaboration, communication and effective working between all parties involved at the time of the incident and previously, as the Panel considers relevant.	51 - 52
8.1 Collaboration	51
8.2 Communication	51 – 52
8.3 Effective Working	52
9. Governance and accountability	53 – 74
9.1 Clinical Governance	53 – 55
9.2 Serious Untoward Incidents management	55 – 66
9.3 Governance	66 – 71
9.2 Liaison with the External Enquiry Panel	71 – 73
9.3 Audits	73 – 74
10. Organisational learning	75 – 77
10.1 Organisational learning	75
10.2 Audit of system changes resulting from the Geoffrey Hodgkins’ review	76
10.3 Creating organisational learning	76 – 77

11. Leadership and Commitment	78 – 84
11.1 Clinical and managerial leadership	78 – 80
11.2 Leadership and audits	80 – 81
11.3 Contact with the family	81 – 83
11.4 Bridging the reality gap	83 – 84
12. Conclusions	85 - 88
Bibliography	89
Glossary	90 – 92
Appendix A: Panel Composition	93 – 94
Appendix B: Declaration of Interest	95
Appendix C: Letter to the Panel from Bruce Hodgkins	96
Appendix E: Consolidated List of Recommendations	97 – 105

**External Enquiry into
The Death of Geoffrey Hodgkins on 20 November 2004**

Terms of Reference

1. The Panel will review the policies, protocols, care pathways and procedures relating to the care of Geoffrey Hodgkins at the time leading up to and of the incident and assess:
 - Their adequacy from a clinical perspective
 - The approaches taken to implementing them and assuring their implementation
2. The Panel will examine the quality and suitability of Geoffrey Hodgkins' overall treatment, care and supervision in the context of:
 - His actual and assessed health and social care needs
 - The actual and assessed risk of potential harm to himself or others
 - His previous psychiatric history including alcohol and drug misuse
 - Any previous forensic history
 - The appropriateness of the decisions made by the practitioners involved and the subsequent treatment and care provided
3. The Panel will examine the extent to which Geoffrey Hodgkins' prescribed treatment and care plans were relevant, adequate, documented, agreed with the service user, carried out, monitored and complied with at all times.
4. The Panel will examine the extent to which the overall management of his care, in the period leading up to the incident, and the incident itself complied with statutory obligations, the Mental Health Act Code of Practice, local operational policies and practice guidance and relevant guidance from the Department of Health including the Care Programme Approach and other relevant sources of best practice. This will include a review of:
 - The policy and protocols of restraint used by the Trust
 - The extent to which the policies and protocols of restraint were followed
5. The Panel will examine the overall quality of the collaboration, communication and effective working between all parties involved at the time of the incident and previously, as it considers relevant.
6. The Panel will, if appropriate, make recommendations for action in the light of the review. The recommendations will identify the responsibilities for taking action within the Fair Oak Service and/or by the Portsmouth City Primary Care Trust management. Any recommendations which relate to individuals will be shared with the individuals concerned in draft form together with those of the Panel's findings that support them to allow those individuals to comment on matters of accuracy.
7. The Panel will Report to the Hampshire and Isle of Wight Strategic Health Authority.
8. Portsmouth City Primary Care Trust will provide reasonable facilities for the Panel to undertake the review including the provision of any documents that the Panel considers relevant and the opportunity to interview any members of staff.

Revised 24 April 2006

Executive Summary

This External Enquiry into the death on 20th November 2004 of Geoffrey Hodgkins following an incident on 19th November 2004, whilst under the care of Portsmouth City Teaching Primary Care Trust (PCT), was commissioned in its final format in November 2005 by Hampshire and Isle of Wight Strategic Health Authority.

The composition of the External Enquiry Panel was agreed with the Hampshire and Isle of Wight Strategic Health Authority which formally appointed all the members of the Panel. The Panel was formed from specialists with expertise in mental health as well as in the areas of nursing and management of health services¹. Following an intensive and extensive review of relevant documentation made available to the Panel, it carried out a visit to Portsmouth between 23rd and 25th April 2006 to interview and take statements from the family of Geoffrey Hodgkins, staff and other parties with an interest.

The Panel is aware that its review will contain elements which will be painful for the family of Geoffrey Hodgkins to revisit but feels that it is in the interest of the family that full details are provided so that any recommendations suggested by the Panel will be based on findings which are transparent to all.

The Panel would like to use this opportunity to make the family aware that it was evident that the staff, who were familiar with Geoffrey Hodgkins, were very fond of him. They spoke warmly of him as an individual who, for most of his time as an in-patient, was a very gentle and friendly person, and who was always apologetic to staff after the occurrence of incidents over which he had no control.

The Panel has identified a number of critical issues relating to the provision of care given to Geoffrey Hodgkins prior to the 19th November 2004, to the management of the incident on the 19th November 2004 and to the way in which the PCT's internal review processes have dealt with the incident subsequently. The Panel has reached the conclusion that the tragic outcome of this incident was not a result of the deliberate actions by one or several individuals. The Panel was not able to draw any conclusion as to whether any different actions by individuals would have resulted in a different outcome. However, it is the view of the Panel that had those critical issues been appropriately considered and addressed the risks posed to Geoffrey Hodgkins would have been substantially reduced.

¹ See Appendix A for the Panel membership

The nature of the critical issues has required the Panel to consider the organisational and governance structures which have, in turn, highlighted a number of inadequacies. These further compounded the Panel's concern about the quality of patient care provided. The critical issues identified by the Panel primarily relate to:

- **Lack of adequate implementation of existing policies, procedures, care pathways including audit of compliance etc.;**
- **Lack of personalised treatment and care;**
- **Lack of consistent level of quality in the provision of care;**
- **Lack of comprehensive implementation, monitoring and audit of adherence to prescribed treatment and care plans;**
- **Lack of appropriate collaboration, communication and effective working;**
- **Lack of adequate governance and accountability arrangements;**
- **Lack of organisational learning;**
- **Insufficient leadership and commitment.**

The recommendations identified by the Panel in this Report will, accordingly, deal with specific recommendations linked to the Terms of Reference but will also identify recommendations relating to the broader organisational issues, which the Panel believes are relevant to both the care received by Geoffrey Hodgkins before and during the critical incident on 19th November 1004 and to patient care generally within the PCT.

The Panel acknowledges that its recommendations, designed to ensure clear and documented management, nursing and medical governance and staffing arrangements, which are essential to the provision of mental health services within the PCT, will have resource implications for the PCT. If accepted, they will also require the full support and commitment of staff within the PCT and especially dedication of senior management time. The PCT therefore should consider ways in which it can assure itself, service users and their carers/families that it is providing high quality, relevant and service user centred mental health services.

1. Portsmouth City Teaching Primary Care Trust

- 1.1 Portsmouth City Teaching Primary Care Trust (PCT) was established on 1st April 2001 and is geographically co-terminous with Portsmouth City Council boundaries. Its role is to commission and provide both primary care and a large range of community health services for the 191,000 residents of Portsmouth City in response to local needs.²
- 1.2 The city of Portsmouth is densely populated with areas of significant deprivation close to areas of relative affluence. The city is multicultural and has a number of small minority ethnic groups. The city was designated an associated Health Action Zone in January 2000 due to its pockets of poor health and deprivation.
- 1.3 The PCT comprises 28 general practices, ranging from single-handed to 7-partner practices, and employs around 1900 people. It has an annual budget of over £180 million.³
- 1.4 The PCT's work is driven by the local Health Improvement Programme (HIMP). The HIMP also underpins partnership working with the local authority on many shared agendas for health improvement and city regeneration just as it is involved in partnerships with the voluntary and private sector.
- 1.5 In 2004 the then Commission for Health Improvement (CHI) carried out a review of the PCT and although most of the 7 key areas were characterised by worthwhile progress and development it was not replicated across the whole organisation or not at strategic or planning level.⁴
- 1.6 The PCT is currently a 2-star trust.
- 1.7 Since April 2002 the PCT, with Portsmouth City Council Social Services Department, has jointly provided and commissioned adult mental health Services after the dissolution of Portsmouth & SE Hants Health Authority. Services are provided from a number of different premises across Portsmouth including St Mary's and St James's hospitals. The PCT is one of few PCTs in England that provide mental health services.⁵

² www.portspct.nhs.uk accessed on 20th April 2006

³ Portsmouth City Council/Portsmouth City Teaching Primary Care Trust *Job description Consultant in community psychiatry Portsmouth North*. Un-dated.

⁴ Portsmouth City Council/Portsmouth City Teaching Primary Care Trust. *Adult mental health Commissioning Plan. 2004/2005*. Version 19/04/06 p. 12

⁵ Healthcare Commission *Portsmouth City Teaching PCT Clinical Governance review*. July 2004 p. 6

- 1.8 The Adult Mental Health (AMH) Service provided by the PCT was, in 2003, awarded three stars in the NHS rating by the Healthcare Commission⁶ and a 'highly recommended' scoring by the Social Services Joint Review⁷, which the PCT considered was a reflection of the excellent partnership working across organisations (voluntary and statutory), staff, service users and carers. However, the Adult Mental Health Service moved to 2 stars in 2004 and to 1 star in 2005.
- 1.9 Of the population of 186,699⁸ covered by the PCT, 2821 (2.31% of the eligible population) were in 2004 registered with Adult Mental Health Services⁹ (an increase of 6% on 2003). In 1999 the Government published a ten-year strategy for mental health services¹⁰ and a National Service Framework (NSF) for mental health services, which contains indicators against which the performance of the service is assessed.
- 1.10 As a result of an annual MORI Service User Survey action is being planned to ensure all service users have and are aware of their care plans.¹¹
- 1.11 During the first quarter of 2004, the Adult Mental Health Service undertook a capacity review aimed at identifying the number and needs of the current client group, defining the capacity and remit of the current service provision and ensuring that services were appropriate to needs. The results of this review are incorporated within the Adult Mental Health Commissioning Plan 2004/05.¹²

⁶ The Healthcare Commission became the successor body of the previous Commission for Health Improvement (CHI) in 2004 and the 2003 rating was based on the 2002/03 performance.

⁷ Portsmouth City Council/Portsmouth City Teaching Primary Care Trust. *Adult mental health Commissioning Plan. 2004/2005.* Version 19/04/06 p. 3

⁸ As recorded in the 2001 census and of which 121,876 people are within the 16 – 64 age band eligible for Adult Mental Health Services.

⁹ Portsmouth City Council/Portsmouth City Teaching Primary Care Trust. *Adult mental health Commissioning Plan. 2004/2005.* Version 19/04/06 p. 5

¹⁰ Department of Health. *Modernising Mental Health Services.* 1999

¹¹ Portsmouth City Council/Portsmouth City Teaching Primary Care Trust. *Adult mental health Commissioning Plan. 2004/2005.* Version 19/04/06 p. 3

¹² Portsmouth City Council/Portsmouth City Teaching Primary Care Trust. *Adult mental health Commissioning Plan. 2004/2005.* Version 19/04/06 p. 4

1.12 In 2004 the Local Implementation Team¹³ identified the following vision for the Adult Mental Health Services:

- **We work to alleviate the suffering of those who experience mental distress and enable the highest degree of recovery**
- **We will include our service users and their carers in all our work and be open and honest with them. Together, we will strive for excellence and creativity**
- **We will reach out to our local communities and help people find their own mental well-being. We will value the people we work with and together we will break down the barriers of stigma**
- **We will develop a skilled workforce with good resources and make it easy for people to find the help they need, when they need it.**

1.13 According to the Mental Health Autumn Assessment for 2005, Portsmouth PCT achieved the highest number of areas awarded green (31) and the least red (2) across Hampshire. The AMH Service also received the Hampshire and Isle of Wight Strategic Health Authority Modernisation Award for Improving Care with E Technology, in recognition of the work undertaken to introduce the balanced scorecard as a tool to modernise and improve services.¹⁴

1.14 Due to changes in the commissioning arrangements between the PCT and its neighbouring PCTs, the termination of the PCT's AMH hosted services arrangements for the Low Secure: Challenging Behaviour & Rehabilitation Units took effect from 31st August 2005¹⁵, which has affected the funding stream to the PCT AMH services. At the time of the incident which is the subject of this Review, this service was based within the grounds of St James' Hospital site in the southeast of Portsmouth City and provided by the two separate but adjacent wards - Fair Oak and Cheriton.

1.15 Cheriton ward, where the incident took place, was an 8 bed Low Secure Rehabilitation Unit for the Fair Oak Challenging Behaviour Service with the aim of helping clients to regain control and responsibility over their own lives.¹⁶ The staffing establishment was given as 1 qualified and 2 unqualified staff per shift. The staff working on the unit were expected to be able to achieve the following:

¹³ Portsmouth City Council/Portsmouth City Teaching Primary Care Trust. *Adult mental health Commissioning Plan. 2004/2005*. Version 19/04/06 p. 4

¹⁴ Business Plan 2006/07 Adult Mental Health, Substance Misuse and Inscape. p. 3

¹⁵ Option Appraisal. Low secure Challenging behaviour & Rehabilitation Units (Fair Oak & Cheriton Wards) June 2005.

¹⁶ Undated and no author document titled "Cheriton House".

- **Full and comprehensive assessments – mental state, risk and skills assessment.**
- **Care planning skills**
- **Understanding of, and skills in, a range of therapeutic activities and interventions etc.**

1.16 In June 2005 a new low secure unit, Southfields, opened and took over the services previously provided by Fair Oak and Cheriton wards and Cheriton became Yew House, a social care facility.

2. Geoffrey Hodgkins – The Service User

2.1 The period leading up to 19th November 2004 including medical history¹⁷

- 2.1.1 Geoffrey Hodgkins was born on 16th September 1967 and first presented with psychiatric symptoms at the age of 10. He was admitted to St James's Hospital in Portsmouth in 1986 under Section 2, Mental Health Act 1983 and re-graded to Section 3 Mental Health Act due to his aggressive behaviour towards others and marked symptoms of paranoid schizophrenia. Since 1986 he had been an in-patient at St James' Hospital with limited periods of time living in the community with his parents.
- 2.1.2 In early 1998 episodes of complex partial seizures started to emerge and the evolution of these seemed to follow a predictable pattern. The seizures would usually start after 8.30 – 9.00pm and Geoffrey Hodgkins would become agitated and begin to pace and stare at his own reflection in the windows and giggle and laugh to himself.
- 2.1.3 At the beginning of 2000 this pattern changed when Geoffrey Hodgkins began to assault staff, kicking, biting and spitting to a degree that would require restraint for very prolonged periods of time. These restraints could include 3 – 4 staff for up to 7 hours. During these times one of his symptoms was hyperventilation. To treat the complex partial seizures he was, in the beginning of 2001, prescribed Paraldehyde PRN to which he responded positively.
- 2.1.4 Following a brain SPECT scan at the end of 2000 Geoffrey Hodgkins was referred to a Consultant Neurologist which resulted in some changes to his medication leading to him having less frequent epileptic episodes.
- 2.1.5 In March 2002, Geoffrey Hodgkins was transferred to Cheriton ward and in June 2002 he became an informal patient. From June 2002 to August 2003 there does not seem to have been any episodes of aggression or violence and he seemed fully compliant with medication and treatment plans.
- 2.1.6 In 2003 it was recommended¹⁸ that Geoffrey Hodgkins be transferred to a long-term and less restricted community placement like the Uplands Hospital, which is a 24 hours specialist nursing home in Fareham.
- 2.1.7 It was noted in March 2004¹⁹ that, following a change in the medication dose of Clonazepam to reduce drowsiness during the day and the

¹⁷ The medical history is taken from the Psychiatric Report of 22 August 2003.

¹⁸ Psychiatric Report of 22 August 2003 p. 6

¹⁹ Discharge Summary dated 25th March 2004.

- increase in the dose of Lamotrigine to prevent relapse of seizures, his psychotic symptoms were more obvious. It was also noted that it was difficult with Geoffrey Hodgkins to maintain a treatment balance of his psychosis and his epilepsy.
- 2.1.8 Although Geoffrey Hodgkins was engaged in Occupational Therapy activities up to April 2004, his level of motivation was described as poor and, due to his medication regime, he was feeling drowsy most of the day, sleeping and having difficulties in engaging in any purposeful activity, requiring prompting from staff to do the daily living tasks including self care. Amongst the things which he enjoyed was visiting his parents and going out with his brother.
- 2.1.9 Geoffrey Hodgkins was received by Uplands Hospital on 14th April 2004 but, due to his aggression, he was, on 20th July 2004, admitted to Solent Intensive Care Unit then re-admitted to Cheriton ward on 26th July 2004.
- 2.1.10 In response to an inquiry from the PCT about placing Geoffrey Hodgkins in a private nursing facility, Kitnocks House wrote²⁰ to the PCT at the beginning of August 2004 confirming that it would be able to provide the necessary level of care for Geoffrey Hodgkins.
- 2.1.11 On 3rd October 2004 Geoffrey Hodgkins set fire to a flip-chart and attacked a member of staff after which he was restrained by 6 persons using the C&R technique. Lorazepam and Haloperidol were administered. During this restraint staff noticed that Geoffrey Hodgkins' breathing became compromised and he was slightly cyanosed and hyperventilating. He was moved onto his back and a Senior House Officer attended who checked blood pressure and respiratory rate and advised staff to monitor his respiratory rate if further Lorazepam was administered and to call 999 if his breathing became inhibited. A one-to-one observation was carried out. The Risk Event Form states that an urgent review of his status was needed.
- 2.1.12 A medical review was carried out on 4th October 2004 and states: ***'Risks including that of respiratory suppression noted in the notes'***.²¹
- 2.1.13 On or about 9th October 2004²² Geoffrey Hodgkins caused another incident by jumping on a chair and throwing a television after which he was restrained and medicated. The Risk Event Form²³ stated that Geoffrey Hodgkins' case should be reviewed urgently concerning his stay at Cheriton ward with an informal status under the Mental Health Act.

²⁰ Letter of 2nd August 2004 from Kitnocks House to Nurse Manager, Cheriton House.

²¹ Medical notes provided by Consultant Psychiatrist to the Panel on 24th April 2006.

²² There seem to be dispute between different documentation about the date of this incident see Section 9.17

²³ Form Serial No: 49888

- 2.1.14 At a medical review carried out on 11 October 2004 Geoffrey Hodgkins' recent deterioration was noted and the medication dose was reviewed by his consultant.
- 2.1.15 At the ward round on 13th October 2004 it was noted that, on balance, Geoffrey Hodgkins' recent behaviour appeared to relate to psychomotor epileptic phenomenon and concern was expressed that he might have missed a couple of doses of medication, which must be taken regularly. Staff were asked to monitor his compliance.
- 2.1.16 Ward rounds on 20th and 27th October 2004 noted that Geoffrey Hodgkins had been sleeping excessively and also during day time. On 27th October 2004 his medication dose was changed again.
- 2.1.17 A medical review was carried out on 3rd November 2004 when it was decided that Geoffrey Hodgkins' mental health status was to be reviewed if his mental health state continued to deteriorate. It also noted that Paraldehyde was to be used once but only if Haloperidol and Lorazepam did not work.
- 2.1.18 On the 12th November 2004 Geoffrey Hodgkins entered the staff office saying that he did not feel well. He threw his cup at a member of staff and was restrained for approximately 2 ½ hours using C&R. The Risk Event Form²⁴ stated that Geoffrey Hodgkins' case should be discussed concerning his Mental Health Act status.
- 2.1.19 It was noted on the 13th November 2004 that Geoffrey Hodgkins was limping and his left ankle was found to be swollen. A bandage was applied to the ankle and Paracetamol given.
- 2.1.20 In the medical notes²⁵ concerns about restraining while Geoffrey Hodgkins was an informal patient were noted and a Section 3 Medical Recommendation form was filled out by one of the consultant psychiatrists.
- 2.1.21 At the ward round on 17th November 2004, it was observed that Geoffrey Hodgkins's ankle was still swollen and red with limited movement. The redness was extended to the shin. An x-ray was requested and cellulitis was queried. However, whilst staff decided not to take him to A&E for an x-ray due to his deteriorating mental state²⁶, this was not recorded in his records.
- 2.1.22 On 18th November 2004, a medical review took place and notes were made about acute cellulitis, oedema and increased temperature of the left

²⁴ Form Serial No 49895

²⁵ Provided by Consultant Psychiatrist to the Panel on 24th April 2006.

²⁶ See Report for Geoffrey Hodgkins, undated.

shin. It was also noted that a second Section 3 Medical Recommendation form had been completed by another doctor as required.

2.1.23 On the 19th November 2004, in the afternoon, the Approved Social Worker completed the Application for Section 3 and Geoffrey Hodgkins was from that time formally detained under Section 3 of the Mental Health Act.

2.2 Chronological sequence of events on the 19th & 20th November 2004²⁷

2.2.1 The Panel has attempted to recreate as accurately as possible a chronological sequence of the events that took place on 19th November 2004. This has been difficult some 1½ years after the event due to the absence of individual contemporaneous statements from the majority of staff at the time of the incident. In April 2006 when the Panel met with the staff, who had been involved in the incident, the staff had already participated in a staff debriefing on 8th December 2004, provided statements to the second internal review which took place in March and April 2005 and provided statements to the Police during 2005.

2.2.2 The Panel understands that it is important for the family of Geoffrey Hodgkins to achieve some understanding of what happened during the evening of the 19th November 2004. The chronology of events provided below is an attempt to get as clear a picture as possible about what actually happened. There are, however, crucial situations where information made available to the Panel is contradictory in terms of who did what and in what order. The Panel has, in those situations, chosen to place the greatest reliance on corroborated statements from staff and statements recounting personal and specific actions. Although the Panel recognises that such a viewpoint is not a guarantee of accuracy, it believes that it mitigates the inaccuracy inherent when bringing together accounts from staff from different units and professions who had not previously worked together as a team and who, therefore, do not necessarily have a common vocabulary to describe actions, reactions, or even individuals' names or professional titles.

2.2.3 The Panel was informed that it had been a really busy afternoon shift on the Cheriton ward with a total of 4 restraints between 4pm and 8pm and assistance had already been required from both security guards and other wards. The evening shift consisted of Nurse 1, a staff nurse, and HCSW 1, a health care support worker (HCSW). Due to the previous activities they both agreed to go into the office to get some of the paper work done around 8pm.

²⁷ The information in this section is based on a compilation of signed staff statements to the Review carried out by a nurse consultant and statements provided to the External Enquiry Panel.

