Browne Jacobson

Shared Insights: Mental health patients: learning from incidents and inquests

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Themes arising from inquests

Samantha Paxman, Partner (Barrister), Browne Jacobson

Sam is a senior member of Browne Jacobson's Barristers team which provides nationwide advocacy services. She has extensive experience representing public bodies at complex inquests including those involving mental health patients and offender health inquests.

Introduction

Mental health is now much more widely talked about, and it is often reported in the press that there is a mental health crisis in the UK and increased pressure on services. The focus on mental health is feeding into the approach of Coroners and families so we are seeing more complex and longer inquests with increased scrutiny.

It is not just MH trusts that are affected. There is also an impact on acute trusts, social services, carer or support organisations that come into contact with those suffering from mental health problems e.g.:

- Assessing someone in crisis at A&E;
- Capacity assessments
- Treating the physical symptoms associated with a mental health problem- such as eating disorders

Families often lack understanding of the statutory frameworks of the Mental Capacity Act (MCA) and the Mental Health Act (MHA) and often question in hindsight why their loved one was not detained under MHA without understanding the legal test for this.

It is subjective – it may not seem that way to professionals and it is not always black and white in physical health either, but in physical health there are diagnostic tests available such as x-rays and blood tests.

Themes we are seeing with Coroners

- **Triangulation of care** - involving the family or carers in discussions especially when taking initial history.
- **Continuity of care** - consistency of professionals involved to ensure the full picture is known and relationships developed. Capturing the holistic picture is important.
- **Communication between teams** - both internally within one organisation and between organisations. Coroners are good at picking up on this and following chain of communication to determine where it fell down.
- **Resource issues** – this often feeds into other themes and is given as a reason for any such shortcomings
  - Documentation of rationale around decision making
  - Triage and pathway of care/ team to support.
  - Determination of level of risk.
  - Decision making around whether patient can be detained under MHA.
  - Discharge decisions - whether in-patient or secondary community services.

- Observation levels.
- Medication, which can be trial and error.

Experiences and learning from participating in RCAs

Dr Asim Yusuf, Consultant Psychiatrist, Black Country Healthcare NHS Foundation Trust

Dr Yusuf is a Consultant Psychiatrist and Clinical Director for Mental Health. He has lots of experience of dealing with RCAs. He explained the cycle of risk management and set out a number of learning points to consider.

Most mental health patients are admitted to manage risk. The issue is how that risk is assessed and managed and **the cycle of risk management**:

- identification of risk
- what type of risk
- how high
- how to be managed and by whom
- how to be monitored

This is very important - many RCAs come down to one step of the cycle not being conducted properly.

Assessing risk - Pro forma v clinical assessment - This probably varies by practitioner. Nursing staff, junior doctors, A&E staff are more comfortable with pro formas. More senior doctors tend not to like pro formas as they find them limiting, and that they sometimes limit the application of clinical acumen – there needs to be a balance.

Taking forward the assessment – once you have identified risks and quantified them what do you do next? The quantification of risk assessment (high medium or low) should flow into management of the risks identified. Consider:

- what needs to be done about the risks you have identified?
- who will be responsible? Identify someone.
- prioritising risks –if a person has 2 or more risk factors.

Professional curiosity – Ask the follow up questions - that second question can often open up and clarify why this is a risk and how big a risk this is.

Avoid inconsistency e.g. patients on level 2 observations but also allowed to go out. Staff focus on what is in front of them and don't step back and see the full picture and ensure it is consistent.

Documentation of clinical rationale – often what needs to be done has been noted and is correct but why it needs to be done has not been recorded. Not only might this be an issue in the Coroners court but colleagues won't understand on handover.

Triangle of care - patient, carer and team – this is often overlooked. Often you get a snapshot of somebody at a risk assessment. But the family have the complete picture and that is valuable. Bringing family members on board is extremely important. If staff push back on confidentiality remember it applies to giving information - receiving information does not breach confidentiality. A decision should be made if the patient is happy for the family member to be involved and whether they have capacity to make that decision.

Minding the gap - When patients are handed over from one team to another it helps where there is a team member following the patient through their journey. Having a familiar face is helpful to the patient and the team.

The clinician's perspective – preparing for and attending inquest

Dr Sally Arnold, General Adult Psychiatrist, Midlands Partnership NHS Foundation Trust

Dr Sally Arnold is a General Adult Psychiatrist. She spoke about her experience of attending an inquest relating to a patient she had treated whilst in her third year of psychiatry training. She shared her learning and practical tips about preparation and supporting staff.

Introduction

The inquest (the first Dr Arnold had attended) was 3 years after the patient had passed away. Dr Arnold admitted the patient to the ward and the patient sadly ended their life on the ward the following day.

