Parliamentary and Health Service Ombudsman

Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust

HC 2260

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Foreword

I am laying this report before Parliament under section 14(4) of the Health Service Commissioners Act 1993.

The investigations summarised in this report found that there were a series of significant failings in the care and treatment of two vulnerable young men who died shortly after being admitted to North Essex Partnership University NHS Foundation Trust (NEP)[1].

There are a number of parallels between the two incidents. In both cases, the young men died soon after being admitted to the Linden Centre and NEP failed to manage environmental risks and carry out an adequate risk assessment.

We have established a timeline that demonstrates wider systemic issues at the Trust, including a failure over many years to develop the learning culture necessary to prevent similar mistakes from being repeated.

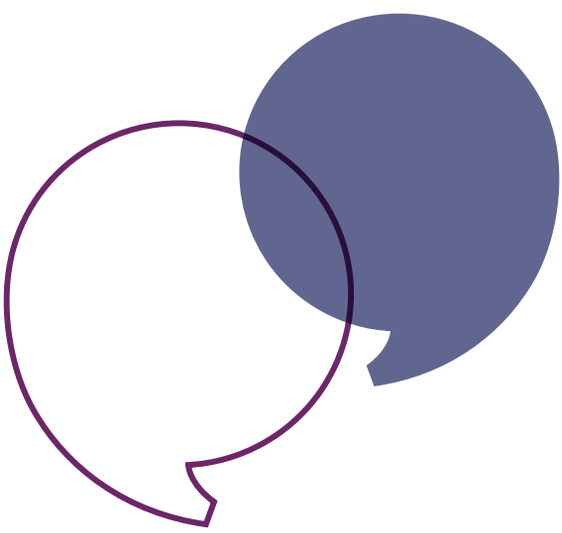
It is important to understand why change took so long despite the feedback from patients' grieving families and the numerous investigations and inspections highlighting that it was so clearly needed.

We have therefore recommended and agreed with NHS Improvement (NHSI) that it will conduct a Review of what happened at NEP. This should include consideration of why the necessary improvements in patient safety only appear to have been completed in 2015, three years after the second death and eight years after the first. The lessons learned from this review should be disseminated across the wider NHS.

In laying this report, I hope that Parliament will also look more closely at the issues I have raised and consider the findings of NHS Improvement's review.

Serious failings by organisations providing mental health services can have catastrophic consequences for patients. NHS trusts must ensure timely improvements to ensure patient safety and protect patients who are at risk of taking their own life.

Rob Behrens, CBE
Parliamentary and Health Service Ombudsman



1 In April 2017, NEP merged with the South Essex Partnership University NHS Foundation Trust (SEP) to become what is now the Essex Partnership University NHS Foundation Trust (EPUT).

About us

The Parliamentary and Health Service Ombudsman (PHSO) makes final decisions on complaints that have not been resolved by the NHS in England and UK government departments and other UK public organisations.

In our 2018-21 strategy[2] we committed to publishing more information about the outcomes of our casework, including the recommendations we make and what organisations have done to comply with our recommendations. Publishing more about what we have found will help public services learn from what went wrong and help them to restore trust among patients while ensuring that future patients do not face similar experiences.

We have an important role in sharing the insight from our casework to help others improve public services and complaint handling. This includes highlighting systemic failings to Parliament, if the complaints we have received indicate there is a need for further learning, including when these come from a single NHS trust, as in the case of this report.

Background

The evidence we have seen in the two investigations highlighted in this report points to significant and repeated failings over more than a decade at the North Essex Partnership University NHS Foundation Trust (NEP). In particular, the investigations highlight issues with the Linden Centre in Chelmsford, where both the individuals, whose cases we are highlighting in this report, received care in the time leading up to their deaths.

We accept that, since the merger of NEP with South Essex Partnership University NHS Foundation Trust (SEP) in April 2017, which saw the formation of the Essex Partnership University NHS Foundation Trust (EPUT), improvements appear to have been made. These led to EPUT receiving a 'good' rating from the Care Quality Commission (CQC) in its latest inspection in 2018.

It is important, however, that the NHS understands why the systemic issues identified in this report, through the wider timeline we have established, were allowed to continue for so many years.

Our investigations relate to the treatment provided in a mental health unit and therefore also link to the report we published last year, *Maintaining Momentum*[3], which looked at problems in acute adult mental health care and treatment across the NHS. If the *Five Year Forward View for Mental Health*[4] as well as the cultural and leadership improvements highlighted in the NHS Long Term Plan are to achieve the system-wide change that is needed, learning from examples such as this needs to be embedded across the system to avoid the same mistakes being repeated.

The Health and Safety Executive (HSE) continues to investigate how NEP managed its mental health wards in relation to reducing and removing potential ligature points. Its investigation looks at incidents between October 2004 and March 2015, an even broader timeline than we have set out.

2 https://www.ombudsman.org.uk/sites/default/files/page/Our%20strategy%202018-2021.pdf
3 https://www.ombudsman.org.uk/mental-health
4 https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Introduction

This report highlights two cases which, although four years apart, when taken alongside the wider timeline we have developed show serious failings in the North Essex Partnership University NHS Foundation Trust (NEP) over a period of more than a decade.