- 2.2.4 Geoffrey Hodgkins was, at that time, in the dining room eating a take away meal and staff did not observe any signs that he was getting upset nor had they done so earlier in the day.
- 2.2.5 Whilst in the office, Nurse 1 and HCSW 1 heard the sound of smashing which was also heard by Nurse 2²⁸ and HCSW 2²⁹, who were talking together whilst Nurse 2 was doing a one-to one observation on another service user further down the corridor. When HCSW 1 and Nurse 1 came out of the office they saw Geoffrey Hodgkins at one end of the corridor with a glass cup in his hand which he threw at another service user who was at the other end of the corridor. Geoffrey Hodgkins then walked past Nurse 2 and into the family room. Geoffrey Hodgkins was noted to be carrying a fork and a glass in his hands when he went into the room. The light was on in the room. Nurse 2 and HCSW 2 were holding on to the door to keep it closed due to concerns about Geoffrey Hodgkins. HCSW 2 suggested that Nurse 1 ring for help and Nurse 1 pulled the pin to get assistance from the Front Hall and other wards. HCSW 2 also suggested that the door to the family room be locked until help arrived and HCSW 2 locked it. Security guards and staff from other wards then arrived. Once inside the family room Geoffrey Hodgkins had turned the light off. The door to the family room had a see-through glass panel.
- 2.2.6 HCSW 1 started clearing the glass from the floor in the corridor and Nurse 3³⁰, the (1701) bleep-holder³¹, arrived from Fair Oak and took control of the situation. Nurse 1 went back to the office to draw up medication for Geoffrey Hodgkins. Nurse 3 suggested that the staff get a quilt to put over Geoffrey Hodgkins for the safety of all involved. HCSW 1 went to get some towels as HCSW 1 knew from past experience that Geoffrey Hodgkins would spit when he was being restrained. There seems to have been some discussion between the clinical staff and some separate discussion between the security guards about which process to follow, about who should enter first and about which positions individuals should take.
- 2.2.7 Outside the door to the family room were Security Guard 1³², Security Guard 2³³, Security Guard 3³⁴, Nurse 2, Nurse 3, Nurse 1, HCSW 3³⁵ and HCSW 2. HCSW 2 was given the quilt to throw over Geoffrey Hodgkins. The light in the room was turned on by Security Guard 1 and every member of staff, apart from Nurse 1, entered the room. Geoffrey Hodgkins was standing with his back to the door and with a lamp in one hand and a fork in the other. Security Guard 3 (and perhaps Nurse 2) took these

²⁸ A staff nurse called to assist from another ward. It was the first day as a qualified nurse for this nurse.

²⁹ A Health Care Support Worker from another ward.

³⁰ Senior nurse for Fair Oak and Bleep-holder for that shift.

³¹ Senior Nurse on duty holding the bleep who has specific responsibilities in case of emergencies.

³² Security guard at that time

³³ Security guard at that time

³⁴ Security guard at that time

³⁵ Health Care Support Worker at that time called from another ward

- things out of Geoffrey Hodgkins' hands and Security Guard 1 brought him down. Nurse 3 took the quilt to throw over Geoffrey Hodgkins as HCSW 2 had ended up against a wall when HCSW 2 had attempted to do so. The quilt ended up under Geoffrey Hodgkins' waist.
- 2.2.8 Geoffrey Hodgkins was on the floor lying on his front. Security Guard 1 took Geoffrey Hodgkins' left arm, Nurse 3 took his right arm; Security Guard 2 took Geoffrey Hodgkins' legs from underneath him and held them. Nurse 2 was on his legs and HCSW 2 took his thighs whilst HCSW 3 also held a leg. Security Guard 3 was laying on Geoffrey Hodgkins' legs and his head was put to one side. HCSW 1 came back with the towels and was asked by Nurse 3 to go to Geoffrey Hodgkins' head. HCSW 1 placed one towel around each hand and a towel around each of Geoffrey Hodgkins' hands and a towel under his head to protect it from the rough carpet. The towels around HCSW 1's hands were because he was spitting and biting. HCSW 1 was kneeling at the top of his Geoffrey Hodgkins' head facing him. Some blood was noticed coming from his face and this was, according to staff, because he had cut himself shaving earlier in the week or had a cold sore and the scab had fallen off during the restraint.
- 2.2.9 Nurse 1 came in and gave Geoffrey Hodgkins an injection of Haloperidol and Lorazepam.
- 2.2.10 During this period, Geoffrey Hodgkins was kicking, swearing and struggling a lot. Nurse 2 took over from Nurse 3 on Geoffrey Hodgkins' right arm so that Nurse 3 and Nurse 1 could reassess the situation. They agreed that Nurse 3 should return to Fair Oak and send over a member of staff to assist with the one-to one observation which Nurse 2 had left. Agency Nurse 1³⁶ arrived and took over Geoffrey Hodgkins' right arm from Nurse 2.
- 2.2.11 Security Guard 2 took Security Guard 1's position on Geoffrey Hodgkins' left arm as Security Guard 1 had to leave to attend to another patient. HCSW 3 and HCSW 2 were each holding a leg whilst the security guards were clearing away the furniture.
- 2.2.12 After about 25 minutes, Nurse 1 decided that the medication was not working as expected. According to Geoffrey Hodgkins' notes, Paraldehyde could be prescribed but, if needed within 2 hours of a restraint it had to be agreed with the duty doctor, otherwise nurses could administer it. Nurse 1 contacted Nurse 3 and informed that the medication was not having an effect. Nurse 3 contacted the duty doctor who was off-site and discussed this. Nurse 3 contacted Nurse 1 and passed on the information that the duty doctor had agreed that Paraldehyde could be given if the nurses considered this to be the best option.

³⁶ Agency nurse at that time who had arrived for night shift

2.2.13 During this period, Geoffrey Hodgkins was still moving about and he was biting into the towel under his head. HCSW 1 was pulling at it to try to get it out of his mouth.

2.2.14 Suddenly, Geoffrey Hodgkins stopped breathing. Both HCSW 1 and Security Guard 2 became aware of this at the same time. Geoffrey Hodgkins' eyes were flicking and he was turning blue. HCSW 1 turned him over to his back and he was released. Nurse 2 was, at that time, leaving the family room having been relieved by Agency Nurse 1. Nurse 2 heard that Geoffrey Hodgkins had gone blue and ran to the office to inform Nurse 1 and asked that a medical emergency call be made. Nurse 2 also asked where the Laerdal masks were and, as they were in the office, took one back and gave it to HCSW 2 who had started performing mouth to mouth resuscitation on Geoffrey Hodgkins. HCSW 1 had, by then, got up and also run to the office to Nurse 1, who was there drawing up Paraldehyde. HCSW 1 then returned to the family room and started doing chest compression. Nurse 1 put out a 9-999 call, called Nurse 3 and went back into the family room. This emergency call was likely to be the first call Hampshire Ambulance Services received at 20.43.40 hours. It was aborted prematurely by the caller.³⁷

2.2.15 Nurse 2 took over the heart massage from HCSW 1. HCSW 2 was still doing mouth to mouth resuscitation, but without the mask as HCSW 2 found this difficult, when Nurse 3 came in and gave HCSW 2 a mask from Nurse 3's key ring. Nurse 3 also asked for oxygen and a Laerdal mask. Geoffrey Hodgkins started breathing again and was put in the recovery position. Nurse 1 rang 999 again whilst in the family room. This call from Nurse 1 was likely to be the third call received by Hampshire Ambulance Services at 20.53.57 hours.³⁸ A second call, at 20.52 hours, had been received by the ambulance services and was a follow up call from St James' Front Hall. It did not contain sufficient information for the Ambulance Service to act upon before it too was aborted by the caller.³⁹

2.2.16 Geoffrey Hodgkins stopped breathing once more and was turning grey so resuscitation was started again. Nurse 3 took over the mouth to mouth resuscitation and asked for an Ambi bag from Fair Oak to be brought over but, when it arrived, did not feel this was as effective as performing mouth to mouth, which had been continuing in the interim. Nurse 1 tried to take a blood pressure but could not get a reading. Security Guard 4 arrived at the main reception for the next shift and was told to go to Cheriton ward where staff were giving Geoffrey Hodgkins resuscitation. Arriving at the ward Security Guard 4 was asked to check Geoffrey Hodgkins' pulse and, after doing so, took over from Nurse 2 in performing chest compressions and

³⁷ Transcript of Hampshire Ambulance Service recording of 19th November 2004

³⁸ Transcript of Hampshire Ambulance Service recording of 19th November 2004

³⁹ Transcript of Hampshire Ambulance Service recording of 19th November 2004

continued doing so even after the arrival of the ambulance crew, whilst they readied their equipment.

2.2.17 Nurse 1 received a telephone call from the ambulance control asking for directions. Nurse 1 guided the ambulance to the ward. Security Guard 3 was waiting outside for the ambulance. When the ambulance arrived on the scene at 20.58 hours⁴⁰ HCSW 1 guided the ambulance crew to the family room where they took over the resuscitation from the Nurse 3. Nurse 3 took over the heart massage. Nurse 1 told Nurse 3 that the Paraldehyde had not been given. Security Guard 4 was asked to assist the paramedics and helped raising Geoffrey Hodgkins onto a stretcher and into the ambulance.

2.2.18 Nurse 3 and Agency Nurse 1 went with Geoffrey Hodgkins in the ambulance continuing the heart massage. Geoffrey Hodgkins was taken to Queen Alexandra Hospital, Accident and Emergency Department, Portsmouth Hospitals NHS Trust, where he arrived at 21.23 hours. Nurse 3 phoned Cheriton ward from the hospital to ask if the family had been contacted and was informed about 00.30 hours on the 20th November the police had made contact with Geoffrey Hodgkins' brother. Around 02.00 hours Geoffrey Hodgkins' brother and sister arrived at the hospital and Nurse 3 left Queen Alexandra Hospital around 02.30 hours on the 20th November 2004.

2.2.19 Geoffrey Hodgkins' life support was turned off on the 20th November 2004 at 08.25 hours and he was declared dead.⁴¹

2.3 The chronology of actions taken after the 20th November 2004

2.3.1 On 21st November 2004 the police were informed by a nurse on the ward about the death of Geoffrey Hodgkins when they visited Cheriton on an unrelated matter.⁴²

2.3.2 On 29th November 2004 a post-mortem examination took place which was performed by a Home Office Pathologist.⁴³ A subsequent post-mortem examination of Geoffrey Hodgkins took place on 16th March 2005. As a consequence of these Post-Mortems and toxicological analysis a narrative verdict was given on 10th January 2006 with a formal cause of death for registration purposes given as:

1a Combined effects of exertion, excitement and restraint.

⁴⁰ Transcript of Hampshire Ambulance Service Patient Record Form. 19th November 2004

⁴¹ CC Portsmouth Hospitals NHS Trust. 20th November 2004.

⁴² Email correspondence between nurse and clinical manager and associate Director AMH of 30th November 2004.

⁴³ Witness Statement to the Coroner from the Home Office Pathologist of 12th January 2005 and 10th January 2006.

- 2.3.3 On the 8th December 2004 a Critical Incident Review into the death of Geoffrey Hodgkins took place within the PCT led by the Commissioning Manager. A total of 22 members of staff were invited to attend and a non-executive director was present as well.
- 2.3.4 On the 21st December 2004 Geoffrey Hodgkins' brother, wrote to the PCT informing it that he had asked MIND to contact the PCT about the circumstances of the death of his brother.⁴⁴
- 2.3.5 On 5th January 2005 Mind, on behalf of Geoffrey Hodgkins' brother, wrote a letter of complaint. A response to this letter was provided by the PCT on 25th January 2005 enclosing the Critical Incident Review Report and offering to meet with the family.
- 2.3.6 Some time during February 2005 the Hampshire and Isle of Wight Strategic Health Authority requested a full investigation.
- 2.3.7 MIND requested further information including copies of medical records and an explanation for the delay in calling an ambulance. This letter of 21st March 2005, also expressed dissatisfaction with the information previously supplied.
- 2.3.8 In April 2005 the SHA asked for an independent external enquiry as required for serious incidents.⁴⁵
- 2.3.9 In May 2005 an internal investigation was completed by one of the PCT Nurse Consultants although this was not considered to be a formal review by the PCT.⁴⁶
- 2.3.10 The Chair of the External Enquiry Panel was originally contacted on 20th May 2005 by Hampshire and Isle of Wight Strategic Health Authority and a Panel was identified. It planned to carry out a visit and interviews on 19th /20th July 2005. However, this was cancelled on the 5th July 2005 as the family of Geoffrey Hodgkins expressed a wish to await the conclusion of the police investigations and the final Report from the Coroner.⁴⁷ A meeting with the family scheduled for 12th July 2005 did not take place either as the family did not wish to attend and the family confirmed that they wished for all future communication to be with their appointed solicitor, Mr Graeme Swain, and Mind rather than directly with the family. Mind formally contacted the PCT on 6th July 2005⁴⁸ and confirmed that Mr Swain rather than Mind would be representing the family in the future.

⁴⁴ Letter of 21st December 2004 from Bruce Hodgkins.

⁴⁵ Email of 20th April 2005 from Director of Service AMH to Associate Director of AMH.

⁴⁶ Email of 29th April 2005 from Associate Director AMH to Risk Manager.

⁴⁷ Email of 5th July 05 from PCT to Panel members.

⁴⁸ Email of 4 July 2005 from MIND to the PCT

Swain & Co Solicitors contacted the PCT and asked for a 2 weeks delay to allow an application for legal aid.

2.3.11 In the absence of a determination of the cause of death by the Coroner it was agreed by the Hampshire and Isle of Wight Strategic Health Authority to postpone the start date of the External Enquiry.⁴⁹

2.3.12 On 11th and 14th October 2005, Swain & Co Solicitors enquired about the delay in setting up the External Enquiry and asked for copies of all records relating to the incident. The solicitors were directed to Hampshire and Isle of Wight Strategic Health Authority regarding process and were asked to comment on the Terms of Reference which were ultimately agreed.

2.3.13 The Chair of the External Enquiry was formally appointed by the Hampshire and Isle of Wight Strategic Health Authority on 8th November 2005 and the final Terms of Reference were approved by its Board on 13th December 2005. Due to some minor correction matters a final revised version was issued on 24th April 2006⁵⁰.

2.3.14 The additional Panel members were formally appointed by the Hampshire and Isle of Wight Strategic Health Authority on 14th March 2006 and the dates for the visit were agreed to be 23rd to 25th April 2006.

⁴⁹ Email correspondence between the PCT and the Hampshire and Isle of Wight Strategic Health Authority of 1st and 13th September 2005.

⁵⁰ The Terms of Reference were amended in April 2006 to reflect correction in spelling and date.

3. Methodology

The following Sections outline the methodology adopted by the External Enquiry Panel in carrying out its commissioned task of investigating the care and treatment received by Geoffrey Hodgkins prior to and during the events leading up to his death on 20th November 2004. The underlying principles used by the Panel in this work were:

- **Independence from the Trust reviewed;**
- **Rigour in its data collection;**
- **Fair, transparent and holistic in its adopted approach;**
- **Open and accessible to the family of Geoffrey Hodgkins;**
- **Open and accessible to all staff within the Trust;**
- **Evidence-based, where possible, in its findings;**
- **Developmental in its recommendations;**
- **Focussed upon providing a quality framework within which the PCT can deliver the best possible service user care.**

The formal structure of the Report is centred around the specific themes contained within the Terms of Reference but has also commented on the overall themes which govern the quality of service delivery within the NHS:

- **Governance and accountability**
- **Leadership and Commitment**
- **Continuous improvements**
- **Creating a learning organisation**
- **Multi-disciplinary working**
- **User involvement**
- **Audit**
- **Critical incident**

3.1 Documentation.

3.1.1 In conducting its review the Panel considered the following documentation:

- Minutes of relevant meetings e.g. Quality and Clinical Governance Sub-Committee, Business Assurance, Mental Health Act Panel meetings, AMH Management Team meetings, Board meetings;
- Data and information about clinical activities relating to the care of Geoffrey Hodgkins including nursing and medical records;

- Establishment figures for the Cheriton ward;
- Information about staff appraisal, training and supervision;
- Critical Incident Reporting systems and Risk Management;
- Adverse Event Reports, Incidents data trends, Complaints figures;
- Relevant internal and external correspondence;
- Mental Health Commissioning Report;
- Local protocols/policies and procedures such as the Observation Policy, Substance Misuse/Mental Health Services Supervision policy, Restraint & Rapid tranquilisation Policy, Emergency Response Procedure;
- Events for Carers etc;
- National policies and guidelines with regards to adult mental health services and especially restraint;
- PCT Annual Reports;
- PCT Business Plans;
- Internal Audit Report – Risk Management 2006;
- Internal and external correspondence;
- Any other relevant documentation

3.2 Interviews

3.2.1 The External Inquiry Panel identified a number of key individuals whom they wished to interview and also benefited from meeting with Geoffrey Hodgkins' brother and the representatives of MIND. The PCT were invited to identify other key individuals whom it considered would have useful information for the Panel. Whilst the Panel met with a number of senior representatives (including the Non Executive Director chairing the Mental Health Act Panel) at an open session held by the Panel, it was concluded that staff within the Unit had not been made aware of the open session despite a specific request from the Panel that they be informed and invited to attend:

“...I will appreciate getting a copy of the letter from the trust to staff about the visit and would furthermore appreciate if you could advertise the open session with its venue to staff generally within the unit.

.....

18.00 - 19.00pm Open session for staff who would like to share their views with the Panel.”⁵¹

3.2.2 The External Enquiry Panel met with and interviewed a total of 34 different

⁵¹ Email of 6th April 2006 from Panel Chair to PCT.

individuals comprising of members of staff, the family and the PCT Board.

3.2.3 All those meeting with the Panel were advised that they could be accompanied if they felt they needed support. They were also advised about the following:

- **that any views expressed would be treated in confidence unless of critical understanding to the specific events leading up to the incident;**
- **that they would be provided with a summary of any notes taken with a view to ensuring notes taken were accurate;**
- **that if personal identifiable information was referred to in the Report, the individuals in question would be given the opportunity to comment on accuracy whilst the Report was in draft form.**

3.2.4 Those attending were also advised of the purpose of the Inquiry and the Terms of Reference and informed that the Panel would, if appropriate, make recommendations for action in light of the review.

3.2.5 When meeting with members of staff, the family and the PCT Board, the Panel focussed their interviews around the following series of questions:

- **Did the interviewee understand the reasons for this Review?**
- **What did happen on the 19th November 2004?**
- **What governance, including management structures, were in place to support the accountability and delivery of quality care for service users in general and for Geoffrey Hodgkins in particular?**
- **Did staff have a common understanding of the different roles, accountabilities and responsibilities within the Cheriton ward?**
- **What was the level of understanding, compliance, monitoring and implementation of existing policies, procedures, protocols etc. in November 2004?**
- **What further personal and/or organisational learning has taken place since the incident?**
- **What further personal and/or organisational learning would the family and staff like to see as outcomes of this incident?**

3.3 Report structure

- 3.3.1 The External Inquiry Panel was very conscious of the need to provide as comprehensive as possible a review of the care provided to Geoffrey Hodgkins prior to and during the events on the 19th November 2004. The Panel has been critical of the quality of the care provided and found that the reasons lay mainly within the cultural fabric of the PCT. The Panel has, therefore, aimed to provide as much evidence as possible for its findings and conclusions. It has also placed emphasis on providing a narrative of the context in which the Terms of Reference should be applied. This is in order to ensure transparency and accountability for its own process and, furthermore, inform the family of Geoffrey Hodgkins, staff, the PCT and the public at large so that they may better understand the rationale behind the Panel's findings and the recommendations it has made.
- 3.3.2 As the Terms of Reference cover a number of inter-linked themes, the discussion of documentation and findings are equally inter-related, which gives rise to a degree of duplication within this Report. Certain issues are discussed at several places within the Report. One section will provide the most in-depth discussion cross-referenced to other parts of the Report where the same issue is also examined. A consolidated listing of all the Panel's recommendations is to be found in Appendix D.

4. Critical Review of Policies, Protocols, Care Pathways and Procedures relating to the Care of Geoffrey Hodgkins

4.1 Review and assessment of the adequacy of policies, protocols, care pathways and procedures from a clinical perspective.

4.1.1 Having reviewed a wide range of different policies, protocols, care pathways and procedures relating to the care of Geoffrey Hodgkins, the Panel identified that the policies, protocols etc were adequate as standard documents although of varying quality. However, although adequate a number of them were very superficial; such as the Policy for Management of Aggression. Of greater concern to the Panel though was the limited evidence of effective dissemination, training and implementation of these when providing patient care as in the case of Geoffrey Hodgkins but also beyond (see section 4.7).

4.1.2 Amongst the policies reviewed the Panel wishes to attach the following more detailed comments to a few selected policies relating to the care of Geoffrey Hodgkins.

4.2 Observation Policy

4.2.1 An Observation Policy, issued in December 2003, was in place at the time of the incident although it was noted, rather confusingly, that this was marked due for review in April 2003 and no evidence was provided that a review of the policy had taken place.

4.2.2 The level of observation is generally documented in notes, as required by the policy, although there are gaps. For example, it was not possible to evidence that the observations were carried out only that they were intended. The form on which the levels are recorded is ward based not patient based and therefore did not form part of the medical notes as provided to the Panel. This needs to be reviewed as each patient's observation forms part of the care given to that patient. The policy does not stipulate the retention period of these forms and it should do so.

4.2.3 The reason for increasing and then decreasing the level of observations was not always recorded in the notes. An example of this is in the period 12 – 15th October 2004 when the levels varied between shifts from level 1 to level 2. Medical notes do, in general, record when the level was increased but the Panel found few records of decreasing levels.

4.2.4 The policy requires a nurse on shift to record the mood of the patient in the clinical notes. This appears to have been carried out and, although the

record of each shift is brief, it does indicate the care provided to Geoffrey Hodgkins by the staff.

4.2.5 The policy required, in circumstances such as Geoffrey Hodgkins', that observations to be undertaken: but based on the review of the policy the Panel found that:

- a) there were gaps in the level of observations that should have been undertaken;
- b) the forms on which the observation levels were recorded were ward based and not patient based and as such were not part of Geoffrey Hodgkins' medical records;
- c) reasons were not always provided for an increase or decrease in observation levels;

4.2.6 The Panel was of the view that these deficiencies in record keeping did not contribute to the tragic outcome. The Panel was, however, of the view that the policy needs to be reviewed with a view to:

- a) ensuring that observation forms are included in a patient's medical records;
- b) ensuring that retention periods are identified;
- c) that the reason for any decrease in observation levels is clearly recorded;

Recommendation:

That the PCT Management Team review the Observation Policy to ensure that all relevant patient information is required to be recorded in the patient records.