She was asked to give an account for the RCA but was not involved in the debrief and only discovered the manner in which the patient had ended their life at the time of the Inquest.

Dr Arnold explained **the extensive planning** she undertook for the inquest to ensure the process went as well as possible. These are her top tips:

1. **Mindset** - witnesses are there to help the Coroner - try and answer the Coroner's questions to the best of your ability. Remember the family are grieving, and their anger towards the Trust can be a reflection of this.
2. **Work closely with the trust legal team**. Ask for specific documents, including incident reports, internal investigation documents, statements from other witnesses and a copy of the observation record. If Trust policies have been updated, ask for a copy of the versions in place at the time.
3. Sally asked her consultant to read her statement and provide constructive feedback. He also attended the inquest to provide **moral support and feedback** afterwards for future learning.
4. **Note any issues identified** when preparing your witness statement and any specific points you know you will be asked about, and what you did at the time.
5. Sally called the clinical director beforehand to discuss her concerns about being asked about areas outside her expertise. He provided guidance on what Sally should be asked and how to politely decline questions outside her clinical remit. He was available at short notice to attend the inquest to answer specific diagnosis and management questions if required.
6. **Read through the inquest bundle in advance** and make a note of relevant page numbers for issues you might be asked about.
7. The inquest was held online. Sally prepared an **initial introduction** to read out setting out who she was and her role when she saw the patient. This helped her feel more confident about answering questions.
8. The family's barrister asked the same question 4-5 times in a different way. Sally's planning beforehand, highlighting key phrases in the observation policy made it easy to find and relay this information, with the same consistent message each time.

Sally explained she was worried beforehand about questions from the coroner, but her experience was that the coroner was very supportive of all witnesses, allowed time to answer open questions, explained the process well and deflected irrelevant questions from the family's barrister. The difficulties came when answering questions from the family's barrister.

Sally's key messages/learning points

Doctors and nurses: Ensure **good documentation** which you are able to understand and interpret for years to come.

Consultants: Sally explained she had **excellent support and advice** from the mental health law team, the trust solicitors, her consultant and the clinical director. When you have a junior involved in an inquest it is good to provide support from their current consultant as well as someone involved in the case. Allow the inquest to be a learning opportunity for the future and go to the inquest with your junior even if you were not involved in the treatment so that **feedback** can be given.

Managers: Encourage junior doctors to ask questions and help them to find the right documents. Not everyone knows their legal team, so **make introductions early on**. Sally's legal team offered a post inquest debrief.

Investigators: Make sure that **all persons involved are invited to the debrief** and feedback from the root cause analysis. Any person who has been interviewed should be allowed to read what has been said to ensure it is accurate, and have a chance to read the report. Sharing can help bring about improvement. If the RCA identifies learning lessons for a doctor, let them know and support them in preparing a statement for the Coroner to reflect this. Sally explained that most anxiety comes from feeling you are to blame, which can significantly impact on a doctor's self-esteem and career progression.

Conclusion

Inquests can feel daunting, especially when a patient has ended their life, and it is easy for the witnesses to feel they are to blame. Remind those attending that they are there to help the coroner, to provide details of their personal experience to help the coroner understand more about the death, and in doing so this can also provide some closure for the family. Ensure good planning. The more support witnesses have, the more confident they will feel.

Resources

We have run a previous Shared Insights session on supporting staff at inquests – you can view the infographic from that on the Shared Insights hub here Second victim | Supporting clinicians through investigations, complaints, claims and inquests

Case Study – Learning from a difficult case

Mandy Ford, Head of Risk Management, Dorset County Hospital NHS Foundation Trust

Mandy is Head of Risk Management at Dorset County Hospital NHS Foundation Trust. She set out a case study arising from the death of a patient before she joined the Trust, which she became involved in prior to the inquest. Mandy explained the learning points for the Trust and the steps taken to implement those.

The patient who had severe autism died 2 years before the RCA and the Inquest and so the family had to wait a long time for details of learning.

Staff on the ward did not listen to the care staff and the family had decided not to visit due to the patient's autism - they thought she would think she was going home. The autism also meant the patient did not like being touched so normal observations were not possible.

She needed to have some tests and restraint for any intervention but that was not adhered to until the 4th day of admission.

Documentation was poor.

Communication with the family regarding the outcome of the tests was poor, they were not involved in end of life care and did not have time to say goodbye properly.

Two years later Mandy contacted the family and they were understandably angry, as were the care agency as none of them felt listened to.

There had been many consultants involved in her care with a lack of continuity and communication wasn't brilliant. The family were very upset and Mandy spent a lot of time with them in the run up to inquest.