4.3 Substance Misuse/Mental Health Services Supervision Policy

4.3.1 This is a policy which was issued in December 2003. The policy directs the different types of supervision of staff. The minimum frequency of supervision is monthly. The policy clearly lays the responsibility for the supervision process with the clinical/assistant manager or service coordinator to implement the supervision structure within their clinical area.

4.3.2 The Panel finds this policy to be adequate although it does not address how the monitoring of supervision will take place, nor does it refer to the availability of supervision training or how difficulties in the supervisory relationships should be dealt with. It also states that the monthly supervision can be group or individual. A member of staff could, therefore, not have any one-to-one supervision session and comply with this policy.

The Panel would suggest that this is not ideal for generating learning. The Panel saw no evidence that supervision sessions with members of staff had taken place following the incident to review the management of the incident and/or the role of the individual in it.

- 4.3.3 Although the policy was said to be issued in December 2003, it stated that it was due for review in May 2003, which was confusing. It appears not to have been reviewed and was presented as the policy in place on 19th November 2004.
- 4.3.4 Document 'CS3 Supervision Policy' is dated February 2006 and is the reviewed policy. This reviewed policy does not add value to the former policy except that it now contains an improved monitoring of the policy.
- 4.3.5 Based on the review of the policy the Panel found that although adequate it would be beneficial if the policy also contained the following aspects:
 - a) how to deal with difficulties in the supervision relationship;
 - b) how to ensure that individual or team-based clinical practice is discussed after a critical incident;
 - c) availability of one-to-one supervision sessions on request.
- 4.3.6 The Panel was of the view that these weaknesses did not contribute to the tragic outcome. The Panel was, however, of the view that the policy would benefit from a consideration of the appropriateness of the points mentioned in section 4.3.5 when next reviewed.

4.4 Resuscitation Policy

- 4.4.1 The resuscitation policy is considered to be fit for purpose. It clearly identifies the level and establishment of the staff at St James' Hospital site required to respond to and provide basic life support and enable the transfer of patients to a place of safety. It also states that the equipment should be provided via a Grab Bag.
- 4.4.2 The policy requires that the nurse and HSCW be trained to the same level and that the bleep-holder should also have ALS training. A critical incident form should be completed after each resuscitation attempt and this should be sent to the Resuscitation Department. The Panel was not provided with any evidence that this happened after the incident on 19th November 2004.
- 4.4.3 The policy requires that the equipment should be checked on a daily basis. The Panel received no evidence that this took place as the record sheets, if any, were not among the documentation provided.

- 4.4.4 At the time of the incident on the 19th November 2004 there did not appear to have been a Grab Bag available and the equipment was not kept in a similar place on each ward area. At the time of the incident the Bleep-holder had access to a mouth shield, attached to the belt. This is not mentioned in the policy as a requirement nor did it appear to be common practice for other staff to wear one. The lack of a Grab Bag and personal mouth shields resulted in staff putting themselves at risk by giving unprotected mouth to mouth resuscitation. However, the risk to the health staff in this instance was increased since Geoffrey Hodgkins was said to be bleeding from a sore or other injury to his face.
- 4.4.5 Based on the review of the policy the Panel found that although adequate it would be beneficial if the PCT assured compliance especially with the following aspects:
- a) completion of a critical incident form after each resuscitation attempt to the Resuscitation Department;
 - b) daily check of equipment being recorded;
 - c) ready availability of resuscitation equipment.
- 4.4.6 The Panel was of the view that these weaknesses did not contribute to the tragic outcome. The Panel was, however, of the view that the policy would benefit from a consideration of the appropriateness of the points mentioned in section 4.4.5 when next reviewed.

4.5 Restraint & Rapid Tranquilisation Policy

- 4.5.1 The Restraint and Rapid Tranquilisation policy allowed for individual information to be recorded, but in this case it was not personalised for Geoffrey Hodgkins and did not meet his needs. It lacked relevant information, it was not completed (not signed) and there was lack of evidenced systematic follow-up after restraints and rapid tranquilisation, despite this being required by the policy.
- 4.5.2 Based on the review of the policy the Panel found that the policy was adequate but that the Panel was not assured about the compliance especially with the following aspects:
- a) lack of comprehensive personalised information recorded for Geoffrey Hodgkins;
 - b) lack of consistent completion of information;
 - c) lack of evidenced and systematic follow-up after restraints and rapid tranquilisation.

4.5.3 The Panel is of the view that the Restraint and Rapid Tranquilisation Policy in the case of Geoffrey Hodgkins should have been informed by:

- the problems he had encountered previously during prolonged periods of restraint;
- a comprehensive medical review to establish his cardiac status including a review of the suitability of alternative medication etc;
- a consideration of alternative distraction and de-escalation techniques.

4.5.4 The Panel received no evidence that any of these very serious issues had been considered as part of the Restraint and Rapid Tranquilisation Policy for Geoffrey Hodgkins. It is the view of the Panel that had those serious issues been properly considered the prolonged periods of restraint, endured by Geoffrey Hodgkins, may not have been required. The Panel cannot conclude that the lack of full consideration of these issues contributed to the death of Geoffrey Hodgkins but is of the view that had these been appropriately addressed the risk posed to him would have been substantially reduced (see section 4.7).

4.6 Emergency Response Procedure etc

4.6.1 The Careplans for Geoffrey Hodgkins⁵² required that a patient will be restrained in the prone (face down) position for no longer than 3 minutes after which period the patient and the team will be instructed to get into the kneeling position. The time should be monitored by the team member at the patient's head. It was very clear from the patient notes and statement from staff that restraint of Geoffrey Hodgkins, whilst in the prone position, commonly lasted several hours but, despite this, no amendments were made to his Careplans nor were considerations evidenced of this or alternative methods of managing the situations.

4.6.2 From the evidence collected the Panel formed the impression that, during the critical incident on 19th November 2004, there were times when no senior member of staff was present in the room. The person at Geoffrey Hodgkins' head, who was one of those who discovered the emergency, left the room to inform the senior nurse about the emergency. The senior nurse was at that time in the office drawing up medication. This absence left the remainder of the staff present (security guards and HCSWs) without anyone to initiate and continue basic life support. The Panel is not in a position to make any judgement as to the effect of this on the final outcome of the critical incident. However, not having a senior member of staff present and in charge at all times during a restraint situation is cause for concern.

⁵² Fairoak Service. Careplan for the management of violence and aggression by the use of physical restraint. Section 4

- 4.6.3 The Panel was equally concerned that, at the time of the incident, security staff were very regularly used in restraint situation despite the Emergency Response Procedure giving them a very different role. This is especially concerning since none of the security guards had undergone the PCT's own approved Care and Responsibility training.⁵³
- 4.6.4 It is a requirement of the Procedure⁵⁴ that all staff involved in direct service user care must be trained in Basic Life Support. Life support, in the form of mouth to mouth resuscitation and chest massage, was initiated by members of the staff present but the Panel was concerned to learn that the staff had great difficulties in using the mouth shield and some were uncertain about the position of the resuscitation trolley within the ward. Equally a Laerdal mask had to be sent for from a different unit.
- 4.6.5 The Procedure⁵⁵ has since been revised and has addressed a number of these issues. In the revised Procedure it is now stressed that more specific information should be given when dialling 999 (although the policy in Section 2.1 has two dial (9) -999 steps with slightly different wording⁵⁶). It is now clearly stated that security staff are not to be used actively to assist in a situation that involves physical restraint of a service user⁵⁷ unless staff are at risk. Furthermore, every member of staff must carry a protective face shield and every unit will have several Laerdal facemasks⁵⁸.
- 4.6.6 The revised Procedure does, in the view of the Panel, address most of the shortcomings of the previous Procedure with regards to content but does not, in itself, address the issue of implementation and monitoring of compliance with it. It was the apparent lack of adherence to the Procedure, the lack of knowledge about who should do what in an emergency and a lack of ability to use existing equipment efficiently in the incident, which caused most concern to the Panel. The revised Procedure does not address the question of appropriate level of staffing on the wards either which is an important issue for the PCT to consider as this was the original reason for the use of the security guards in the restraint situation.
- 4.6.7 Based on the review of the policy the Panel therefore found that the procedure at the time of the incident was just adequate and that the

⁵³ See internal PCT email of 30th June 2005 from Education and Training Manager to Risk Manager etc

⁵⁴ Emergency Response procedure to Psychiatric and Medical Emergencies for St James Hospital POL-E-2 Issued Dec 2003 Section

⁵⁵ Emergency Response procedure to Psychiatric and Medical Emergencies for St James Hospital site and AMH Units. AMH-pr-2(Dec 2005)

⁵⁶ Emergency Response procedure to Psychiatric and Medical Emergencies for St James Hospital site and AMH Units. AMH-pr-2(Dec 2005) Section 2.1

⁵⁷ Emergency Response procedure to Psychiatric and Medical Emergencies for St James Hospital site and AMH Units. AMH-pr-2(Dec 2005) Section 1.5.1

⁵⁸ Emergency Response procedure to Psychiatric and Medical Emergencies for St James Hospital site and AMH Units. AMH-pr-2(Dec 2005) Section 2.4.1 and 2.4.2

revised procedure goes some way to address the weaknesses. However, the Panel's major concern was about the compliance and application into practice especially with the following aspects:

- a) Inappropriate prolonged restraints periods in the prone position;
- b) Inappropriate use of security guards at the time of the incident;
- c) Use of staff not trained in the PCT's own approved Care & Responsibility training;
- d) ineffective communication;
- e) lack of effective use of equipment.

4.6.8 The Panel was of the view that Emergency Response Procedure did not in itself contribute to the tragic outcome. The Panel was, however, very concerned about the impact on the quality of the care provided to Geoffrey Hodgkins due to the lack of compliance with the procedure (see Section 7.2).

Recommendation:

That the PCT audit implementation of and compliance with the Emergency Response Procedure and identify and monitor clear action plans to address any shortcomings identified.

Recommendation:

That the PCT Senior Management review the staff establishment with regards to skills mix and numbers to ensure that high quality and safe patient care can be provided.

4.7 Approaches taken to implement policies, protocols, care pathways and procedures and assuring their implementation.

4.7.1 The Panel saw no evidence of the instructions on how policies were disseminated, no evidence of impact of training of staff apart from training in C&R and little evidence of staff using policies to inform practice. Whilst the absence of relevant policies etc. is a very critical issue, it is equally important to acknowledge that policies in themselves do not ensure quality of service. This most important aspect of care is dependent on the implementation of policies into practice.

4.7.2 The Panel was concerned by the limited evidence of systematic audit taking place of policies and procedures as such audits would have previously highlighted the areas of non-compliance which have now been identified by the Panel and raised throughout this Report.

4.7.3 According to the PCT there is *"a robust, open but un-minuted weekly meeting for all consultants and equivalent lead medics (locums etc) to*

review clinical problems, procedures, RT issues and procedures, service user problems and a range of peer support issues and questions. The lead consultant for AMH.... Is planning to minute this meeting in the future".⁵⁹

- 4.7.4 There were Careplans in place for Geoffrey Hodgkins with regards to the Management of Violence and Aggression but the Panel saw examples where these were not dated, not signed by the patient and the section named '**Actions individual to the patient**' not completed. It was not possible to ascertain that they had in any way impacted on the day-to-day management of Geoffrey Hodgkins' care.
- 4.7.5 The Careplans used for Geoffrey Hodgkins were based on a template and it seems that no effort was made to make them relevant to his particular care needs. Part of the Careplan⁶⁰ deals with the actions/checks which should happen during and following a restraint; such as pulse, blood pressure, respiration, temperature at every 2 hours post restraint for a period of up to 24 hours. The Patient Notes did not provide evidence that this happened systematically nor was there evidence of systematic adherence to the requirement⁶¹ for a medical assessment no later than 2 hours after the commencement of the physical restraint requirement.
- 4.7.6 The Panel was very concerned by the use of a Careplan that stipulated actions not reflected in practice thus creating a false sense of conformance with best practice.
- 4.7.7 The Panel received no evidence that these very serious issues arising from the lack of compliance with existing policies, protocols, care pathways and procedures relating to the care of Geoffrey Hodgkins had been comprehensively addressed within the PCT. It is the view of the Panel that had those serious issues been properly considered the prolonged periods of restraint, endured by Geoffrey Hodgkins, may not have been required. The Panel cannot conclude that the lack of full consideration of these issues contributed to the death of Geoffrey Hodgkins but is of the view that had these been appropriately addressed the risk posed to him would have been substantially reduced.

Recommendation:

That the PCT Senior Management Team ensures that policies, procedures and guidelines in place to safeguard patient care are realistic in scope, structured to address individual needs and monitored for compliance and relevance.

⁵⁹ Email from Director of Service AMH to Panel on 20th April 2006.

⁶⁰ Fairoak Service. Careplan for the management of violence and aggression by the use of physical restraint. Section 5

⁶¹ Fairoak Service. Careplan for the management of violence and aggression by the use of physical restraint. Section 5

5. Examination of the Quality and Suitability of Geoffrey Hodgkins' Overall Treatment, Care and Supervision.

5.1 Quality and suitability of Geoffrey Hodgkins' overall treatment, care and supervision.

5.1.1 In the Panel's examination of the quality and suitability of Geoffrey Hodgkins' overall treatment, care and supervision the focus has primarily been on the period from Geoffrey Hodgkins' re-admission to the Cheriton ward on 26th July 2004 and forwards. However, from the documentation provided to the Panel it is apparent that a senior nurse back in 2000 had already expressed concern to a consultant on behalf of self and other colleagues regarding Geoffrey Hodgkins' care:

***"...due to the unnecessary and prolonged discomfort that he has to endure whilst under restraint....periods of restraint may last from anything of an hour to five hours plus, during which time Mr Hodgkins is sweating profusely.... His breathing becomes very laboured and is extremely noisy, leading staff to feel that he is at risk from a massive coronary..... His colour frequently takes on a grey tinge.... The staff on Fair Oak would like Mr Hodgkins care to be reviewed to explore alternative ways of caring for him that does not include long periods of restraint and the administration of medication that has no effect. Our main concern is that he will have a major coronary whilst under restraint which will be distressing for both Mr Hodgkins, his family and the staff on Fair Oak and will result in an investigation which could be avoided.... He also needs a comprehensive physical review."*⁶²**

5.1.2 The Panel is aware that this letter was written prior to the establishment of the PCT; however the PCT is responsible for ensuring an organisational culture where staff not only feel safe in raising serious issues concerning the quality of service user care but also are assured that these issues will be addressed.

5.1.3 The Panel was not provided with any evidence that the concerns raised in this letter from staff, who were very familiar with Geoffrey Hodgkins, were ever addressed. No formal response to the letter was found in the documentation received. Geoffrey Hodgkins remained a patient at Fair Oak and Cheriton wards until the date of his death, apart from a very brief period at Uplands Hospital in 2004.

⁶² Letter of 20th August 2000 from Deputy Senior Nurse on behalf of the nursing team to consultant.

5.1.4 As mentioned previously (see Section 4.6.1) the Panel was also concerned that there was nothing in the documentation to suggest that a review was undertaken to explore alternative ways of caring for Geoffrey Hodgkins that did not include long periods of restraint and/or that a review had taken place of the administration of medication despite the fact that the medication used for tranquilisation seemingly had little effect.

5.1.5 Generally, the Panel found that the quality and suitability of Geoffrey Hodgkins' overall treatment, care and supervision was lacking. The Panel has below, under the relevant section headings, outlined its examination of the different aspects of his treatment and care as well as its findings and recommendations.

5.2 Geoffrey Hodgkins's actual and assessed health and social care needs.

5.2.1 The Panel did not see any indication of a comprehensive health review having taken place despite concerns about the health risks associated with the restraints due to his display of symptoms; nor any evidence of the requested review of alternative ways of caring for Geoffrey Hodgkins as an in-patient that did not include long periods of restraint and the health risks associated with these; and no evidence of a comprehensive physical review.

5.2.2 The quality of Geoffrey Hodgkins' actual and assessed health and social care needs was also affected by the lack of comprehensive multi-disciplinary input (see Section 5.6), and what seemed to be a lack of a planned approach to Geoffrey Hodgkins' health and social care needs.

5.2.3 The Panel found that concerns had been raised by staff in relation to the legal status of Geoffrey Hodgkins during his last stay at Cheriton and the impact of this on the nursing and care he received.⁶³ The use of Common Law, as the legal framework for restraint and medication against the will of informal patients, is an approach that the Panel feel the PCT should be very cautious of pursuing for in-patients. The Panel therefore shares the serious concerns expressed by staff.

Recommendation:

That the PCT reviews the legal implication of the care it provides to informal patients including practice of restraint, consent to treatment procedures, right of leave and rights of nearest relatives.

⁶³ See for example History Sheet 9th October 2004.

5.2.4 Equally, the Panel was concerned by the organisational culture which allowed serious concerns raised by the clinical staff about the quality of care of a service user such as Geoffrey Hodgkins to pass without documented consideration of action by senior clinicians or managers within the PCT. The Panel also found that despite a stated commitment by the PCT⁶⁴ to ensure that staff knew how to report concerns via line management or clinical governance lines, the Panel received no evidence that the necessary actions have yet been taken to prevent such a situation recurring. Nor did the Panel receive any evidence to demonstrate that the commitment had resulted in any actions.

Recommendation:

That the PCT Senior Management Team urgently consider ways of improving the clinical governance system so that it allows for the monitoring of and response to any concerns raised by staff about the quality of care provided, including the use of a whistle-blowing policy.

5.3 Actual and assessed risk of potential harm to self and others

5.3.1 According to his Risk Management Plan⁶⁵ the last recorded date of Geoffrey Hodgkins' self-harm was in 1993.

5.3.2 The same Risk Management Plan also states that there are certain 'trigger factors' which will cause Geoffrey Hodgkins to react such as intimidation from others. Equally importantly, the Risk Management Plan notes that there is a good response to staff intervention that uses 'distraction techniques'.

5.3.3 Geoffrey Hodgkins had a recent history of violence associated with increasingly disturbed behaviour during October and November 2004. During his 'episodes' he would be violent to staff, fellow patients and damage furniture. In his Risk Management Plan it is noted ***'Very difficult to stop "fit" because of lack of triggers. Will need minimum of 4 staff to restrain if required'***.⁶⁶ There is again a discrepancy between this Plan, the Crisis and Contingency Plan⁶⁷ and information provided to the Panel. The latter Plan and information to the Panel identified triggers prior to an 'episode' such as ***'excessive giggling, staring into window/mirror, locked away in toilet'***.

5.3.4 From the information made available to the Panel it would appear that during the evening of the 19th November 2004 it was the inappropriate

⁶⁴ Minutes of the meeting of Clinical Directors. Not-dated May 2005

⁶⁵ Risk Management Plan. 16th August 2004

⁶⁶ Risk Management Plan. 16th August 2004

⁶⁷ Crisis and Contingency Plan 16th August 2004

behaviour of another patient that served as the trigger for Geoffrey Hodgkins' behaviour and the Panel received no information to indicate that there had been any of the psychotic 'triggers' present on the 19th November 2004 prior to this event. This, in the view of the Panel, suggests that it was the behaviour of another patient that triggered the incident but that staff failed to recognise the potential difference between the triggers caused by vulnerability and those of psychotic nature. The result was that no attempt was made by staff to use distraction techniques despite it being mentioned as a technique which could generate a good response from Geoffrey Hodgkins.

- 5.3.5 With regards to harm to himself, the Panel was not made aware of any recently recorded actual or assessed risks of potential self harm for Geoffrey Hodgkins. In the documentation made available to the Panel records had been made of past episodes of actual and assessed risk of potential harm to others including other patients and staff. Information provided to the Panel stated that during restraint episodes there had been a need for several members of staff to be involved due to his behaviour. The Panel concluded that this history of harm to others during periods of restraint had an impact on the decisions made by staff on the 10th November 2004 with regards to the approach taken.

Recommendation:

That the PCT Senior Management Team reviews its policies and procedures including training of staff in rapid tranquilisation to take account of risk history, trigger factors and alternative interventions as well as the need for accurate and relevant documentation of risks.

5.4 Previous psychiatric history

- 5.4.1 The Terms of Reference⁶⁸ request that the Panel examines the quality of care provided to Geoffrey Hodgkins in the context of any previous psychiatric history including alcohol and drug misuse. Geoffrey Hodgkins had been a mental health service patient for most of his life and his psychiatric history was known to the PCT. The Panel saw no information that it considered relevant.

5.5 Previous forensic history

- 5.5.1 The Terms of Reference⁶⁹ request that the Panel examines the quality of care provided to Geoffrey Hodgkins in the context of any previous forensic history. The Panel saw no information that it considered relevant.

⁶⁸ See Terms of Reference section 2, bullet point 3

⁶⁹ See Terms of Reference section 2, bullet point 4

5.6 Appropriateness of the decisions made by the practitioners involved

5.6.1 Contained within the patient notes are different documents that relate to the care of the patient but there seems to be little cross-referencing between the separate assessments to the extent that they, at times, seem to be in conflict. Although there were different needs and risk assessments there did not seem to be one comprehensive risk assessment covering all the relevant history, such as, the risks to Geoffrey Hodgkins from the medication regime he was under, despite its reported effect of excessive sleepiness, and his risks from the prolonged periods of restraint. Neither were there indications in the risk plans of any pro-active interventions from staff to protect Geoffrey Hodgkins from bullying and intimidating patients. Specific examples of distraction techniques that might have been most effective and in which situations they should be used and by whom were also absent apart from in one document⁷⁰ which sets out different approaches to be adapted depending upon the deterioration of Geoffrey Hodgkins' mental state. These different approaches include the range from monitoring, to medication, and to keeping Geoffrey Hodgkins within closed doors and in sight whilst calling for assistance.

5.6.2 The Panel was very concerned that it was provided with no evidence that any attempt was made by staff at the very beginning of the incident to contain the situation. Geoffrey Hodgkins was in a locked room which had a door with a see-through panel so he could have been kept in sight. No attempt was made to talk to him, offer him medication or use any other method to calm the situation. Before staff entered the family room there was, to the knowledge of the Panel, no attempt made by Geoffrey to be destructive and/or violent. No smashing of furniture in the room was recorded nor verbal or physical threats towards staff, nor banging on windows nor throwing of the things in his hand. The Panel was informed that the use of the room to store furniture / lamps was considered by staff to be a health and safety issue and one of the reasons that GH was felt not to be safe in the room.