Mandy's key learning points

- Communication was key including listening to carers and families. Keep communication open.
- The importance of providing support to staff. You can prepare staff but can't tell them all the questions they will be asked on the day.
- Try to build a relationship with the coroner's office.
- Capture the learning early and act on it early – the Trust has appointed a Learning Disability Champion and did a patient story video with family and staff involved which is used on induction.
- Continuity of care is important– now patients have a named consultant rather than consultants being on rotation.
- Press attention –making staff aware that the press may report their names in connection with the inquest and the Trust can't prevent that.

Mandy has kindly agreed to share the documentation relating to Gemma's story linked here.

She sets out more details about the steps taken by the Trust to implement the learning on the next page.

Case Study – Learning from a difficult case

Mandy Ford, Head of Risk Management, Dorset County Hospital NHS Foundation Trust

Reflection/summary

- Understanding of compliance with legislation was poor. Clinical staff did not know their duties under the Mental Capacity Act 2005, including the Deprivation of Liberty Safeguards (now known as Liberty Protection Safeguards) or the Code of Practice for either. The Trust did not have out-of-hours safeguarding expertise, in particular, at weekends.
- Clinical staff ought to have had access to the patient's clinical 'passport' and discussed her clinical care with her family and carers to establish treatment in her best interests, once her mental capacity had been assessed. For people without mental capacity to make a particular decision (for example the patient refusing assessment), clinical staff must involve family and carers in decisions in relation to serious medical treatment; in the absence of family or carers, clinical staff ought to instruct an Independent Mental Capacity Advocate or seek a declaration from the Court of Protection.
- Lack of awareness and lack of training to clinical staff resulted in this failure to comply with legislation.

Findings and Learning

- The Trust worked with the care agency to raise awareness of patients with autism across the Trust. They came in and presented training sessions for staff and the family also attended this session.
- The Trust took the opportunity to launch ‘Gemma’s story’.
- The Trust undertook an awareness campaign on Autism and the ‘This is me’ document and ‘Care passport’ documentation.
- Newsletter was sent to all staff Trust wide to share the importance of listening to family/carers and following the information documented or information verbally given by family/carers.
- This is Me / Care passport included in the Trust’s induction and preceptorship programmes.
- Safeguarding information is provided on induction, including contact details. Online training packages available to staff. Safeguarding training is mandatory and includes what to do out of hours.
- Browne Jacobson supported the Trust with training sessions on the MCA
- Handover sheets amended to include information provided by other professional colleagues, to enable actions to be undertaken on the advice given.
- Reviewed how handover is provided to each shift and on Doctors ward rounds. This includes nursing documentation and any information from family/carers. These were audited.
- Documentation audits completed.
- Appointed a Learning Disability and Mental Capacity Act Advisor.

Summary of discussion & Resources

- A number of points were discussed during the call including:
- The future of CPA
- The importance of record keeping and the difficulties of staff not having enough time to make adequate notes. Samantha emphasised the importance of documenting rationale for decision making. Dr Yusuf suggested a change in mindset so that record keeping is seen as a clinical element of treatment and a way of communicating with colleagues rather than an admin task. It does not need to be a perfect essay in beautifully written English - just get the information down clearly.
- Provision of support and documents to staff who are called to give evidence at inquest, and the value of debriefing afterwards.
- Offering staff the opportunity to observe an inquest before they have to attend one as a way of getting experience. Samantha explained all inquest proceedings are open court proceedings so you can attend as an observer and suggested speaking to the Trust legal/ inquest team to find out what inquests they have coming up or contact the Coroner's court directly to ask to attend one. A number of people on the call said their Trusts support/offer this. Browne Jacobson also runs a **mock inquest** which may assist.
- How often the authors of internal investigation reports (SUI/RCA) are asked to attend an inquest. Samantha explained this happens quite often although it depends on the complexity of the case. Sometimes it can be more useful for someone who is part of the team responsible for implementing the learning to attend instead of the report author.
- How capacity issues are being escalated in organisations and risks being recorded on risk registers. It was noted that this is an important factor to record so it can be shared with other organisations where appropriate.

Resources – round up

Gemma’s story – details kindly provided by Mandy Ford and Dorset County Hospital NHS Foundation Trust linked here

NHS Resolution Inquest resources can be found here. Witnesses may find it useful to watch **NHS Resolution’s films Giving evidence at inquest: a well prepared witness** and **How to prepare for an inquest**, and also to read NHS Resolution’s leaflet entitled **Inquests: Guide for Health Providers**.

Browne Jacobson resources

We held a **previous Shared Insights session on supporting staff at inquests** – the infographic is on the Shared Insights hub **here**

You can view our **Mock Inquest films here** and **here**. These were produced in partnership with Dr Robert Hunter, HM Senior Coroner for Derby and Derbyshire, and aim to help clinical witnesses prepare for giving evidence remotely and to illustrate how best a witness can help the Coroner and the family during a remote inquest hearing.

For further guidance on giving evidence remotely read our checklist **here**.

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