Recommendation:

That the PCT Senior Management Team reviews the use of intervention and de-escalation steps for dealing with violence and aggression and consider alternative models.

5.6.3 The Panel was concerned that the breathing problems experienced by Geoffrey Hodgkins during a restraint period on 3rd October 2004 did not lead to a medical assessment of his physical health. There was,

⁷⁰ Document titled *Geoffrey Hodgkin's ...Relapse in mental state/Aggression*. 24th October 2003

- apparently, no review of the restraint methods or the medication used when dealing with Geoffrey Hodgkins nor a consideration of the maximum length of restraint to be applied.
- 5.6.4 Of other issues relating to the appropriateness of decisions taken by the practitioners involved, the Panel noted that the referral of Geoffrey Hodgkins for an x-ray was not followed up by the nursing staff and no record of this was made in his records. The considerations leading to this decision were not documented. Another issue considered by the Panel relates to the lack of effective response from Geoffrey Hodgkins, according to his medical history, to the medication prescribed for his 'episodes'. No evidence was provided to the Panel that an adequate review of this part of his medical regime had taken place. Generally, the supporting documentation for decision-making since Geoffrey Hodgkins' re-admission to Cheriton is not of good quality. There are inconsistencies, lack of completed forms, undated and un-signed forms⁷¹ and lack of documented considerations and decisions.
- 5.6.5 The Panel was equally disappointed by the apparent lack of appropriate multi-disciplinary decision-making. The Panel saw an example of a Multidisciplinary Service Review⁷² for Geoffrey Hodgkins where only minimal information was included on the top of the first of 4 pages and the remainder was left unanswered. There was no indication that any multidisciplinary input had been sought for this review.
- 5.6.6 The Panel found no evidence of any true Multi-disciplinary meetings taking place since Geoffrey Hodgkins' readmission and the Panel did not see any evidence of planned and structured activities being offered to Geoffrey Hodgkins. This was contrary to the support, which his family mentioned he was receiving, prior to being placed at Uplands Hospital. This support was also evidenced by documentation to the effect that Geoffrey Hodgkins, whilst under the care of Fair Oak, had received such input⁷³. From the information provided to the Panel, it seems as if the ward rounds at Cheriton were characterised by the maxim 'those who were around would attend' rather than an established planned meeting with documented and minuted multi-disciplinary input to the care and planning for the individual patients.
- 5.6.7 It appears from the documentation about Cheriton ward⁷⁴ that occupational therapy support was available via the Occupational Therapist who was part of the Fair Oak service. The Panel was informed that, apparently, an Occupational Therapist attended ward rounds. However,

⁷¹ Identified Need and Care Planning forms not completed, not dated and not signed, Needs and Risk Assessment forms not completed, not dated not signed.

⁷² Multidisciplinary Service Review. 21st July 2004

⁷³ Psychological Therapies Progress report for CPA Review. 16th April 2003.

⁷⁴ Undated document named *Cheriton House Current Establishment*

the Panel saw no evidence of Geoffrey Hodgkins ever having an Occupational Therapy assessment or treatment. The Panel found no mention of any psychology input to Geoffrey Hodgkins' care or to Cheriton ward at all. A ward such as Cheriton should have had access to a psychologist to look at alternative ways of managing challenging behaviour and to assess patients for psychological therapies. The Panel is concerned that no active approach was taken to improve the quality of life for Geoffrey Hodgkins by, for example, a cognitive behaviour therapy nurse, an occupational therapist etc, especially in light of him being obese and a heavy smoker.⁷⁵

5.6.8 The Panel found that the pharmacy contract was not sufficient. There seems to be limited clinical support mostly on acute wards. There was no evidence of systematic input to Cheriton ward, for example, no information about attendance at ward rounds, or regular visits. The Panel found this absence worrying as the ward was caring for long term patients on medication for years and the medication management should therefore have been a priority. It had been noted by staff that Geoffrey Hodgkins did not respond to medication used for rapid tranquillisation and yet it continued to be used. The Panel was also surprised to be informed about Paraldehyde being prescribed to Geoffrey Hodgkins, as this is a drug rarely used in modern psychiatry. It is the view of the Panel that it was a major weakness in the care of Geoffrey Hodgkins that there was insufficient pharmaceutical advice and input to his care.

5.6.9 The Panel gained the impression overall of Geoffrey Hodgkins' last stay at Cheriton ward being treated merely as a containment stage before moving him on to a long-term private provider. This is not an acceptable quality of service, nor one which either a patient or relatives/carers should reasonably expect. The period since Geoffrey Hodgkins' re-admission was thus characterised by staff liking Geoffrey Hodgkins as an individual and wanting to care for him but whose approach was not systematic, not truly multi-disciplinary and not evidenced based.

Recommendation:

That the PCT Senior Management Team ensures that appropriate and relevant multi-disciplinary review and care planning takes place for each individual patient including the involvement of pharmacists.

⁷⁵ Undated document named *Geoffrey Hodgkins*

6. Examination of the extent to which Geoffrey Hodgkins' prescribed treatment and care plans were relevant, adequate, documented, agreed with the patient, carried out, monitored and complied with at all times.

6.1 Examination of prescribed treatment and care plans

6.1.1 It is the view of the Panel that the treatment provided to Geoffrey Hodgkins was not sufficiently personalised. The Careplans used were templates which did not reflect the changing needs of Geoffrey Hodgkins through the time when his disturbed episodes became more frequent during the months of October and November 2004.

6.1.2 The medication prescribed to Geoffrey Hodgkins was changed on 27th October 2004 following a number of disturbed episodes during that month. However, there was no indication of subsequent radical change in medication following the increase in disturbed episodes prior to the 19th November 2004.

6.1.3 Due to the increased frequency of disturbed episodes during November 2004 a decision was taken to change the status of Geoffrey Hodgkins and a Section 132 Information to Patients and Relatives form was filled in. However, the form was not signed by Geoffrey Hodgkins and the form was not filled in with regards to the patient understanding his rights. His brother, who was nominated as his nearest relative, informed the Panel that he had not been contacted by the PCT about the change in Geoffrey Hodgkins' status despite the documentation stating otherwise. However, he had, according to the Approved Social Worker, been consulted about the Section 3 application.

6.1.4 The Panel was very concerned that important documentation relating to the change in Geoffrey Hodgkins' Mental Health Act status was not completed correctly and that his next of kin did not recall feeling part of the process.⁷⁶

Recommendation:

That the PCT Senior Management Team considers ways of effectively communicating with service users and their relatives when changes of mental health status occur and ensures relevant evidence of that communication.

⁷⁶ Portsmouth City PCT St James Hospital. Section 123 Information to Patients and Relatives has not been ticked with regards to whether the patient understand the explanation of his/her right, see also Section 9.17

- 6.1.5 Documentation for the treatment and care of Geoffrey Hodgkins was generally weak. For example, it lacked cross-reference between Careplans and daily records, and too many documents in his case were not signed or up-dated as his needs changed. In some cases it was not possible to identify who was responsible for the Careplans. In one example it contained two parts each written by different members of staff of whom neither was the named nurse. The Careplans seemed to be written as a routine template procedure and not live documents which staff referred to and reviewed.
- 6.1.6 The most crucial aspects of Geoffrey Hodgkins' care and treatment were not recorded in the Careplans. There was a plan for managing a psychotic episode, but the plan stated that Geoffrey Hodgkins should be offered 1 to 1 time by a staff member when unsettled to prevent aggressive behaviour; social needs were referred to vaguely such as activities and time to visit his brother should be facilitated wherever possible. Also, there was no mention of the CBT nurse, whom Geoffrey Hodgkins' brother referred to, and who was involved in Geoffrey Hodgkins' previous care.
- 6.1.7 The Panel found that there should have been a comprehensive review of care plans and treatment programme, including consideration of alternative approaches to managing challenging behaviour such as seclusion areas, 'extra care areas' or de-escalation rooms.
- 6.1.8 The Panel received no evidence of discussions with Geoffrey Hodgkins since his re-admission, for example, to obtain his agreement to his Careplans.
- 6.1.9 The Panel examined minutes of a meeting held in March 2006⁷⁷ which suggested the use of a 'Health Screen Assessment' tool relating to physical health assessment and admission to hospital from April 2006. However, the Careplan Approach existing at the time of Geoffrey Hodgkin's re-admission to Cheriton ward in July 2004 also included the requirement for a health check⁷⁸ both within 24 hours of admission and at least every six months thereafter. The Panel saw no evidence that this had occurred.
- 6.1.10 The Panel's concern was, therefore, not so much focussed on the existence of relevant policies and procedures, although important, but on compliance with these. Policies or procedures, however good they might be, will not bring any benefit to the quality of service delivery if they are not adhered to in practice by those charged with delivering the services to the service users. It is a key function of good quality management to ensure that policies are reflected in practice (see Section 7).

⁷⁷ Physical health Care – meeting 29th March 2006

⁷⁸ Fairoak Service. Careplan for the management of violence and aggression by the use of physical restraint. Section 2.

6.1.11 Overall, the Panel found that the prescribed treatment and care plans for Geoffrey Hodgkins were not sufficiently relevant, adequate, documented, agreed with Geoffrey Hodgkins, carried out, monitored and complied with at all times.

Recommendation:

That the PCT Management Team ensures the relevance, standard, documentation, user involvement, implementation, monitoring and compliance to personalised patient treatment and care plans.

7. Examination of the extent to which the overall management of Geoffrey Hodgkins' care, in the period leading up to the incident, and the incident itself complied with statutory obligations, the Mental Health Act Code of Practice, local operational policies and practice guidance and relevant guidance from the Department of Health including the Care Programme Approach and other relevant sources of best practice

7.1 Overall management of care

7.1.1 The Panel concludes that Geoffrey Hodgkins' overall management of care complied only partly with statutory duties and best practice and not in any managed, monitored or comprehensive way.

7.1.2 Amongst the issues which gave the Panel the greatest cause for concern was to the lack of attention paid to Geoffrey Hodgkins' mental health status, especially with regards to his and his nearest relative's rights, and lack of formal consent to treatment including restraints. This is especially so as Geoffrey Hodgkins was restrained under 'Common Law' whilst an informal patient a total of 4 times up until 19th November 2004.

7.1.3 The other issues causing concern were the lack of adherence to the PCT's own policies on restraint, the lack of an appropriate use of the Care Programme Approach to inform practice, the lack of alternative modes of interventions instead of restraints, the lack of a personalised and agreed escalation/de-escalation plan. Apart from a brief mention in the Care plans, the Panel saw no evidence of the impact of the Bennett Inquiry in any of the documentation provided (see Section 7.2 – 7.3).

7.2 The PCT's policy and protocols of restraint.

7.2.1 In the period leading up to the incident on 19th November 2004 and during the incident itself, the PCT had in place a Careplan for Physical Restraint with a reference to the Bennett Inquiry recommendations but the Panel received no evidence of a comprehensive action plan on the integration of the Bennett Inquiry recommendation into the PCT's policy and protocols for dealing with restraint. The Panel received no evidence of the presence of an escalation/de-escalation policy or any evidence of how the Department of Health guidance and best practice from elsewhere had influenced the PCT's own policies etc.

7.2.2 A Risk Management Policy was present but the Panel received no evidence of any active inter-relationship between the information collected

as required by this policy and the information collected and utilised as part of the Careplan for Physical Restraint.

- 7.2.3 Based on the evidence provided to the Panel, the Panel concluded that the PCT policy and protocols on restraint have very few references to any statutory obligations, the Mental Health Code of Practice, other local operational policies and practice guidance, relevant guidance from the Department of Health including the Care Programme Approach and other relevant sources of best practice.

Recommendation:

That the PCT Management Team reviews the PCT policy and protocols on restraint and ensures that these take into account all statutory obligations, relevant guidance and best practice and ensures relevant inter-relationships between its operational policies.

7.3 Adherence to PCT policies and protocols on restraint.

- 7.3.1 When reviewing the documentation the Panel saw evidence of a lack of adherence to the PCT's Careplan for Physical Restraint as this did not contain any mention of the use of quilts/duvets and towels as recognised tools. The Careplans, including Geoffrey Hodgkins' Careplans, did contain a reference to the recommendations in the Bennett Inquiry for a maximum of 3 minutes restraint in the prone position but this was not adhered to in practice. On the contrary, Geoffrey Hodgkins was, according to the information provided to the Panel, on occasions restrained for up to 6 hours.

- 7.3.2 The Emergency Response Procedure used at the time of the incident⁷⁹ stated⁸⁰ that ***'It is the responsibility of the Nurse in Charge of the clinical area requesting support, to co-ordinate the response team'*** and in case of medical emergencies ***'Dial (9) 999 and give the following information: -Type of emergency, - Location , - Respond to the questions being asked of you'***⁸¹ and ***' The member of staff discovering the emergency must ensure: -555 is activated, - initiate and continue basic life support/first aid until the duty senior nurse advice them otherwise.'***⁸² Finally, the Procedure states with regards to the use of security guards that ***'The security guard will assist in directing people as delegated by the Duty Senior Nurse and to***

⁷⁹ Emergency Response procedure to Psychiatric and Medical Emergencies for St James Hospital POL-E-2Issued Dec 2003, Reviewed June 2002, Due for review April 2004.

⁸⁰ Emergency Response procedure to Psychiatric and Medical Emergencies for St James Hospital POL-E-2Issued Dec 2003 Section 1.2.8

⁸¹ Emergency Response procedure to Psychiatric and Medical Emergencies for St James Hospital POL-E-2Issued Dec 2003 Section 2.1

⁸² Emergency Response procedure to Psychiatric and Medical Emergencies for St James Hospital POL-E-2Issued Dec 2003 Section 2.3.1

***communicate with front hall staff as required*⁸³ and that *'All staff involved in direct service user care must be trained in Basic Life Support and receive mandatory yearly updates'*⁸⁴.**

- 7.3.3 In the case of the Geoffrey Hodgkins incident on 19th November 2004 it was the nurse in charge who requested support but it was the Duty Senior Nurse (bleep 1701) who coordinated the response team.
- 7.3.4 It is clear from the transcripts of the phone calls made to the Hampshire Ambulance Services⁸⁵ during the incident that the information required to be given by the procedure was not provided. The Ambulance Controller was, therefore, not in a position to send an ambulance to the site. The first call from Cheriton seems to have been aborted by the caller before any useful information was provided. The second call, nearly 10 minutes later, was a follow up call from St James' Front Hall and that, too, did not contain sufficient information for the Ambulance Service to act upon before it was aborted by the caller. The third call, which was received about 1 minute later, was the first call to provide sufficient information for the Ambulance Service to act. The Panel found the loss of more than 10 minutes due to poor communication with the Ambulance Service extremely worrying. However, the Panel was not able to draw any definitive conclusion as to whether any different actions by individuals would have resulted in a different outcome.
- 7.3.5 The procedure has since been revised (see Section 4.6.5) and now stresses the information that needs to be given. However, the issue of importance in this incident is not related to the procedure itself but to its implementation in practice. Staff seem to have been confused by the situation and did not follow procedures which is indicative of insufficient or ineffective training.

⁸³ Emergency Response procedure to Psychiatric and Medical Emergencies for St James Hospital POL-E-2 Issued Dec 2003 Section 2.3.5

⁸⁴ Emergency Response procedure to Psychiatric and Medical Emergencies for St James Hospital POL-E-2 Issued Dec 2003 Section 2.4

⁸⁵ Transcript of Hampshire Ambulance Service recording of 19th November 2004

7.3.6 The Panel's view that policies are not practiced was also supported by an internal Audit report In January 2006⁸⁶ which states:

“there is a lack of management information to show that staff at all levels are carrying out the processes consistently and completely.”

Recommendation:

That the PCT Senior Management Team reviews the current training provision. It should also consider whether emergency drills or similar simulations are required to ensure application in practice of relevant policies, procedures and guidance.

7.4 Risk management procedures and incident reporting

7.4.1 The PCT operates a structure whereby risks are managed by the Business Assurance Committee. The risk management system manages all organisational risks but, in the view of the Panel, is not sufficiently aware of the multi-dimensional risk factors that come into play when dealing with patients with complex mental health issues. The Panel found that the PCT would benefit from an over-arching Risk Management policy specifically addressing issues such as:

- The approach to risk identification and management;
- Multi-disciplinary input to risk management;
- Prevention and de-escalation of risk events;
- Risk assessment procedures;
- Individual risk management plans incorporating Warning Indicators and Contingency plans

7.4.2 Some of these issues were identified in the case of Geoffrey Hodgkins but in a very incomplete and inconsistent way. For example the Panel saw no evidence of an individualised plan for Geoffrey Hodgkins about C&R, or rapid tranquilisation. There was a standard ***'Care Plan for the Management of Violence and Aggression by the use of physical restraint'*** form signed by the named nurse but not signed by Geoffrey Hodgkins. The form has a section for ***'Actions individual to the patient'***, which was left blank, although there were a number of special factors in Geoffrey Hodgkins' case e.g. respiratory problems and epilepsy. Particularly concerning was the lack of revision of care and treatment following the restraint incident on 3rd October 2004, when respiratory

⁸⁶ Portsmouth City Teaching Primary care Trust Risk management AD-R15602. *Internal Audit Report*. 19 January 2006 Executive Summary.

problems and hyperventilation were observed. During the visit it became apparent to the Panel that not all staff involved in the incident on the 19th November 2004 was aware of this previous incident. Additionally, the Panel saw no evidence of a Contingency Plan being in place.

7.4.3 According to the risk management procedures in place at the time of the incident, staff were required to fill out a Risk Event Form with a unique serial number after each risk event. The Panel reviewed the risk forms relating to Geoffrey Hodgkins which were filled in after each risk event as well as a number of risk events occurring during the 19th November 2004⁸⁷. The Panel was surprised to find that on all the 6 risk event forms relating to the 19th November 2004 the sections relating to senior/manager's action were not filled in before 6th December 2004. This was more than 2 weeks after specific risk events and was irrespective of the nature of the risk.

7.4.4 The completion of important forms was commented upon by the Internal Audit Review:

“There is space for actions, both immediate and planned, on the adverse event report forms ... There is also space for comments on follow up action, which is the service manager's responsibility to ensure occurs, but very few have been completed and none could be viewed by the auditor.”⁸⁸

Recommendation:

That the PCT Senior Management Team reviews the purpose of the Risk Event Forms and initiates an audit of the completion of the forms to ensure a comprehensive and relevant Risk Register.

7.4.5 The Panel requested several times to see copies of the incident reporting records relating to Geoffrey Hodgkins to ensure that the risk management system in place was sufficient robust to stand scrutiny and provide audit of actions. Prior to and during the visit the Panel was provided with different reporting extracts. All were incorrect as they did not include all the incidents which had taken place during October/November 2004. Some of the formats provided were not structured around normal search criteria such as name/form number and some did not use a systematic approach to incident dates⁸⁹. A data search sheet of an incident involving Geoffrey Hodgkins also included an incident involving another patient. The

⁸⁷ Risk Event forms 49900 - 49905

⁸⁸ Portsmouth City Teaching Primary Care Trust. Internal Audit report – Risk management (AD – R15602) 19th January 2006 Section 22 p. 4

⁸⁹ e.g. 10/07/2004; 11/05/2004; 11/12/2004, 19/11/2004 which indicate that the order in which date and months are used are not consistent

breathing difficulties observed during the restraint on 3rd October 2004 were not noted on one of the Incident Reporting Print-Outs nor were the categories 'severity' or 'likelihood' completed.

- 7.4.6 Having raised these inaccuracies at the visit as a serious concern about the PCT's ability to provide appropriate and relevant risk information to inform its risk management system, the Panel was then provided with evidence that all the relevant incidents involving Geoffrey Hodgkins were correctly reported. Although it is reassuring that the system, albeit after several attempts, was able to provide the requested documentation, it was very worrying that so much incorrect documentation was provided initially and was only corrected when the Panel repeatedly highlighted inaccuracies.

Recommendation:

That the PCT Senior Management Team ensures that regular audits of the appropriateness, accuracy and relevance of risk and incident policies and procedures are carried out and appropriate actions plans identified and monitored for impact.

8. Examination of the overall quality of the collaboration, communication and effective working between all parties involved at the time of the incident and previously, as the Panel considers relevant.

8.1 Collaboration

8.1.1 In order for effective collaboration to take place it is essential for those involved to understand the situation they are dealing with, the approach to managing the situation and the expectation of the contribution of each individual. From staff statements it is clear that there was lack of clarity about who was in charge on the 19th November 2004. Some members of staff expressed to the Panel a sense of inability to raise concerns about the approach taken as they were not on their own territory. It is, therefore, the assessment of the Panel that little effective collaboration took place between the members of staff involved in the incident and that the response to the incident was characterised by a series of individual actions rather than a collaborative, well managed intervention.

8.2 Communication

8.2.1 The Panel did not receive any evidence of effective communication between the various parties at the time of the incident. Staff involved did not know what was expected of them and did not ask questions either. Effective communication seems to have been not merely ineffective but altogether absent. The crucial communication with the Hampshire Ambulance Services at first attempt at 20.43.40pm was of unacceptable standard as it did not provide the ambulance service with any information upon which it could act (see Section 7.2.4).

8.2.2 Following the internal Critical Incident Review, staff were not communicated with effectively. From statements to the Panel, they did not seem to recognise any outcomes of the review, did not feel involved in the identification of recommendations and did not feel that any learning had taken place within the organisation.

8.2.3 The second internal review did not result in any action plan and the Panel did not receive any evidence to demonstrate that the report had been shared with staff and that any learning arising from this had been identified. The communication up through committees to Board level was equally difficult to identify for the second review and the Panel saw no

management response to any of the very damaging issues highlighted in the report.

- 8.2.4 Finally, there appeared to be no planned approach to the handling of communication and support to Geoffrey Hodgkins' family as the Panel saw no evidence of a communication strategy involving Geoffrey Hodgkins' family. Several requests were made by the family for more information and the PCT merely reacted to these requests for information rather than involving the family proactively at the very important stages immediately after the incident.

Recommendation:

That the PCT Senior Management Team together with the Communication Manager review its existing communication strategies with particular regards to the effective management of Critical Incidents.

8.3 Effective Working

- 8.3.1 It is the assessment of the Panel that there was no evidence of effective team working between the parties at the time of the incident. There was no evident leadership, no clear division of roles and responsibilities and no agreed action plan for what to do when and by whom.

- 8.3.2 From the statements provided by staff involved in the incident, it appears that each undertook their tasks for a variety of different reasons and changed those tasks during the incident according to whether someone by chance came and offered to take over, or someone needed a break or was required for other tasks somewhere else. However, each of those decisions was dealt with on an individual basis rather than in a planned way. There was no plan for dealing with any complications and when the restraint started it was a health care support worker who took the role at the head of Geoffrey Hodgkins' and who made the decision to use the towels. Similarly, when the breathing problems occurred the person, who should have taken charge of the resuscitation procedures, had left the room. The role of the nurse in charge was also unclear during the incident as this person was not present in the room all of the time and did not seem to ensure effective working through the direction of tasks.

Recommendation:

That the PCT Senior Management Team reviews the PCT policies for managing violence and aggression and resuscitation in order to establish clear roles and responsibilities for qualified as well as unqualified staff involved in such situations.

9. Governance and Accountability

9.1 Clinical Governance

9.1.1 The Panel, in its discussion about the effectiveness of the Clinical Governance structure in place within the PCT, has used the following definition of Clinical Governance:

“A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.”

A First Class Service – Quality in the new NHS⁹⁰

9.1.2 The Panel was concerned that a serious incident such as in this case did not result in any exceptional reporting or figure on the agenda or in any minutes of the Clinical Governance Sub-Committee at their meeting on 15th December 2004, 22nd March 2005, 29th November 2005, 20th December 2005 or 21st February 2006 nor was it mentioned at the Clinical Governance meeting on 17th March 2005, where the minutes state that ‘CIR’s taken out of CG meeting’.⁹¹

9.1.3 The relationship between the various Clinical Governance committees is unclear from the minutes and from the committee structure plan provided to the Panel by the Chair of the PCT. The paper copies provided to the Panel are all titled ‘Clinical Governance’ or ‘Clinical Governance Sub-Committee’.

9.1.4 By not taking a lead role in the management of serious untoward incidents and, apparently, not even discussing the repercussions of such an incident at the most senior clinical governance meetings immediately after the event, the Panel found it difficult to find evidence that the Clinical Governance committee and reporting structures complied with the ethos of continuous quality improvement and safeguard high quality care as laid out in the principles of Clinical Governance. The Panel therefore recommends that:

Recommendation:

That the PCT Board and Senior Management Team review the current clinical governance structure to ensure that the PCT is providing the most appropriate committee and reporting structure enabling a

⁹⁰ *A First Class Service – Quality in the new NHS*. Department of Health. 1998 p.33

⁹¹ Minutes of Clinical Governance Meeting 17th March 2005.

culture of continuous improvement of services and safeguarding high standard of care.

9.1.5 Minutes of the Clinical Governance Sub-committee and the Mental Health Act Panel are provided to the PCT Board Part II and ***“The Board is asked to note the minutes of all these meetings”***.⁹² It states in the minutes from the Mental Health Act Panel⁹³ that ***“No actions are outstanding from the Geoffrey Hodgkins internal review”***. However, the Panel was not provided with evidence of any in-depth Board discussion of any specific or generic learning generated within the PCT following this incident. The only other reference provided to the Panel of the incident being discussed at Board level was the minutes of the June 2005 Board meeting⁹⁴, when an update of the case of Geoffrey Hodgkins was provided and discussed. However, there is no evidence provided by the minutes of any discussion about organisational learning or the safeguarding of service user care.

9.1.6 Training and development of staff is one of the pillars of good clinical governance and part of that is ensuring that the workforce is skilled adequately to provide the right quality of care to those receiving it. An Internal Audit Report commented upon the training of staff:

“Individual services are expected to carry out training needs assessments and then supply the training department with training plans for their staff. Staff interviewed during the audit were not aware if this was actually carried out ... The lack of recording of attendance at mandatory/statutory training has been raised as an area of concern in other reviews and this has led to the training being brought in-house”⁹⁵

9.1.7 The PCT confirmed to the Panel that it had recently brought training in-house in order to provide a more appropriate training support arrangement for staff. The PCT also supplied the Panel with information about the members of staff involved in the incident on 19th November 2004 who had been C&R trained prior to the incident⁹⁶. It appears from the information that the security guards involved in the restraint were not trained in C&R at that time and that no record was held with regards to the agency nurse. The other staff had all completed the C&R training.

⁹²Agenda item 12. Minutes of Meetings provided for PCT Board Part II Meeting March 2006.

⁹³Mental Health Act Panel Minutes of 8th December 2005 agenda item 6

⁹⁴ 16th June 2005 Minutes of PCT Board meeting part 2, item 4

⁹⁵ Portsmouth City Teaching Primary Care Trust. Internal Audit report – Risk management (AD – R15602) 19th January 2006 Section 24 p. 5

⁹⁶ Internal PCT email of 30th June 2005 to Risk Manager from Education & Training Manager.

9.1.8 The Panel was very concerned that the PCT, at the time, allowed security guards, who were not trained to deal with restraint situations, to participate in such on a regular basis. The Panel was satisfied that this practice has now been stopped as part of the revised Emergency Response Procedure. The Panel remained, however, concerned that the PCT, to date, holds no record of the training received by agency staff. This could lead to members of staff becoming involved in serious situations for which they have no training.

Recommendation:

That the PCT Senior Management Team ensures that only staff trained in C&R are involved in the restraint of patients in its care.

9.1.9 The Panel was also concerned to learn that as Geoffrey Hodgkins was sleeping excessively during day and night, he had become overweight in addition to being a heavy smoker. One aspect of a Clinical Governance agenda is to safeguard high standards of care. Despite this there did not seem to be any health improvement initiatives directed at Geoffrey Hodgkins after his re-admission to Cheriton in June 2004 to address obesity or his smoking habits even though these initiatives rank highly amongst the PCT's targets.

Recommendation:

That the PCT Board and Senior Management Team ensure that their health improvement initiatives relate to in-patients as well as to the general public.

9.2 Serious Untoward Incidents management

9.2.1 The PCT, at the time of the incident, had arrangements in place to deal with serious untoward incidents including the investigation/reporting of these in the form of a Risk Event Response Policy and Guidelines for carrying out a Critical Incident Review.⁹⁷

9.2.2 The first internal Critical Incident review was carried out on 8th December 2004 which was 18 days after the incident despite the fact that the Risk Event Response Policy stipulates that all Critical Incident reviews should take place within 10 days of the incident occurrence. If a thorough incident review is to take place it could be that 10 days is too short a time to collect all the relevant information, however the PCT should comply with its own policies or, in default, record the reasons for non-compliance.

⁹⁷ Operational Policy Risk Event Response Policy COR/010. Oct 2003 and Guidelines for Carrying out a Critical Incident Review (CIR). COR/011. Oct 2003

Recommendation:

That the PCT Senior Management considers, as part of its review of the Risk Event Response Policy, the adequate timing of the first critical incident review and audit the PCT compliance with the required deadline.

- 9.2.3 The Critical Incident Review which took place on 8th December 2004 invited a large number of individuals to attend in addition to the staff who were present during the incident. By the time of the Critical Incident Review all the security guards had been instructed by the Facilities Coordinator to write detailed accounts of the event.⁹⁸ However, the rest of the staff did not make any written notes setting out their personal account of the incident, despite external and internal management correspondence stating otherwise.⁹⁹ The lack of notes from staff, made when events were still fresh in their minds, has been a major contribution to the difficulties in establishing a chronology of events during the evening of the 19th November 2004.
- 9.2.4 The initial Critical Incident Review set out the restraint history of Geoffrey Hodgkins since the beginning of October 2004 and the chronological sequence of events primarily during 19th November and leading up to the death of Geoffrey Hodgkins on 20th November 2004. The Report also identified 4 issues that could have been done differently, summary remarks as well as a section named ***'What are the learning points and actions required (or already taken) to prevent this incident happening again?'*** in which 12 points are listed (see Section 9.2.7 below).
- 9.2.5 The Guidelines¹⁰⁰ for dealing with critical incidents states that a Critical Incident Report should identify Root Cause/s such as ***'Latent failures ... Condition of work ... Active failures ... Control/defences ...'*** and that ***'A CIR Report is produced within 7 working days of the last review meeting'***. In the case of the Critical Incident Review carried out on the 8th December 2004 the first report was produced sometime in January 2005 but seems to have been published sometime in March 2005, amended again in May 2005, which is several months following the December 2004 review meeting. There was no evidence provided to the Panel that this lack of adherence with the PCT's own guidelines gave senior management cause for concern.
- 9.2.6 The Panel would suggest that it might not be realistic to provide a comprehensive critical incident report within 7 days of a review meeting

⁹⁸ Email of 23 November 2004 from Facilities Coordinator to Associated Director AMH.

⁹⁹ SUI Media and Briefing. Hampshire and Isle of Wight Strategic Health Authority. 19th November 2004 and Email of 22 November 2004 from Associate Director AMH to head of AMH Commissioning

¹⁰⁰ Guidelines for Carrying out a Critical Incident Review (CIR). COR/011. Oct 2003 Section 10 and 11

which encompasses a Root Cause analysis but several months delay is not a standard considered acceptable.

Recommendation:

That the PCT Board together with the Senior Management Team consider the internal Reporting systems following Serious Critical Events including Reporting to Board level and monitor compliance with its own policies.

9.2.7 The Critical Incident review identified the following 12 learning and action points:

- **999 calls**
- **Emergency Procedure**
- **Equipment**
- **Resuscitation mouth shields**
- **C & R**
- **Physical health checks for in-patients**
- **Who leads in an emergency**
- **Staffing levels**
- **Care planning**
- **Drug supplies**
- **Lighting**
- **Support from the Orchards¹⁰¹**

9.2.8 All the learning and action points were given deadlines between immediately and April 2005. Since the Report was probably not published before March 2005 the Panel consider that it would have been appropriate to have listed the deadlines as either **completed, in progress or deadlines after March 2005**. Given the tight deadlines, it was surprising that, even in January 2006, progress reports on the action list was still being presented to committees, especially since none of the actions were listed as on-going.

9.2.9 The Panel was concerned that issues raised within the Critical Incident Report, for example, observation made by staff noticing a change in Geoffrey Hodgkins in the week preceding the incident but not noted in the patient's record¹⁰², did not result in any learning or action point about the importance of comprehensive and updated documentation of changes in a patient's health. Also, the decision of staff not to take Geoffrey Hodgkins to A&E for an x-ray, despite a request from one of the doctors at a ward round, was noted in the review but did not lead to any specific

¹⁰¹ Critical Incident Review. 8th December 2004.

¹⁰² Critical Incident Review. 8th December 2004, Section 6

learning/action points nor to any reaction from senior management receiving the Report.¹⁰³

9.2.10 Equally, the Report¹⁰⁴ mentions that the staff discussion about the need for prolonged restraints of Geoffrey Hodgkins, contrary to the existing guidance¹⁰⁵ was not recorded in the patient's Risk Management or Crisis & Contingency Plans. This lack of documentation of an important staff discussion about the care of Geoffrey Hodgkins, although noted in the Report, did not lead to any learning or action point about risk management, consideration of alternative model of care, patient documentation etc. Finally, the Report¹⁰⁶ mentions that a completed Integrated Care Pathway for Rapid Tranquillisation would have been expected following the incident on 3rd October 2004 but that this was not found within the patient notes. This finding did not result in a specific learning or action point within the Critical Incident Report.

9.2.11 Having studied the Critical Incident Report and the author's comments about lack of documentation over a wide range of information critical to the provision of care to Geoffrey Hodgkins, the Panel finds it disconcerting that the Critical Incident Report identified issues but did not associate positive actions to them. Also, that senior management on receipt of the Critical Incident Report did not immediately pick this up is equally worrying. The subsequent internal medical review of the incident identified some of these issues but there does not seem to be a link between the different reviews nor cross-referenced findings.

9.2.12 The Critical Incident Report seems to have been published in March 2005 and, despite comments made about inaccuracy from different members of staff during January and February 2005, these individuals were informed in March 2005¹⁰⁷ that the Incident Report would not be changed as it had been published. However, the Report was amended in May 2005 without those individuals initially present being informed about this new amended version.

¹⁰³ Critical Incident Review. 8th December 2004, Section 2

¹⁰⁴ Critical Incident Review. 8th December 2004, Section 6

¹⁰⁵ The Independent Enquiry into the Death of Bennett Report (Dec 2003) and the NIMHE Mental Health Policy Implementation Guide on Developing Positive Practice to Support the Safe & Therapeutic Management of Aggression (Feb. 04).

¹⁰⁶ Critical Incident Review. 8th December 2004, Section 6

¹⁰⁷ Letter of 7th March 2005 from CIR Chair to staff

9.2.13 It is the view of the Panel that this first Critical Incident Review was not fit for the purpose of being a thorough incident review but was instead more of a staff debriefing session. The reasons for this view are that the Critical Incident Review:

- Took collective statements rather than individual statements;
- Did not include within the report comment about missing information within the chronology.
- Did not check the accuracy of the Report with those attending;
- Did not bring in all members of staff familiar with the care of the service user;
- Did not carry out a root cause analysis;
- Did not critically review the clinical notes or past history of the service user;
- Did not include correct dates or all the episodes in the history prior to the incident resulting in restraint in the period 3rd October to 19th November 2004¹⁰⁸
- Was judgemental in some areas without providing the evidence e.g. *'... staff should dial (9)999 for a medical emergency ... Whilst the course of action taken by staff at the incident did not affect the outcome in any way some staff attending the CIR reported they were not aware of this procedural change.'*¹⁰⁹

9.2.14 The Panel is aware ¹¹⁰ that the Chair of the Critical Incident Review did not have the patient's notes at the time of writing the Review as these were still with the Coroner and no copies had been made of them by the PCT before they were passed on. This could, with benefit, have been mentioned in the Report and led to a recommendation about a review of patient's notes at the earliest opportunity. The Panel was surprised that the PCT would provide the Coroner with the patient's notes without retaining copies and would recommend that the PCT review this practice as part of its Critical Incident procedures. The Panel was also concerned, when requesting missing pages from the patient notes, to be informed by the PCT that some pages might have been lost.¹¹¹

Recommendation:

That the PCT Senior Management Team reviews the way in which it stores and shares documentation with external bodies.

¹⁰⁸ Restraint episode on 7/10 was recorded as happening on 8/10 and incident on 15/11 resulting in 3 hours restraint not included.

¹⁰⁹ Critical Incident Review. 8th December 2004 Section 6.

¹¹⁰ Correspondence between chair of Critical Incident Review and Director of Service AMH 29th December 2004

¹¹¹ Information provided verbally by Director of Service AMH to Panel Chair

9.2.15 The Panel was also surprised by an initial reluctance to change even major issues of inaccuracy such as the time of death of Geoffrey Hodgkins, people being party to the incident etc. The Panel also thought it rather unfortunate that the footer on the Report gave the date of the 8th November 2004 and that this was not corrected in the revised version. The initial Report did not contain page numbers¹¹² which made referencing very difficult nor did it contain the date on which the Report was completed.

9.2.16 In May 2005 a further internal report was completed ***‘Report regarding the critical incident that took place on Cheriton House, St. James Hospital, 19th November 2004’***¹¹³ However, according to internal correspondence this report should not be seen as a formal review¹¹⁴ but it is unclear why since all staff involved in the incident were interviewed and their personal statements signed. This report identified a range of important issues which, if acted upon, would have led to significant improvement. Amongst these were:

- ***“Not all staff were confident or competent in Control and Restraint.***
- ***A number of non-clinical staff was involved in the restraint. This is not consistent with NICE guidelines relating to the management of violence.***
- ***The basic equipment needed for the resuscitation was either not available or not in good working order.***
- ***Staff were clear that certainly two, and possible three 999 calls were put out. Some of these were aborted and it is unclear why.***
- ***The family room where the restraint incident took place was being used to store items that it was possible to use in an aggressive way.***
- ***Physical health issues identified previously were not thoroughly addressed.”***¹¹⁵

¹¹² All pages in the Report is numbered 10, see Critical Incident Review. 8th December 2004.

¹¹³ This report was produced by the PCT Nurse Consultant, Adult Mental Health Service.

¹¹⁴ See email of 29th April 2005 from Service Manager AMH to Risk Manager.

¹¹⁵ Report regarding the critical incident that took place on Cheriton House, St. James Hospital, 19th November 2004. Undated, no page numbers. Written by PCT Nurse Consultant Adult mental Health.

9.2.17 The report also identified 5 important recommendations, which the Panel consider to be of great relevance to the provision of care and lessons learned beyond this particular incident. These recommendations were:

- ***“The establishment and skill mix of Cheriton should be reviewed.***
- ***Non clinical staff, in this instance the Security guards, should not be involved in the clinical procedures of any kind.***
- ***Current Control and Restraint training should be reviewed by the Education and Training Lead to ensure all staff are up to date and that processes and systems surrounding the use of Control and Restraint e.g. role of the person in charge and the role of qualified nurses are clearly understood.***
- ***The physical health of patients with long-term mental health problems should be assessed on a regular basis – at least annually.***
- ***Clarification regarding the best and most effective use of medication in order to prevent lengthy episodes of restraint needs to be sought”.***¹¹⁶

9.2.18 No action plan was identified as part of this report despite very clear recommendations relating to both managerial and clinical issues arising from this incident but with ramifications beyond. The Panel was very disturbed to find that such a thorough and relevant report did not result in any documented reporting up through the system to the PCT Board, did not lead to any defined action plan and did not result in any documented change despite highlighting apparent weaknesses in the system.

9.2.19 The Panel is aware that the previously routine practice of using security guards in restraint situations has now been stopped and that all PCT nursing and HCSW staff had, by the time of the incident on 19th November 2004, undergone C&R training. However, the Panel was not provided with any documentation demonstrating that the establishment and skills mix had been considered by management despite the fact that only 1 qualified and 1 un-qualified member of staff were on duty at the time of the incident. The other two staff present on the ward at the time had been brought across from other wards. The Panel has not been provided with any documentation that the training of C&R has been changed to ensure that the role of the person in charge and the role of the qualified nurses are fully understood. The Panel is particularly concerned about this as it seems that, for a long period of time during the restraint, the qualified nurses were absent from the room and the person in charge was not the person who took charge at the crucial times. For example, the decision to

¹¹⁶ Report regarding the critical incident that took place on Cheriton House, St. James Hospital, 19th November 2004. Undated, no page numbers. Written by PCT Nurse Consultant Adult Mental Health.

lock the door to the family room, the decision to throw a duvet over the patient, the decision about who should do what during the restraint and the management of the resuscitation attempts fell to different people. During the restraint period the Health Care Support Workers, the Security guards and one nurse from a different ward who had just qualified that day, were the ones who primarily managed the situation between them but informally with no-one in charge overall. This lack of evident leadership was also raised by the internal report.¹¹⁷

9.2.20 The Panel is also aware that the issue of physical health annual checks and review of medication in relation to restraint have been covered by a subsequent medical review. However, the medical review does not appear to be cross-referenced to the internal reviews and there seems to be no coordinated response to the different reviews and their findings.

9.2.21 In the informal internal report a number of key issues were also highlighted and the Panel was especially concerned about the following:

- ***“Towels were used as they routinely were with G.H restraint situations. This was because he would always spit when he was distressed and so staff used them to hold close to his face in order to control this and protect themselves. However, one person interviewed did express concern about the way the towels were being used...”***
- ***As far as the 2 Cheriton based staff were concerned there had been no indications at all that G.H. was becoming unwell that afternoon. He had been eating (something he apparently didn't do when he was distressed)... There were some suggestions from those interviewed that ... had gone into G.H room and hit him and that this was what had precipitated the problem.***
- ***Some of the health care support workers expressed considerable unhappiness in relation to the way that the qualified staff were talking about this – their impression was that they were more concerned about losing their jobs if G.H died than they were about him.***
- ***Two of the people interviewed said that, whilst G.H. was being restrained on the floor, a cigarette was being smoked and passed around a number of members of staff who were standing above this”¹¹⁸***

¹¹⁷ Report regarding the critical incident that took place on Cheriton House, St. James Hospital, 19th November 2004. Undated, no page numbers. Key issues emerging. Written by PCT Nurse Consultant Adult Mental Health.

¹¹⁸ Report regarding the critical incident that took place on Cheriton House, St. James Hospital, 19th November 2004. Undated, no page numbers. Key issues emerging. Written by PCT Nurse Consultant Adult Mental Health

9.2.22 The Panel finds it unacceptable for senior management within the PCT not to have taken effective action when they received such a critical report highlighting very serious issues concerning both the management of the critical incident and about the organisational culture. In evidence provided to the Panel, members of staff had either been offered a cigarette during the restraint situation or seen others smoking. The Panel did not hear statements to the effect that some members of staff were afraid of losing their jobs but was told that there was inappropriate talk about the length of time this restraint might possibly take. Irrespective of the specific content of the conversations, it is clear to the Panel that the nature of the conversation left some members of staff feeling uncomfortable. Management should have reacted to these indicators of poor organisational culture but there is no evidence that it did so.

Recommendation:

That the PCT Senior Management Team takes the appropriate management action to address the serious issues highlighted in the informal internal report

9.2.23 A medical review of the notes and clinical issues relating to the death of Geoffrey Hodgkins were subsequently requested by the Director of Service. This had not been included in any of the previous internal incident reviews despite their relevance to the quality of service delivery and organisational learning. This medical review identified recommendations and actions which the AMH Management Team was asked in August 2005 to consider and authorise immediate implementation if appropriate and agreed by the Team.

9.2.24 The four recommendations were:

- **Any concerns about the physical effects of restraint and rapid tranquillization on a service user should be discussed at a multidisciplinary meeting. These concerns should be recorded on the service users risk event record and, as is currently the case, this document should be routinely reviewed during future episodes. – By When: Immediate**
 - **Monitoring: Audit lead by AMH Q &CG group December 2005**
- **The allergies section on the medication card should be expanded to cover “Allergies and other concerns” and concerns about the physical effects of a particular form of medication should be entered here.**
 - **By When: Immediate**

- **Monitoring: Audit lead by AMH Q &CG group December 2005**
- **There should be multidisciplinary training sessions involving doctors, nurses and service users of residential units, during which there is a discussion of Trust policies for restraint and rapid tranquillization. This process could be used to inform the review of the Trust Rapid Tranquillization Policy.**
 - **By When: October 2005 and ongoing**
 - **Monitoring: Audit lead by AMH Q & CG group March 2006**
- **There should be at minimum an annual review of physical health care needs that have been assessed and recorded at admission.**
 - **By When: October 2005**
 - **Monitoring: Audit lead by AMH Q & CG group March 2006¹¹⁹**

9.2.25 The Panel fully concur with the recommendations put forward by the Director of Service to the AMH Management Team but did not see any evidence of requested audits having taken place or actions identified following these recommendations. This again raises the underlying concern of the Panel that the PCT is capable of identifying the right recommendations but does not have a sufficiently robust governance structure in place enabling recommendations to be translated into actions that are implemented, monitored and evaluated.

Recommendation:

That the PCT Board urgently ensures that it receives and fully discusses the implementation, monitoring and evaluation of the recommendations arising from the medical review and any issues not yet addressed from the Internal Reviews.

9.2.26 The Panel was also concerned by a number of further issues which none of the internal reviews identified. The further issues identified by the Panel were:

- **A review of restraint practices for each individual patient including the use of duvet and towels and the documentation of these in Careplans;**
- **A review of the need for availability of a duty doctor on site 24/7;**

¹¹⁹ Follow up actions and recommendations in respect of the death of Geoffrey Hodgkins – 9th August 2005 – updated 17th August 2005

- A review of quality of documentation generally e.g. staff felt that Geoffrey Hodgkins should not attend x-ray due to his mental state but did not document this anywhere.

Recommendation:

That the PCT Senior Management Team reviews all the critical issues within the various formal and informal reviews and identifies appropriate actions to address those hitherto neglected.

9.2.27 Concerns were raised within the PCT about the existing arrangements for dealing with Serious Untoward Incidents and a proposal for a review of these was put forward in February 2006¹²⁰ following a meeting between the Head of Quality, the Business Assurance Manager and the Risk Manager. Amongst the key findings identified were:

- ***“Most Critical Incident reviews identified events by reference to the service user’s notes and contributions from members of staff attending the review meeting.***
- ***CIR’s rarely took place within 7 days of an incident...***
- ***The CIR meeting is used as a forum for fully debriefing staff involved in the incident***
- ***The process by which the identification of all possible witnesses takes place is not clearly described in any of the CIR Reports reviewed...***
- ***...Few Reports clearly identified the local management action (and reason for them)***
- ***Involvement of individuals from outside of the specific service is rare.***
- ***In many cases the CIR Report provided a thorough narrative of patient history but without focus on opportunities for Service/PCT to learn lessons and implement actions that might reduce the potential for reoccurrence.***
- ***Reports... rarely appear systematic enough to identify what were Root Causes in accordance with NPSA ...guidance.***
- ***....recommendations ...made by the Investigating Officer to be translated in to action plans by service managers ... do not usually state an order of priority”.***

9.2.28 It is clear from the proposal for a review of the PCT processes that there is some understanding of the weaknesses within the current system. Given the fact that the PCT has known since spring 2005 that an External Enquiry would take place into the events leading up to the death of

¹²⁰ Proposal for review of critical Incident Review Process. 6th February 2006

Geoffrey Hodgkins including a review of policies, procedures and protocols, the Panel is surprised and disappointed that the PCT has not taken on board the internal concerns and already produced a revised and more appropriate arrangement for dealing with Serious Untoward Incidents. This is an area where the Panel expected that the Clinical Governance Committees, the PEC and the Board would have taken an active interest and ensured that revised processes were in place before the visit of the External Enquiry as the PCT knew that these issues would be scrutinised.

Recommendation:

That the PCT Board urgently ensures that an appropriate and revised process for dealing with Serious Untoward Incidents is developed and approved by the Board, shared with staff within the PCT and audited for compliance.

9.3 Governance

9.3.1 ***“Corporate governance has become increasingly important throughout society, since effective governance is the cornerstone of well-managed organisations whether they are in the public, private or voluntary sectors”.***¹²¹

9.3.2 According to the Audit Commission Corporate Governance is:

“The framework of accountability to users, stakeholders and the wider community, within which organisations take decisions, and lead and control their functions, to achieve their objectives.”¹²²

9.3.3 According to the Audit Commission, good corporate governance combines the ‘hard’ factors, such as robust systems and processes, with the ‘softer’ characteristics of effective leadership and high standards of behaviour. “It also incorporates both strong internal characteristics and the ability to

¹²¹ Audit Commission *Corporate Governance Framework*. 4 August 2005. www.audit-commission.gov.uk accessed on 2 May 2006.

¹²² Audit Commission *Corporate Governance: Improvement and trust in local public services. Understanding Corporate Governance*. 14 October 2003. www.audit-commission.gov.uk accessed on 2 May 2006.

scan and work effectively in the external environment. The internal combination of 'hard' and 'soft' characteristics involves:

- **“leadership that establishes a vision for organisations, generates clarity about strategy and objectives, roles and responsibilities, and fosters professional relationships;**
- **culture based on openness and honesty, in which decisions and behaviours can be challenged and accountability is clear;**
- **supporting accountability through systems and processes, such as risk management, financial management, performance management and internal controls. They must be robust and produce reliable information to enable better decisions to be reached about what needs to be done in order to achieve objectives; and**
- **external focus on the needs of service users and the public, reflecting diverse views in decision making, producing greater ownership among stakeholders and maintaining clarity of purpose.”**

9.3.4 According to the PCT, it has aspired to set up a governance structure ***‘which minimised bureaucracy, involved clinicians in decision-making and developed responsibility for decision-making’***.¹²³ The Panel was informed that the PCT operates a system of a ***‘very far reaching scheme of delegations from the board’***¹²⁴ and has consciously reduced the number of committees¹²⁵ with the aim of creating greater efficiency. A number of managers interviewed stated that the committees have inter-linked functions, that key individuals sit on a number of committees to ensure that issues are fully covered and that lead committees are identified. The PCT Chair informed the Panel that she carried out some of the monitoring of committees by attending their meetings at random and using this information in her fortnightly supervision meetings with the Chief Executive.

9.3.5 The PCT states¹²⁶ that ***‘in the PCT, the terminology “Board” extends almost controversially beyond the traditional concepts of a trust Board to encompass the PEC, its sub-committees, and much of the work of the Executive team...’***

9.3.6 Whilst this might be a novel and innovative way of working, the Panel was concerned by the lack of transparency and formality in the governance

¹²³ Undated Entry for HFMA Governance Award by Portsmouth City Teaching Primary Care Trust.

¹²⁴ Letter to Sir I Carruthers from the PCT Chair dated 26th March 2006.

¹²⁵ According to the statement by the Chair of 24th April 2006. The Chair gave the Panel a chart outlining the committee structure to the Panel but since the Remuneration Committee was absent the Panel was left not knowing if no remuneration committee exist or was omitted from the chart.

¹²⁶ Undated Entry for HFMA Governance Award by Portsmouth City Teaching Primary Care Trust.

structure that led to crucial issues not being addressed at the right level and by the lack of audit of decision-making and reporting. The PCT acknowledges this as a potential weakness but seems to accept these consequences:

“Unfortunately this means that we do not have the same paper trails that other organisations do as we do not take decisions at a board level that belong at the PEC nor do we ratify the decisions the PEC take. We merely monitor that they are doing what they said they would”¹²⁷

9.3.7 It is the view of the Panel that, whilst it would not dispute that such a scheme might be functional and effective with regards to certain non-critical business transactions, it has clearly failed to provide any assurance that the PCT dealt effectively and appropriately with an extremely serious and potentially damaging incident.

Recommendation:

That the PCT Board urgently reviews its leadership role as the accountable body for the management of critical incidents and ensures that the PCT deals effectively and efficiently with these and that learning generated is disseminated and practice impacted.

9.3.8 The Panel was repeatedly informed that minutes could not be produced from a number of meetings¹²⁸ as minute-taking was not routine for all meetings as part of the drive to reduce bureaucracy.

9.3.9 The PCT seems to have a tendency to call committees and policies by names that are different from the usual NHS descriptors, which has made auditing more difficult. The usual NHS Serious Untoward Incident Policy is, in the PCT, named ‘Risk Event Response Policy’ which title detracts from the serious nature of the incidents it supposedly addresses. The more commonly termed Risk Management Committee is replaced in the PCT with a ‘Business Assurance Committee’ and the Mental Health Act Panel seems to deal with issues not related to the Mental Health Act and not covered by its Terms of Reference such as Critical Incidents, for example.

9.3.10 The impact of this is that the External Enquiry found it very difficult to establish a clear and consistent audit trail of the Reporting of the Geoffrey Hodgkins’ critical incident, and to identify the main means of monitoring the action plan and the methods by which the action plan has been evaluated for impact and organisational learning. Even in those cases where minutes had been taken, these were often so brief that a

¹²⁷ Letter to Sir I Carruthers from the PCT Chair dated 26th March 2006.

¹²⁸ E.g. meetings held with Security team, Executive team meetings, medical management team meetings and AMH management team meetings as well as directors meetings.

meaningful audit of content became impossible. Similarly, the brevity makes it very difficult to establish any rationale for the decision-making. The Clinical Governance meeting in January 2006, for example, has one item under Matters Arising 'Critical Incident Reviews', where the minutes do not reflect any thorough discussion about critical progress, implementation or organisational learning points arising from any of the 5 cases covered. The Minutes of the meeting of Clinical Directors in December 2004 and April 2005¹²⁹ again do not reflect any thorough discussion about actions to be taken etc.

9.3.11 This difficulty was compounded by the lack of proper agendas for meetings and, in cases, the lack of documented reporting on previous minutes.¹³⁰

Recommendation:

That the PCT reviews the current practice of minute-taking to enable clear audit trails of the discussions taking place within meetings, actions agreed and follow-up of previous actions.

9.3.12 The Operational Policy Risk Event Response Policy¹³¹ requires that from the notification of an incident the nominated Executive Director '*... will ensure records are kept of all subsequent actions taken as part of the process of managing the incident/s*'. Having reviewed all the documentation, which was in part volunteered by the PCT but to a large extent provided as a result of requests of the PCT by the Panel, it is the firm belief of the Panel that insufficient records were kept as required both by its own policy and by best practice on how to manage critical events generally. The Internal Audit report on Risk Management supports this view:

"There is a lack of centralised monitoring of actions resulting from incidents and this means that the PCT cannot be sure that actions are being implemented, which could mean that the likelihood of incidents reoccurring is not being reduced."¹³²

9.3.13 Furthermore, the Panel could not find any specific action plan addressing this significant observation in the Internal Audit Report.

¹²⁹ Minutes of the meeting of Clinical Directors. 3rd December 2004 and 7th April 2005

¹³⁰ For example Minutes of Clinical Governance meeting 17th March 2005: No agenda, no item such as Reporting on matters arising from last meeting not on the agenda, no minutes that allows audit of decision-making. Clinical Governance Minutes of 19th January 2006 with not listed agenda and everything seemingly dealt with under Matters arising which makes cross-referencing very difficult.

¹³¹ Operational Policy Risk Event Response Policy COR/010 Appendix 3 Section 2 Oct. 2003

¹³² Portsmouth City Teaching Primary Care Trust. Internal Audit report – Risk management (AD – R15602) 19th January 2006 Section 22 p. 4

Recommendation:

That the PCT Senior Management Team urgently ensures that structures and systems are in place to enable efficient tracking and monitoring of progress of actions plans relating to critical incidents.

9.3.14 Some policies also demonstrated that they had not been subjected to reviews at the time planned. For example, the Emergency Response Procedure to Psychiatric and Medical Emergencies for St James Hospital POL-E-2 which was reviewed in June 2002, issued in December 2003 and was due for review April 2004 was provided to the Panel as the policy in place at the time of the incident in November 2004. Others were not dated although they contained a review date.¹³³

Recommendation:

That the PCT Board and Senior Management Team review its governance structure with regards to its policies and ensure audit of and compliance with its own internal monitoring and review plans.

9.3.15 Lack of consistency in reporting on the action plan demonstrated again the lack of proper audit structures. For example, the December 2005 minutes from the Mental Health Act Panel (see Section 9.3.16) record that there are no actions outstanding from the Geoffrey Hodgkins internal review whilst the AMH Management Team December minutes¹³⁴ states "**Action plan updated by ... in August Most of early actions are likely to have been completed Clinical Governance audit probably hasn't happened however. The action plan needs to be reviewed to check compliance ...**". The AMH Management Team January minutes¹³⁵ state "**...gave an update on the Geoffrey Hodgkins action plan asked that a short progress Report in relation to the Geoffrey Hodgkins action plan be presented to the next clinical governance group.**" This is further supported by the Clinical Governance minutes in January 2006¹³⁶ which state:

"Patient Geoffrey Hodgkins – update on action plan submitted to Adult Mental Health Management Group¹³⁷ – copy attached to Minutes of the Clinical Governance notes for information".

9.3.16 The minutes of the Mental Health Act Panel, but not of the AMH Management Team, go to the Board. The result was that the Board at its

¹³³ Adult mental Health Procedure for the Prescribing, Administration and Requisitioning of Medicines. Date unknown but review date included and the approved by Section not completed.

¹³⁴ AMH Management Team. 19th December 2005 item 3

¹³⁵ AMH Management Team. 16th January 2006 item 3

¹³⁶ Clinical Governance meeting 19th January – no agenda but listed under matters arising

¹³⁷ The Panel assumes that the AMH Management Group referred to here is the same as the AMH Management Team

meeting in March 2006¹³⁸ was informed that there were no actions outstanding from the internal review at a time when internal committees were still receiving updates on the action plan. The Board cannot, therefore, have properly discharged its ultimate responsibility for governance.

Recommendation:

That the PCT Senior Management Team ensures that actions plans have clearly identified leads, time scales, monitoring systems, reporting routes and feedback mechanisms.

Recommendation:

That the PCT Board reviews its own role in ensuring organisational learning and efficiency when dealing with Serious Untoward Incidents and satisfies itself that it is in a position to discharge its responsibility for governance.

9.3.17 The limited number of committees requires some committees to have a very wide remit. For example, the Mental Health Act Panel covers issues not relating to the Mental Health Act with the potential for losing focus. The current Terms of Reference for the Mental Act Panel¹³⁹ now gives it the task of monitoring adverse events involving detained and voluntary patients but it is not clear what that monitoring function involves beyond simply receiving notification. The difference in legal status of detained and voluntary patients is not clearly set out in the Terms of Reference either as a number of tasks relate equally to both groups of patients.

Recommendation:

That the PCT Board at the review of the Mental Health Panel's Terms of Reference in August 2006 re-consider the remit for the Panel and its current monitoring function with regards to complaints and adverse events.

9.4 Liaison with the External Enquiry Panel.

9.4.1 It became apparent to the Panel that PCT lacked an understanding of how to collect and present documentation to an External Enquiry. The Chair of the Panel was asked to specify the Panel's requirements for documentation and did so in writing to the PCT in November 2005 and

¹³⁸ Board part II agenda no 12. 16th March 2006

¹³⁹ Mental Health Act Panel. Terms of Reference. August 2005. Section 4. d.

again reiterated this in March 2006¹⁴⁰ as the PCT, once more, asked for the Chair's requirements:

- 'I would like the following: It would be useful if***
- there is an index of content with page numbers***
 - the papers in each section are structured so that the oldest papers are first and then chronological***
 - that each page is numbered.***
 - that the previous internal reviews are included with all the statements taken***
 - that we have copies of all correspondence with the SHA and other external bodies concerning the reporting and subsequent discussion about the incident***
 - that we have copies of all internal correspondence inc board, PEC and Clinical Governance Committee meeting where the incident was discussed and copies of any actions agreed.***
 - patient records are ordered chronologically***
 - patient assessments are ordered chronologically.'***

9.4.2 The Panel never received all the documentation requested in this outline. That which it did receive following repeated requests had different numbering in the different files provided for each Panel member and it was not structured as requested. The Panel, therefore, was not able to do any meaningful cross-referencing during their visit or subsequently. Several documents identified in the requests above were not provided to the Panel prior to the visit and some did not arrive until after the end of the visit.

9.4.3 At the planning meeting with the PCT, the Panel Chair stressed the importance of the 'Open Session' for all staff not formally identified by the Panel to ensure that all felt that they had had an opportunity to be heard. However, despite several requests, the Panel never received a copy of the invitation to staff¹⁴¹ and was disappointed as the session, although attended by 7 senior and middle managers, was not utilised by staff generally. Previous experience has shown these sessions to be popular and the Panel concludes that staff were not informed as requested.

9.4.4 The Panel acknowledges that the preparation, collection and presentation of a comprehensive set of documents for an enquiry is often an unfamiliar and daunting task. The Panel recommends that the PCT, as part of its Incident Reporting System, provide senior staff with appropriate training in the collection and presentation of statements and other documentation as well as in report writing. It was also apparent from the documentation that there was a lack of clarity around the division between the roles and responsibilities of the PCT and of the Hampshire and Isle of Wight

¹⁴⁰ Email to PCT on 29th November 2005 and again on 7th March 2006

¹⁴¹ See also Section 3.2.1

Strategic Health Authority which was highlighted in correspondence with the Solicitors and in relation to the meeting with the Coroner.

9.4.5 The Panel would like to stress that the PCT staff were very friendly and helpful during the visit. However, the overall impression gained by the Panel was that the PCT did not fully grasp the significant difference between internal and external inquiries. There appeared to be a lack of understanding and appreciation of the crucial role of the PCT and its self-interest in supplying the Panel with all relevant and timely information in a structured manner. It was, for example, agreed that the PCT should appoint a junior member of staff as the liaison officer. However, senior management does not seem to have maintained engagement in the process and left this individual to fail. The Panel would have expected any actions relating to a Serious Untoward Incident, which was subject to an External Enquiry, to be monitored extremely closely by the PCT Senior Management Team even if day-to-day liaison was delegated. For example, when the Chair of the Panel emailed the PCT about certain incomplete information¹⁴² identifying missing pages, the reply was that they were within the Medical records, which they were not. The Panel has still not received these. The overall response to the request was *'...unfortunately, I cannot answer some of these questions...'* It is the view of the Panel that a Liaison officer's role is not to answer questions from the Panel but to ensure the conduit of information. The role of the liaison officer should have been addressed by the Senior Management Team from the outset, clarified and, most importantly, supported.

Recommendation:

That the PCT provides relevant staff with appropriate training on the preparation, collection and presentation of documentation for reviews and on incident management including report writing.

Recommendation:

That the PCT and the Hampshire and Isle of Wight Strategic Health Authority discuss how to ensure greater clarity of roles and responsibilities when dealing with Serious Untoward Incidents.

9.5 Audits

9.5.1 Another important aspect of ensuring accountability and providing an audit trail for scrutiny is ensuring that papers are dated, reviewed and, preferably, attributed to an author. The Panel was provided with numerous documents¹⁴³ and policies which were undated and un-attributed. Some of

¹⁴² Email from Panel Chair on 7th March 2006 to PCT

¹⁴³ Examples of not dated documents are: Fairoak and Cheriton Wards Disinvestment. Financial Issues Discussion Document (no date); Cheriton House (Description of main purpose etc) (no date); Portsmouth City Primary Care Trust.

the policies did not have a review date. The Panel acknowledges that it might be that the Panel has received incomplete copies of documents from the PCT, however it assumes that the PCT wished to give the Panel as accurate as picture as possible of the current and past governance arrangements. These omissions occur to such an extent that they give the Panel serious cause for concern.

9.5.2 A further example of the difficulties encountered when trying to establish clear audit trails is the lack of accuracy in a number of documents. For example the Risk Event Forms¹⁴⁴ identify a restraint episode involving Geoffrey Hodgkins on 7th October 2004, the Critical Incident Report identifies what seems to be the same episode on the 8th October 2004¹⁴⁵ and the medical notes¹⁴⁶ provided to the Panel list the seemingly same incident as having occurred on 9th October 2004. The History Sheet for Geoffrey Hodgkins does not mention any episodes on 7th or 8th October 2004 but identify one event on 9th October requiring rapid tranquilisation, namely one at around 12.30pm. It is very worrying that there seems to be inaccurate reporting of such events and that this was not picked up by any of the reviews or by senior management. The Section 132 document ***'Information to patients and Relatives'***¹⁴⁷ was not completed as it does not clarify whether or not Geoffrey Hodgkins understood the explanation of his rights. The Panel also believed that it was unfortunate that the SUI Media and Briefing¹⁴⁸ was dated 19th November 2004 as the time of the report making, just as the Critical Incident Review had the 8th November 2004 at the bottom of each page and the first version also had the wrong time of death.

Recommendation:

That the PCT Board and Senior Management Team when presented with documents ensure that they are relevant, of an appropriate quality and comprehensive in content in order to allow for scrutiny and quality decision-making to be based on these.

Review of Integration in the Adult Mental Health Service (no date); In House Security Document (no date); Critical Incident Review Report Amended May 2005 (no date); Report regarding the critical incident that took place on Cheriton House, St. James Hospital, 19th November 2004 (No date), Needs and Risk Assessment forms (undated), Report for Geoffrey Hodgkins (undated)

¹⁴⁴ Risk event Form no 49888

¹⁴⁵ Critical Incident Review Report. Amended May 2005 Section 2

¹⁴⁶ Medical notes provided by Consultant Psychiatrist to the Panel on 24th April 2006

¹⁴⁷ Portsmouth City PCT St James Hospital. Section 123 Information to Patients and Relatives has not been ticked with regards to whether the patient understands the explanation of his/her right.

¹⁴⁸ SUI Media and Briefing. Hampshire and Isle of Wight Strategic Health Authority. 19th November 2004

10. Organisational Learning

“Organizational learning is the process by which the organization’s knowledge and value base changes, leading to improved problem-solving ability and capacity for action”¹⁴⁹

10.1 Organisational learning

10.1.1 In the publication ‘**An Organisation with a Memory**’¹⁵⁰ from the Department of Health it is stated:

“When an adverse event occurs, the important issue is not who made the error but how and why did the defences fail and what factors helped to create the conditions in which the errors occurred. The system approach recognises the importance of resilience within organisations and also recognises the process of learning as enhancing such resilience’.

10.1.2 The Panel is aware that the PCT has obtained the status of being a ‘Teaching PCT’ which involves providing a local centre for learning to spread good practice across the local health service. The Panel is, therefore, doubly concerned by the lack of evidence of effective learning taking place prior to Geoffrey Hodgkins’ incident on 19th November 2004 and subsequently. It has seen no evidence of learning sets functioning effectively within the organisation nor of learning loops being established to ensure that the learning is being fed back to inform practice, nor were any other effective structures or performance management systems in evidence that would support the implementation of effective organisational learning.

Recommendation:

That the PCT Board and Senior Management Team consider the format of an infra-structure that will enable the effective implementation, monitoring and evaluation of organisational learning.

¹⁴⁹ Probst and Buchel quoted in Burnes, B (4.ed) Managing Change – a Strategic Approach to Organisational Dynamics.2004. Prentice Hall. p. 128

¹⁵⁰ Department of Health *An Organisation with a Memory*’ Chapter 3, Section 3.7. 13th June 2000

10.2 Audit of system changes resulting from the Geoffrey Hodgkins' reviews

10.2.1 In the Guidelines for Carrying out a Critical Incident Review¹⁵¹ it is expected that an auditing process will be in place to ensure system changes resulting from Critical Incident Reviews. The Panel acknowledges that the action plan following the December 2004 Review has probably not been completed, as it saw no evidence of it being signed off by the committees dealing with the content, although the Board was informed to the contrary (see Section 9.3.16). However, the Panel saw no plans, either, as to how the monitoring of the actions was going to take place, by whom, and by when. It is the expectation of the Panel that its External Enquiry Report will generate action plans, audit of system change and organisational learning. The Panel was seriously concerned by the current lack of transparency in the management of action plans and fully supports the sentiment of the Internal Audit Report:¹⁵²

“... there is a lack of management information to show that staff at all levels are carrying out the processes consistently and completely. This, coupled with a lack of follow-up actions resulting from risk assessments and incidents, is inadequate to provide assurance to the PCT that risks and incidents are being appropriately managed.”

Recommendation:

That the PCT Senior Management Team ensures that an audit is taking place of system changes as a result of the internal and external review of the critical incident relating to Geoffrey Hodgkins and that the findings and/or recommendations are disseminated to and fully discussed by the Board, relevant committees and amongst staff generally.

10.3 Creating organisational learning

10.3.1 The system of Clinical Governance was said by several managers within the PCT to be comprehensive and effective but the Panel heard of and saw few signs of learning at staff level since the incident. At the time of the incident, staff involved were not clear where equipment was stored on the ward and how to use it despite all nursing and care staff having completed the C&R training. An important part of organisational learning is to ensure

¹⁵¹ Guidelines for Carrying out a Critical Incident Review (CIR). COR/011. Oct 2003 Section 16

¹⁵² Portsmouth City Teaching Primary Care Trust. Internal Audit report – Risk management (AD – R15602) 19th January 2006 *Executive Summary*

that changes are embedded in practice rather than merely in policies and procedures.

10.3.2 In the Guidelines for Carrying out a Critical Incident Review¹⁵³ it is stated that a Critical Incident review should ensure that lessons learned are shared in order to prevent reoccurrence of similar incidents within the service. It also states '*... the organisation as a whole should also learn from serious incidents and key lessons or actions will be cascaded by the Quality & Clinical Governance Committee throughout the organisation where appropriate*'. Staff who attended the Critical Incident Review stated very clearly (see Section 11.1.3) that they felt no learning had been identified that resulted in actions designed to prevent reoccurrences of similar events.

10.3.3 The Panel was very concerned by this lack of evidence of organisational learning deriving from such a serious incident.

Recommendation:

That the PCT Board and Senior Management Team ensure that mechanisms are in place to identify, share and audit organisational learning from serious incidents generally.

¹⁵³ Guidelines for Carrying out a Critical Incident Review (CIR). COR/011. Oct 2003 Section 15

11. Leadership and Commitment

11.1 Clinical and managerial leadership

11.1.1 It is the view of the Panel that insufficient evidence was presented to demonstrate high quality clinical and managerial leadership. The Panel also supports the view expressed by a, presumably, internal review of integration in the Adult Mental Health Services within the PCT¹⁵⁴ ***‘The pressure of being a small provider was acknowledged and many recognised the burden that the mental health service was on the PCT and social care budgets’***. For a small provider with a main focus on delivering primary and commissioning secondary health care provisions for its population, there is a danger that the parts of the service which are not mainstream are not subject to the same level of close scrutiny and leadership attention.

11.1.2 As an example, it was highly worrying that the second internal critical incident review (see Section 9.2.21 above) highlighted key clinical issues which did not lead to any action plan and therefore no follow up. The issues which the Panel were most concerned about were the lack of reaction to a number of staff referring to a cigarette being passed around restraint despite the existence of a non-smoking policy, the nature of the conversation amongst certain members of staff during the restraint and the fact that there appears to have been a short period of time during the restraint when no-one knew what to do. Neither clinical nor managerial leadership was evidenced in the documentation or statements to the Panel that suggested that actions were taken to address these serious service issues. Nor was the Panel provided with any evidence of the second review having resulted in any internal and shared action plan and therefore any impact on the quality service delivery.

Recommendation:

That the PCT Board examines its approach to values and ethics to ensure an alignment between the corporate approach and practice.

11.1.3 It was equally disconcerting for the Panel that staff present at the first Critical Incident Review did not recall any changes being made or learning being generated because of the incident despite some actions clearly being identified as a result of this review. Staff did not feel that they had had any influence in defining any shortcomings or suggestions for quality improvements. The lack of feedback to staff on the actions generated by the two reviews and the establishment of learning loops are issues which

¹⁵⁴ Portsmouth City Primary Care Trust. *Review of Integration in the Adult Mental Health Service*. Undated p. 5 and no author/s.

the clinical leadership within the PCT should seriously consider within the PCT's clinical governance and quality improvement agenda.

11.1.4 The Panel was also concerned that Critical Incident Reporting does not seem to be a standing agenda item for the Professional Executive Committee (PEC). According to the Risk Event Response Policy¹⁵⁵ this Committee only receives an annual Report as part of the annual Clinical Governance Report detailing actions following trend identification and opportunities for cross-organisational learning. By the time of the External Enquiry Review more than a year had lapsed since the death of Geoffrey Hodgkins and yet the Panel did not receive copies of any reports to the PEC referring to the any of the internal reviews into Geoffrey Hodgkins' critical incident as part of any trend identification or opportunities for cross-organisational learning. This was despite the fact that many of the critical issues were generic rather than specific in nature.

Recommendation:

That the PCT Senior Management Team considers ways of improving the clinical leadership's role in creating organisational learning through feedback loops and staff involvement in quality improvement initiatives.

11.1.5 According to the Risk Event Response Policy¹⁵⁶ a summary of actions following a Critical Incident Review is passed to the Board for discussion under Part II of the board agenda. The Panel asked repeatedly for the PCT to provide it with copies of the minutes of any internal committees, including Board minutes Parts I and II, where the case of Geoffrey Hodgkins had been discussed. The Panel only received copies of Board minutes Part II for one meeting in June 2005 where an update was given¹⁵⁷ and copy of the agenda for the March 2006 Board meeting, which included for notification the minutes of the December Mental Health Act Panel stating that the Critical incident review's action plan had been completed. This sparse information did not make the Panel feel confident that the PCT Board had been fully briefed about, and discussed the adequacy of, the internal management of the critical Incident and the impact on the service.

11.1.6 The Panel was very concerned and disappointed that the PCT Board did not take a more active role in monitoring the Geoffrey Hodgkins incident from either a service quality, a risk management or a leadership perspective as all these dimensions are crucial elements of good

¹⁵⁵ Operational Policy Risk Event Response Policy COR/010 Section 4.2 Oct 2003

¹⁵⁶ Operational Policy Risk Event Response Policy COR/010 Section 4.2 Oct 2003

¹⁵⁷ Board Minutes Part II, 16th June 2006 item 4 '*The Board was updated on case of Patient Geoffrey Hodgkins, who had been mentioned in the pink paper on part 1 of the Board.*'

governance. An Internal Audit report on Risk Management in January 2006¹⁵⁸ stated:

“There is inadequate Board training with regards to risk management and incidents as the last training identified by the auditor was for the ‘three teams at the top’ about two years ago and this did not include non-Executive Directors.”

11.1.7 Despite this comment, the Panel saw no evidence of this report having resulted in a separate action plan for the PCT Board to address its shortcomings when dealing with risk management and incidents. Both functions are of extreme importance to the PCT overall with regards to its governance, its liabilities, its relationship with service users and carers and its reputation. It is therefore very concerning that these issues seem to have been neglected.

Recommendation:

That the PCT Board urgently review the active involvement of all Board members in risk management and incident handling and formulate, regularly monitor and evaluate an action plan to address the short-comings identified by the internal Audit Report and this External Enquiry.

11.1.8 The Panel was equally concerned that the police were informed about the death of Geoffrey Hodgkins by a nurse on 21st November 2004 when police happened to be visiting Cheriton on an un-related matter¹⁵⁹. The criteria at the time for reporting incidents to the police¹⁶⁰ did not refer directly to this type of incident although much lesser incidents were included. The Panel considered that it was inappropriate for a nurse on the ward to be the person reporting the incident to the police and found that the reporting to the police should have been the responsibility of the service manager or similar senior member of staff. There was no documentation provided to the Panel to show that management immediately after the incident considered which external bodies should be informed other than the required reporting to the Strategic Health Authority.

11.2 Leadership and audits

11.2.1 The Panel has mentioned in several places in this Report the lack of audit of compliance with existing policies. The overall responsibility for ensuring

¹⁵⁸ Portsmouth City Teaching Primary Care Trust. Internal Audit report – Risk management (AD – R15602) 19th January 2006 Section 29 p. 6

¹⁵⁹ Email correspondence between nurse and clinical manager and associate Director AMH of 30th November 2004.

¹⁶⁰ Operational Policy Risk Event Response Policy COR/010 Section 4.3 Oct. 2003

that a comprehensive system of relevant audits is carried out and reviewed rests with both the clinical and the managerial leadership within the PCT. The Panel heard that the audit unit had little capacity. However, decisions about prioritisation, quality and risks are those which, ultimately, the Board will have to take based on recommendations from the clinical and managerial leaders. To abstain from carrying out relevant audits through a lack of prioritisation of resources is an abrogation of responsibility for decision-making and is not an acceptable managerial or clinical position.

Recommendation:

That the PCT Senior Management Team examines the current audit cycle to ensure that all relevant policies/procedures and guidance are included and put forward to the PCT Board recommendations about potential resource implication of instituting and maintaining a comprehensive audit system.

11.3 Contact with the family

- 11.3.1 The External Enquiry Panel believes that communicating effectively with service users and/or their carers, in this case the family of Geoffrey Hodgkins, is a vital part of the process of dealing with perceived and real errors or problems in the delivery of high quality treatment and care. This involves creating a culture of openness; enabling the expression of sorrow and regret at the outcomes of adverse incidents and, in cases such as this, involving the family actively in the review process so that the family can achieve a better understanding of what has happened and what will happen.
- 11.3.2 From the statement presented to the Panel it appears that the PCT Chaplain visited the family some time in December 2004 but this individual was not able to answer the questions relating to the incident asked by the family. No other personal contact was made or offered to the family during this initial and very sensitive period of time.
- 11.3.3 It is clear from the PCT's own policy on critical incidents in 2004¹⁶¹ that the nominated Executive Director within 48 hours of the incident should ensure that relatives who may be affected by the incident are appropriately informed before any media briefing. It states furthermore that all relevant partners should be kept informed of investigation developments and it states that:

¹⁶¹ Operational Policy Risk Event Response Policy COR/010 Appendix 3 Section 2.6 Oct. 2003

“A record of all information given to the patient, relatives... should be kept”.¹⁶²

The Panel requested several times from the PCT ***“that we have copies of all correspondence with the SHA and other external bodies concerning the reporting and subsequent discussion about incident”***¹⁶³ and ***“copy of all correspondence with the family since 20 November 2004, as we have very little.”***¹⁶⁴

11.3.4 From the statements by the family of Geoffrey Hodgkins to the Panel and the correspondence between the PCT and both Mind and the firm of solicitors Swain & Co, it was very clear that little information had been volunteered by the PCT to the family since the death of Geoffrey Hodgkins on 20th November 2004. A letter from the PCT in October 2005 to Swain and Co Solicitors states:

“All documentation and correspondence following Mr Hodgkin’s death held by the PCT is currently being compiled under headings as advised by the chair of the independent inquiry. You will receive a copy of all such documentation as soon as this has been compiled”.¹⁶⁵

11.3.5 It seems to the Panel that the PCT failed to fully appreciate the importance for the family to understand what had happened to Geoffrey Hodgkins, why it had happened the way it did and the lessons arising from the incident that would prevent a reoccurrence for other patients.

11.3.6 During the visit the External Review Panel had the opportunity to meet Geoffrey Hodgkins’ brother, who attended together with two representatives of MIND. It was very clear from the conversation that the family felt a number of questions remained unanswered and that they had not received the support and explanation about the incident from the PCT that they had expected. This is demonstrative of the lack of proactive communication with the Hodgkins family.

11.3.7 In a letter of 21st December 2004, Geoffrey Hodgkins’ brother wrote to the PCT asking about the circumstances of the death of Geoffrey. No response to this request from the PCT has been found. In a letter dated 25th January 2005 the PCT did offer to set up a meeting with the family, but no previous attempt seems to have been made. This letter was a response to a formal complaint on behalf of Geoffrey Hodgkins’ brother made by MIND on 5th January 2005 about the lack of information provided to the family. On the 24th April 2006 Geoffrey Hodgkins’ brother handed to

¹⁶² Operational Policy Risk Event Response Policy COR/010. Oct 2003 p 2 Section 4

¹⁶³ Email from Panel Chair of 29th November 2005 to PCT

¹⁶⁴ Email from Panel Chair of 2nd May 2006 to PCT

¹⁶⁵ Letter of 10th October 2005 from Risk Manager to Swain & Co Solicitors

the Panel a letter setting out a list of issues¹⁶⁶ which the family would like to raise regarding the care of Geoffrey and expressed the wish that the Panel address most if not all of these within the Review.

11.3.8 It is clear from the PCT internal correspondence that the original intention was to include MIND in the communication strategy¹⁶⁷ but the communication strategy for involving and informing the family was not provided in any of the documentation received by the Panel. Internal review of the medical notes found no clinical or confidentiality reasons for not sharing these.¹⁶⁸ The concern for the Panel therefore remains that this is one of the many situations where there is a deep schism between intention and reality within the PCT.

11.3.9 From June 2006 the PCT is required to have in place a 'Being Open Policy' and the Panel recommends that the PCT Board and Senior Management Team take this opportunity to ensure that liaison between the PCT and the patient/their families is taking place in practice including by the appointment of Liaison Officers.

Recommendation:

That the PCT Board and Senior Management Team ensure that the implementation of the 'Being Open Policy' will include appropriate mechanism for keeping the patient/families involved by, for example, appointing a Liaison Officer to each case to facilitate the exchange of information.

11.4 Bridging the reality gap

11.4.1 The overall impression gained by the Panel when examining the leadership and management of the incident relating to Geoffrey Hodgkins is one of a gulf between management impressions and understanding and what actually happened and/or could be evidenced. The strong conviction expressed by several managers that the PCT was good at what it was doing might have created a false culture and one of complacency based on the assumption that 'things are going well because we think they are

¹⁶⁶ See Appendix D for copy of letter to Chair from Geoffrey Hodgkins' brother dated 24th April 2006.

¹⁶⁷ Email correspondence between PR & Communications Manager and Director of Service of 1st December 2004 and between Associate Director AMH and Director of service AMH etc of 21st January 2005

¹⁶⁸ Email correspondence from Consultant Psychiatrist to Operational Manager. 17th May 2005.

going well' rather than any critical evaluation of the effectiveness of the organisation particularly when handling this serious event.

Recommendation:

That the PCT Board and Senior Management Team critically scrutinise their respective leadership roles and the way in which the organisation collectively has managed this serious incident in order to generate learning for the Board, the Senior Management Team and the PCT as a corporate body.

12 Conclusion

- 12.1 The death of Geoffrey Hodgkins was a tragic incident first and foremost for his family but also for the staff who cared for him during his long period as an inpatient. Based on the information provided the Panel was not able to draw any definitive conclusion as to whether any different actions by individuals during the incident on the 19th November 2004 would have resulted in a different outcome. However, it is the view of the Panel that the communication with the Ambulance Service was inefficient and caused avoidable delay in getting Geoffrey Hodgkins to the Queen Alexandra Hospital.
- 12.2 The policies, protocols, care pathways and procedures relating to the care of Geoffrey Hodgkins at the time leading up to the incident seem to have existed although the quality is varied. However, the major issue of concern for the Panel in its examination of these was the lack of audit trails to provide evidence of their implementation, adherence in practice and effectiveness.
- 12.3 The overall quality and suitability of the treatment, care and supervision provided to Geoffrey Hodgkins were found to have major inadequacies as some of the Careplans used were templates that took no account of his specific physical and mental health, social or personal needs. There was a lack of an appropriate multidisciplinary approach to his care and past and present medical concerns were not followed up. Alternative models of dealing with Geoffrey Hodgkins' behaviour were not properly documented or considered despite nursing staff requests for this. A step-up approach and diversion strategies were mentioned in some notes but not reflected in Geoffrey Hodgkins' Careplans or in practice.
- 12.4 There was no evidence of input from an occupational therapist or of any input with a view to reduce his smoking and obesity since Geoffrey Hodgkins' re-admission although these were corporate health improvement aims for the PCT. His past social visits to his brother were not taking place regularly since his re-admission in July 2004 and his family was unaware of his deteriorating behaviour.
- 12.5 Past episodes documented in his notes about breathing problems during restraint were not followed up and it was known that the medication prescribed for Geoffrey Hodgkins was having only a limited effect on his ability to calm down during periods of restraint.
- 12.6 The prescribed treatment and Careplans were not seen as personalised to meet his needs and therefore not adequate to provide the right framework for his care. Many needs and risk assessment forms were not completed, not dated, not signed and not agreed with Geoffrey Hodgkins and there

- was little evidence that they were carried out in practice and no evidence that they were monitored and complied with at all times.
- 12.7 The Panel found that the overall management of the incident on the 19th November 2004 was characterised by confusion, lack of leadership, unacceptable standard with regards to completing a crucial telephone call, lack of appropriate skills in using equipment in the resuscitation and lack of immediate availability of the right equipment. It was inappropriate that the staff involved in the critical incident on the 19th November 2004 were primarily security guards and health care support workers despite the fact that most of the security guards lacked appropriate training in these skills. There seems to have been a lack of clarity of the roles of the qualified staff in the restraint and subsequent resuscitation attempt and there was a time when no experienced staff were involved in the restraint and resuscitation.
- 12.8 The time limit of 3 minutes of restraint recommended by the Bennett Inquiry as well as in Geoffrey Hodgkins' careplan was not adhered to in practice and no written documentation was provided within his Careplans to justify this divergence. The use of a duvet/quilt and towels, which had also been used on previous occasions of restraint, and their suitability were not commented upon by senior management despite not being noted as a proper means of restraint in Geoffrey Hodgkins' Careplans.
- 12.9 The Panel received no evidence that the lack of overall quality and personalised treatment, care and supervision provided to Geoffrey Hodgkins nor the lack of systematic compliance with existing policies, protocols, care pathways and procedures relating to the care of Geoffrey Hodgkins had been comprehensively addressed within the PCT. It is the view of the Panel that had those serious issues been properly considered the prolonged periods of restraint, endured by Geoffrey Hodgkins, may not have been required. The Panel cannot conclude that the lack of full consideration of these critical issues contributed to the death of Geoffrey Hodgkins but is of the view that had these been appropriately addressed the risk posed to him would have been substantially reduced.
- 12.10 The Panel was also seriously concerned by the organisational culture that has resulted in the lack of senior management reaction to statements given by staff about smoking during the restraint episode and about comments by some staff perceived as inappropriate by others present during the restraint.
- 12.11 At the time of the incident staff were called from two other wards in addition to security guards being called to the Cheriton ward. Many of these individuals had not worked together previously and were not familiar with each others names, roles and responsibilities. Due to the lack of leadership being exercised the Panel was left with the impression that

there was no coherent collaboration as everyone was doing what they thought should be done and communication between the individuals was very poor. This led to the situation where no-one knew what to do the first time of Geoffrey Hodgkins' turning blue and where a health care support worker carried out mouth-to-mouth resuscitation without equipment as there was no-one else who did so.

- 12.12 The communication with the Ambulance Service was inefficient. The communication between management and staff about the learning arising from the critical incident review was reported to the Panel as being non-existent. The communication between various committees and to the Board about the different internal reviews and recommendations/actions arising from these was diffuse, inconsistent or absent. Communication with the External Enquiry Panel was characterised by a willingness to assist but an inability to deliver on time and to an appropriate standard on many requests for information both prior to the Panel visit and subsequently.
- 12.13 However, most importantly, the PCT seems to have failed to communicate effectively with the family since the death of Geoffrey Hodgkins despite the family's natural wish to know what had happened. This lack of openness and lack of appreciation and concern for the family's needs to obtain full and comprehensive information without having to repeatedly ask for it to be provided is one of the gravest failings of the PCT and one which it could have addressed initially most easily. It is therefore the one which will be the most difficult for the PCT to apologise for as there was no proper reason for it ever to have occurred.
- 12.14 A very significant feature of the PCT that came across strongly to the Panel was the pride which most members of staff had in the PCT and its way of working. However, it seemed to the Panel that there was a huge gulf between the expressed clarity of processes, and co-operation across committees at senior management level and what was found at front line delivery. Corporate aims were clearly not followed through in Geoffrey Hodgkins' case as there were no attempts to address his heavy smoking or obesity. The PCT expressed pride in its Carers' Strategy which was said to be 'excellent' but the Panel saw no evidence of regular involvement of Geoffrey Hodgkins' brother since Geoffrey Hodgkins' re-admission in July 2004. The mental health service was described as being of 'flagship and gold standard', yet, the Panel found very little evidence of systematic audit systems to provide the evidence for this, but saw instead many examples of a lack of appropriately personalised treatment and care for Geoffrey Hodgkins. The PCT expressed pride in its innovative approach to delegated authority but the Panel saw little evidence that the Board had full knowledge of and actively debated very critical issues of quality of care for which the Board ultimately remains accountable. The reduced

bureaucracy model promoted by the PCT seems to have led to an acute lack of audit trails for crucial decision-making processes concerning the progression of action plans and a lack of senior management and leadership reaction to serious cultural, clinical and managerial issues raised by staff and its own internal reviews.

- 12.15 The Panel in its approach has aimed at addressing the issues set out in the Terms of Reference, addressing concerns raised by the family of Geoffrey Hodgkins and assisting the PCT in learning from the incident in order to minimise the risk of such an incident occurring again and to improve the overall quality of care provided by the PCT to its service users. However, such a learning process firstly requires an acknowledgement of existing weakness in the systems and the organisational culture. The Panel hopes and expects that part of Geoffrey Hodgkins' legacy to the PCT will be a willingness to take on these challenges and that these will be embraced by the whole PCT as an opportunity to provide quality health care services in the future.

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Glossary

Accountability	To be called to account for something for example actions taken or lack of actions which should have been taken
Action plan	An agreed plan of action with a timetable that sets out what should happen, by whom, when and how.
Ambi bag	Oxygen mask and bag
AMH	Adult mental health
ASW	Approved Social Worker
Audit, clinical audit	An examination of records to check their accuracy. In clinical audits those involved in providing services assess the quality of care. The results of a process or intervention are assessed, compared with the existing standard for the area, changed if necessary and then re-assessed.
Bleep-holder	Senior Nurse on duty holding the bleep who has specific responsibilities in case of emergencies.
Board	A group of people who are responsible for the strategy and major decisions in an organisation. A PCT Board normally consists of a lay chair, a chief Executive officer, 5 lay non-executive directors and the executive directors of the PCT.
Carers	People who look after their relatives and friends on an unpaid, voluntary basis often in place of paid care workers.
CBT	Cognitive Behavioural Therapy is a form of psychological therapy based on learning therapy principles. It is used mostly in depression but increasingly shown to be a useful component of treatment in schizophrenia.
CHI	Commission for health Improvement. Does no longer exist but taken over by CHAI also called the HealthCare Commission which is a Government body inspecting all NHS organisations.
CIR	Critical Incident Review
Clinical governance:	<p>The framework through which NHS organisations and their staff are accountable for the quality of service user care. It includes:</p> <ul style="list-style-type: none">a service user centred approach which treats service users with courtesy, involves them in decisions and keeps them informed;an accountability for quality which ensures that clinical care is up to date in their organisations;ensuring high standards and safety;improvement in service user services and care, <p>Briefly, this means clinical governance covers the procedures and working practices adopted by the NHS to ensure that service users receive the highest possible quality of care.</p>
Clinician/clinical staff:	A fully trained, qualified health professional – doctor, nurse, therapist, technician etc.
Community care:	Health and social care provided by healthcare and social care professionals, usually outside hospital and often in the service user's own homes.

Consent	Permission from a patient, or sometimes a patient's nearest relative, to allow a health treatment or investigation to happen.
C & R	Care & Responsibility. A technique, previously called Control and Restraint, in which appropriate mental health staff are trained in methods to protect patients and/or staff from self-harm and violence.
CPR	Cardio pulmonary resuscitation
Front Hall	24-hours base for security staff at St James's hospital site.
General medical services (GMS):	Services provided by general medical practitioners under Part II of the Health Act 1999.
Governance	Assessment, control and monitoring of the functions supporting the delivery of an organisation's objectives
Haloperidol	Anti-psychotic medication
HCSW	Health Care Support Worker
Health action zone (HAZ):	Regional initiatives set up by the government to improve health in targeted areas of poor health and deprivation. HAZs are made up of members from the NHS, local authorities voluntary and private sectors, coordinated by a local 'partnership board'.
Health community:	All organisations with an interest in health in one area including the voluntary and statutory organisations.
Health improvement :	A locally agreed work programme to improve health programme (HimP) and which delivers the national priorities and targets.
Incident	Something which has happened that was not planned and which might be harmful to patients, staff, the public or the organisation itself.
Incident reporting system	A system which requires staff to report all matters where there has been a problem for example patient care
Independent contractors:	GPs, dentists, pharmacists and opticians are independent contractors in that they deliver health services in return for payment by the PCT but they are not PCT employees (they are self employed).
Inpatient	A patient who stays overnight in hospital
Lorazepam	Medication for the relief of anxiety disorders
Mental Health Act	Act of 1983 that concerns the 'reception, care and treatment of mentally disordered patients etc'
Multi-disciplinary team	A group of people from different professional backgrounds who are involved with the treatment and care of patients and who meet regularly to discuss how best to provide the treatment and care with input from each profession.
N.I.C	Nurse in charge
NPSA	National Service user Safety Agency
NSF	National Service Framework sets guidelines, standards and defines services models for specific medical conditions or patient groups. The mental health NSF was published in 1999.
1701 Bleep Holder	Senior Nurse on duty holding the bleep who has specific responsibilities in case of emergencies.
Occupational therapist	A professional who works with people to assess and develop for example daily living skills and social skills for mental health patients

PCT	Primary care trusts are local health organisations who develop primary and community services and commission secondary (hospital services) for their local population.
Personal medical services:	A locally, rather than nationally, agreed contract services (PMS) which allows for new models of Primary care services provision, including salaried GPs and collaborative management arrangements between practices and with other professions.
PEC	A structure unique to PCTs, which ensures that committee (PEC) working professionals are involved in strategic decisions about planning and delivering a PCT's services. PECs have up to 18 members. These include the chief executive of the PCT, a social services representative, clinical staff employed by the PCT and independent contractors – GPs, nurses, allied health professionals, dentists, optometrists and pharmacists.
Primary care:	Family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.
Protocol	A policy or strategy which defines appropriate actions which should be taken
Psychiatrist	A medical doctor who specializes in the diagnosis and treatment of mental health problems
Resuscitation	A range of procedures used when someone has suddenly become seriously ill in a way that is life threatening.
Risk assessment	An examination of the likelihood and impact of risks associated with a particular service or procedure.
Schizophrenia	A severe mental illness of unknown cause with the effect of delusions and hallucinations
Service users	People who use public services including mental health services for their needs and/or problems
SUI	Serious Untoward Incident which led or might have led to harm in one or several patients, which is of sufficient severity to warrant a special investigation
Terms of Reference	The rules by which a group such as a panel does its work

Appendix A: Panel Composition

David Dunkley - Head of Brent Mental Health Service

B.Sc. [Soc Sciences] in Psychology
Diploma in Applied Social Studies and C.Q.S.W.
Diploma in Management Studies

Trained as a social worker and an approved social worker.
Currently holds the overall responsibility for the management of the integrated Brent Mental Health Service, ensuring that statutory requirements and performance standards [for the Mental Health Trust and the Local Authority] are met within resources. He is the most senior representative of Brent Mental Health Service to members of the public, statutory and voluntary organisations including service users and carer groups. He is a member of the Brent Local Implementation Team which sets the Brent mental health strategy and monitors progress.

Sarah Healey – Nurse Executive, South Downs Health NHS Trust

RGN 1973
HV cert/ Certificate District nursing
BSc Professional Practice in Nursing 1985
MA Social Policy 1989
Kings Fund J&J Nursing Leadership Programme

Currently the Nurse Executive of South Downs Health NHS Trust which is a community and mental health trust co-terminus with Brighton and Hove City Council. She sits on the board of Brighton and Hove PCT. As head of Clinical Governance she has experience of mental health governance and service development. She is a member of the Acute Care Forum and has been involved in the clinical benchmarking against NICE guidelines. She has undertaken training by the NPSA in root cause analysis techniques and has led reviews of homicide and other serious untoward incidents.

Paul Warren - Consultant Psychiatrist to the Crisis Resolution and Intervention Service (CRIS) Associate Medical Director and Lead Clinician (North Hampshire) Hampshire Partnership NHS Trust

BM 1980
Member of the Royal College of Psychiatrists (MRCPsych) 1985

Involved in the day to day management of service users treated in their own homes as an alternative to hospital and the acute assessment of a variety of service users in mental health Crisis. Responsible now as the medical lead of the CRIS team. Responsible for the development and implementation of a fully compliant Crisis Resolution and Home Treatment Team (CRIS) in North Hampshire. Psychiatric Advisor to the Alton Counselling Service. Member of HPT Directorate Service Team, HPT Mental Health Act Working Group, HPT Clinical Governance Board, North Hampshire Locality Business Team and chair of North Hampshire Locality Clinical Governance Group and North Hampshire Primary Care Trust National Service Framework Local Implementation Team (LIT).

Tove Steen Sørensen-Bentham – Principal Lecturer in Public Service Management, University of Brighton and non-executive director, Eastbourne Downs PCT. Independent management consultant.

LLM 1981

MSc Social Policy 1983

Is joint Programme Leader for the Brighton Business School MBA programme and course leader for the MBA Public Service Management. Has since 1981 worked in senior public service management positions in Denmark and the UK. She has represented the Danish police in the EU over a period of 6 years negotiating international agreements. She is particularly interested in quality, strategy, leadership and change in the public services. She has been a non-executive director in a health authority and in a PCT since 1996 and chair of various committees such as risk, audit, clinical governance, race equality etc. She was complaints convenor from 1996 to 2004 dealing with more than 240 requests for independent reviews and has carried out a number of external reviews of critical events within NHS organisations.

APPENDIX B: Declaration of Interest

David Dunkley B.Sc., Dip. Applied Social Studies, C.Q.S.W., Dip. in Management Studies – Panel member

I have had no previous dealing with Portsmouth City Teaching Primary Care Trust and have no social association with any staff working for the Trust.

Sarah Healey RGN; HV Cert; BSc, MA – Panel member

I have had no previous dealing with Portsmouth City Teaching Primary Care Trust and have no social association with any staff working for the Trust.

Tove Steen Sørensen-Bentham L.L.M, MSc – Panel chair

I have had no previous dealing with Portsmouth City Teaching Primary Care Trust and have no social association with any staff working for the Trust.

Paul Warren BM, Member of the Royal College of Psychiatrists (MRCPsych) – Panel member

I have had no previous dealings with Portsmouth City Primary Care Trust and have no social association with any staff working for the Trust.

APPENDIX C:

Letter to the Panel from Geoffrey Hodgkins' Brother

FOR THE ATTENTION OF:

The Chair of the External Enquiry Panel

We would like to request that the External Enquiry panel look at the following issues:-

- The last active risk assessment to be looked at for restraining Geoffey.
- Were alternative ways investigated to manage Geoffrey's episodes?
- Why did staff continue to use a restraint procedure that was compromising Geoffreys' physical health?
- The last active care plan to be looked at. Did the care plan reflect his needs?
- What action was taken after the letter of 20/8/2000 from [REDACTED] (Deputy Senior Nurse) was sent to [REDACTED] (Letter attached)
- Why did it take so long for Geoffrey to be transferred to QA hospital on the night of 19/11/04 after he stopped breathing on Cheriton Ward?
- To investigate the lack of information given to Geoffrey's family regarding the necessity to restrain Geoffrey for such long periods of time and in such a way.
- The panel to look into the appropriateness of Security guards called and used on Wards.
- What was the role of the Security guards on the ward the night of 19/11/04?
- We would like to know who the five people were involved in the restraint and were these people trained and competent.
- Why Geoffrey's physical care was not attended to prior to his death. Particularly the injury sustained to his leg during the restraint on the 12.11.04 at 22.15pm.
- Why he was not taken for an X-ray as requested by the Doctor on 17/11/04 although medical notes state he was settled and mentally stable. (Medical notes attached)
- Was independent advocacy available for Geoffrey?

We would like to take this opportunity to highlight the fact that the panel is looking at a case that the cause of Death to date is not known, there is no Coroners report.

Our overriding wish as a family is that no other person should be held in restraint for such long periods of time and suffer such prolonged distress and discomfort. Which can ultimately lead to their death.

Appendix D: Consolidated List of Recommendations

Terms of Reference 1:

Review and assessment of the adequacy of policies, protocols, care pathways and procedures from a clinical perspective.

4.2.6 Recommendation:

That the PCT Management Team review the Observation Policy to ensure that all relevant patient information is required to be recorded in the patient records.

4.6.6 (1) Recommendation:

That the PCT audit implementation of and compliance with the Emergency Response Procedure and identify and monitor clear action plans to address any shortcomings identified.

4.6.6 (2) Recommendation:

That the PCT Senior Management review the staff establishment with regards to skills mix and numbers to ensure that high quality and safe patient care can be provided.

Terms of Reference 1:

The approaches taken to implementing policies, protocols, care pathways and procedures and assuring their implementation.

4.7.7 Recommendation:

That the PCT Senior Management Team ensures that policies, procedures and guidelines in place to safeguard patient care are realistic in scope, structured to address individual needs and monitored for compliance and relevance.

Terms of Reference 2:

Examination of the quality and suitability of Geoffrey Hodgkins' overall treatment, care and supervision in the context of:

- **His actual and assessed health and social care needs.**

5.1.5 Recommendation:

That the PCT reviews the legal implication of the care it provides to informal patients including practice of restraint, consent to treatment procedures, right of leave and rights of nearest relatives.

5.1.6 Recommendation:

That the PCT Senior Management Team urgently considers ways of improving the clinical governance system so that it allows for the monitoring of and response to any concerns raised by staff about the quality of care provided, including the use of a whistle-blowing policy.

Terms of Reference 2:

Examine the quality and suitability of Geoffrey Hodgkins' overall treatment, care and supervision in the context of:

- **The actual and assessed risk of potential harm to himself or others.**

5.3.5 Recommendation:

That the PCT Senior Management Team reviews its policies and procedures including training of staff in rapid tranquilisation to take account of risk history, trigger factors and alternative interventions as well as the need for accurate and relevant documentation of risks.

Terms of Reference 2:

Examine the quality and suitability of Geoffrey Hodgkins' overall treatment, care and supervision in the context of:

- **The appropriateness of the decisions made by the practitioners involved and the subsequent treatment and care provided.**

5.4.2 Recommendation:

That the PCT Senior Management Team reviews the use of intervention and de-escalation steps for dealing with violence and aggression and consider alternative models.

5.4.9 Recommendation:

That the PCT Senior Management Team ensures that appropriate and relevant multi-disciplinary review and care planning takes place for each individual patient including the involvement of pharmacists.

Terms of Reference 3:

Examination of the extent to which Geoffrey Hodgkin's prescribed treatment & care plans were relevant, adequate, documented, agreed with the patient, carried out, monitored and complied with at all times.

6.1.4 Recommendation:

That the PCT Senior Management Team considers ways of effectively communicating with service users and their relatives when changes of mental health status occur and ensures relevant evidence of that communication.

6.1.11 Recommendation:

That the PCT Management Team ensures the relevance, standard, documentation, user involvement, implementation, monitoring and compliance to personalised patient treatment and care plans

Terms of Reference 4:

Examine the extent to which the overall management of Geoffrey Hodgkins' care, in the period leading up to the incident, and the incident itself complied with statutory obligations, the Mental Health Act Code of Practice, local operational policies and practice guidance and relevant guidance from the Department of Health including the Care Programme Approach and other relevant sources of best practice. This will include a review of:

- The Policy and protocols of restraint used by the Trust**

7.2.3 Recommendation:

That the PCT Management Team reviews the PCT policy and protocols on restraint and ensures that these take into account all statutory obligations, relevant guidance and best practice and ensures relevant inter-relationships between its operational policies.

Terms of Reference 4:

Examine the extent to which the overall management of Geoffrey Hodgkins' care, in the period leading up to the incident, and the incident itself complied with statutory obligations, the Mental Health Act Code of Practice, local operational policies and practice guidance and relevant guidance from the Department of Health including the Care Programme Approach

and other relevant sources of best practice. This will include a review of:

- The extent to which the policies and protocols of restraint were followed

7.3.6 Recommendation:

That the PCT Senior Management Team reviews the current training provision. It should also consider whether emergency drills or similar simulations are required to ensure application in practice of relevant policies, procedures and guidance.

7.4.4 Recommendation:

That the PCT Senior Management Team reviews the purpose of the Risk Event Forms and initiates an audit of the completion of the forms to ensure a comprehensive and relevant Risk Register.

7.4.6 Recommendation:

That the PCT Senior Management Team ensures that regular audits of the appropriateness, accuracy and relevance of risk and incident policies and procedures are carried out and appropriate actions plans identified and monitored for impact.

Terms of Reference 5:

Examination of the overall quality of the collaboration, communication and effective working between all parties involved at the time of the incident and previously, as the Panel considers relevant.

8.2.4 Recommendation:

That the PCT Senior Management Team together with the Communication Manager review its existing communication strategies with particular regards to the effective management of Critical Incidents.

8.3.2 Recommendation:

That the PCT Senior Management Team reviews the PCT's policies for managing violence and aggression and resuscitation in order to establish clear roles and responsibilities for qualified as well as unqualified staff involved in such situations.

The recommendations below relate to the PCT's organisational structure and culture which underpins the quality of the delivery of health care services.

Governance and Accountability

- **Clinical Governance**

9.1.4 Recommendation:

That the PCT Board and Senior Management Team review the current clinical governance structure to ensure that the PCT is providing the most appropriate committee and reporting structure enabling a culture of continuous improvement of services and safeguarding high standard of care.

9.1.8 Recommendation:

That the PCT Senior Management Team ensures that only staff trained in C&R are involved in the restraint of patients in its care.

9.1.9 Recommendation:

That the PCT Board and Senior Management Team ensure that their health improvement initiatives relate to in-patients as well as to the general public.

Governance and Accountability

- **Serious Untoward Incidents Management**

9.2.2 Recommendation:

That the PCT Senior Management considers, as part of its review of the Risk Event Response Policy, the adequate timing of the first critical incident review and audit the PCT compliance with the required deadline.

9.2.6 Recommendation:

That the PCT Board together with the Senior Management Team consider the internal Reporting systems following Serious Critical Events including Reporting to Board level and monitor compliance with its own policies.

9.2.14 Recommendation:

That the PCT Senior Management Team reviews the way in which it stores and shares documentation with external bodies.

9.2.22 Recommendation:

That the PCT Senior Management Team takes the appropriate management action to address the serious issues highlighted in the informal internal report

9.2.25 Recommendation:

That the PCT Board urgently ensures that it receives and fully discusses the implementation, monitoring and evaluation of the recommendations arising from the medical review and any issues not yet addressed from the Internal Reviews.

9.2.26 Recommendation:

That the PCT Senior Management Team reviews all the critical issues within the various formal and informal reviews and identifies appropriate actions to address those hitherto neglected.

9.2.28 Recommendation:

That the PCT Board urgently ensures that an appropriate and revised process for dealing with Serious Untoward Incidents is developed and approved by the Board, shared with staff within the PCT and audited for compliance.

Governance and Accountability

- **Governance**

9.3.7 Recommendation:

That the PCT Board urgently reviews its leadership role as the accountable body for the management of critical incidents and ensures that the PCT deals effectively and efficiently with these and that learning generated is disseminated and practice impacted.

9.3.11 Recommendation:

That the PCT reviews the current practice of minute-taking to enable clear audit trails of the discussions taking place within meetings, actions agreed and follow-up of previous actions.

9.3.13 Recommendation:

That the PCT Senior Management Team urgently ensures that structures and systems are in place to enable efficient tracking and monitoring of progress of actions plans relating to critical incidents.

9.3.14 Recommendation:

That the PCT Board and Senior Management Team review its governance structure with regards to its policies and ensure audit of and compliance with its own internal monitoring and review plans.

9.3.16 (1) Recommendation:

That the PCT Senior Management Team ensures that actions plans have clearly identified leads, time scales, monitoring systems, reporting routes and feedback mechanisms.

9.3.16 (2) Recommendation:

That the PCT Board reviews its own role in ensuring organisational learning and efficiency when dealing with Serious Untoward Incidents and satisfies itself that it is in a position to discharge its responsibility for governance.

9.3.17 Recommendation:

That the PCT Board at the review of the Mental Health Panel's Terms of Reference in August 2006 re-consider the remit for the Panel and its current monitoring function with regards to complaints and adverse events.

Governance and Accountability

- **Liaison with the External Enquiry Panel**

9.4.5 (1) Recommendation:

That the PCT provides relevant staff with appropriate training on the preparation, collection and presentation of documentation for reviews and on incident management including report writing.

9.4.5 (2) Recommendation:

That the PCT and the Hampshire and Isle of Wight Strategic Health Authority discuss how to ensure greater clarity of roles and responsibilities when dealing with Serious Untoward Incidents.

Governance and Accountability

- **Audits**

9.5 Recommendation:

That the PCT Board and Senior Management Team when presented with documents ensure that they are relevant, of an appropriate quality and comprehensive in content in order to allow for scrutiny and quality decision-making to be based on these.

Organisational Learning

- **Organisational Learning**

10.1.2 Recommendation:

That the PCT Board and Senior Management Team consider the format of an infrastructure that will enable the effective implementation, monitoring and evaluation of organisational learning.

Organisational Learning

- **Audit of system changes resulting from the Geoffrey Hodgkins' review**

10.2.1 Recommendation

That the PCT Senior Management Team ensures that an audit is taking place of system changes as a result of the internal and external review of the critical incident relating to Geoffrey Hodgkins and that the findings and/or recommendations are disseminated to and fully discussed by the Board, relevant committees and amongst staff generally.

Organisational Learning

- **Creating Organisational Learning**

10.3.3 Recommendation:

That the PCT Board and Senior Management Team ensure that mechanisms are in place to identify, share and audit organisational learning from serious incidents generally.

Leadership and Commitment

- **Clinical and Managerial Leadership**

11.1.2 Recommendation:

That the PCT Board examines its approach to values and ethics to ensure an alignment between the corporate approach and practice.

11.1.4 Recommendation:

That the PCT Senior Management Team considers ways of improving the clinical leadership's role in creating organisational learning through feedback loops and staff involvement in quality improvement initiatives.

11.1.7 Recommendation:

That the PCT Board urgently review the active involvement of all Board members in risk management and incident handling and formulate, regularly monitor and evaluate an action plan to address the short-comings identified by the internal Audit Report and this External Enquiry.

Leadership and Commitment

- **Leadership and Audits**

11.2 Recommendation:

That the PCT Senior Management Team examines the current audit cycle to ensure that all relevant policies/procedures and guidance are included and put forward to the PCT Board recommendations about potential resource implication of instituting and maintaining a comprehensive audit system.

Leadership and Commitment

- **Contact with the Family**

11.3.9 Recommendation:

That the PCT Board and Senior Management Team ensure that the implementation of the 'Being Open Policy' will include appropriate mechanism for keeping the patient/families involved by, for example, appointing a Liaison Officer to each case to facilitate the exchange of information.

Leadership and Commitment

- **Bridging the Reality Gap**

11.4.1 Recommendation:

That the PCT Board and Senior Management Team critically scrutinise their respective leadership roles and the way in which the organisation collectively has managed this serious incident in order to generate learning for the Board, the Senior Management Team and the PCT as a corporate body.