In each case a young man, first Mr R and then Mr Matthew Leahy, was admitted to the Linden Centre in Chelmsford, part of the NEP at the time. Within a short time of their admission, both tragically died.

We found a series of significant failings in both cases. In Matthew's, these were compounded by an insufficient Serious Incident Investigation. Based on the timeline we have established and related evidence such as the CQC's inspection reports, the learning from these incidents does not appear to have prevented mistakes from reoccurring.

It is this broader picture that has led to us producing this report.

The timeline in the next chapter highlights a range of additional evidence that should have acted as a warning signal to the Trust's leadership that there were serious failings that needed to be addressed. These are not issues that we have looked at through our own investigations, which are limited by the scope of the individual complaints we receive.

However, we believe that in an organisation committed to learning and improvement, the evidence from these cases should have prompted immediate action led from the very top of the Trust with senior accountability for delivering and evidencing improvement. Instead, it appears there was a systemic failure to tackle repeated and critical failings over an unacceptable period of time.

An example of the wider evidence that is available but that sits outside the scope of our investigations can be seen in the May 2017 response to the review of an Freedom of Information (FOI) request dating back to September 2016 for the number of attempted suicides at the Linden Centre since 2006. The response to this sets out that, *'A review of all attempted suicides that were transferred to A&E would require a manual trawl of records and the cost of compliance would exceed the appropriate limits. The Trust is therefore applying section 12 exemption to this part of your request.'*

Given the failures of treatment that had been highlighted at the Linden Centre and more widely across the Trust, it is surprising that the NEP's leadership team had not requested that such information was recorded and made available to it. This would have given better visibility about what incidents were taking place and whether mistakes were reoccurring.

If such information was not readily available - and the response to this FOI request suggests it could not be pulled together without many hours work, if at all - it invites the question about what was being recorded and monitored to facilitate a culture of learning across the Trust and to ensure mistakes were not repeated. Such matters sit outside the scope of our investigations into individual incidents, but suggest further scrutiny about what happened at the systemic level in the Trust during this period would be useful.

As was recently highlighted in the NHS Long Term Plan[5], *'evidence shows that the quality of care and organisational performance are*

5 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

directly affected by the quality of leadership and the improvement cultures leaders create.' Mistakes will always be made, but they must also be learnt from. As the Long Term Plan suggests, the drive for this must be visibly led from the very top of an organisation.

In this case, the broader evidence we have seen indicates that there were serious deficiencies in the culture of learning and improvement across NEP. In addition, although recent evidence suggests the situation has improved since the creation of EPUT, according to the CQC's most recent inspection report there remains work to do.

We believe there could be valuable learning taken from a more fundamental review of the approach to leadership, learning and improvement at NEP and why the pace of change only seemed to improve following the merger to create EPUT. It is important that the opportunity to do this is not lost.

The timeline

From our investigations, we have developed a broader timeline about what happened at NEP during and after the cases that came to us.

Reflecting on this timeline, as we concluded our most recent investigation and considered our recommendations, our concern was that it highlighted very similar warnings that reoccur across a significant number of years. Despite their seriousness, the pace of change appears incredibly slow.

In our view, this warrants review by the NHS at the national level. We set out our recommendations in the next chapter.

The timeline that links to the cases summarised in this report is set out below.

- **December 2008** – Mr R is admitted to Galleywood Ward, one of NEP's two acute adult inpatient wards at the Linden Centre in Chelmsford. He dies shortly after this.
- **July 2009** – Serious Incident Panel Inquiry into Mr R's death notes that *'the Trust failed* [Mr R]*, did not discharge its obligations to him and must learn from this'*. Seventeen recommendations for improvement are made by the Panel in relation to the replacement and development of staff, ensuring NICE guidelines are followed and more robust risk assessment of ligature points.
- **November 2012** – Four years after Mr R's death, Mr Matthew Leahy also dies shortly after being admitted to the Linden Centre.
- **January 2013** – Serious Incident Panel Inquiry into Matthew's death makes further recommendations about the management of observation levels, care planning, record keeping, the recruitment of permanent staff and the management of environmental risks, specifically a review of equipment to reduce the risk of self-ligature. During its investigation, NEP also found that Matthew's care plan had been written after his death, which led to disciplinary action against the staff involved and a referral to the Nursing and Midwifery Council.
- **January 2015** – A Coroner's inquest finds Matthew, *'was subject to a series of multiple failings and missed opportunities over a prolonged period of time by those entrusted with his care. The jury found that relevant policies and procedures were not adhered to impacting on* [Matthew's] *overall care and well-being leading up to his death.'*
- **February 2015** – CQC's inspection, published in May 2015[6], finds a number of high-risk ligature points around NEP's mental health wards at the Linden Centre, which had not been identified by its own safety audits. The inspection report refers to Matthew's case. CQC says NEP had trialled options to remove ligature points but had not fully addressed the issue. CQC also finds a lack of detail in risk assessments and care plans. It requires NEP to make improvements in these areas.
- **August 2015** – CQC's inspection report[7] published in January 2016 rates NEP as *'requiring improvement'* overall and rates its acute wards for adults of working age and psychiatric intensive care units as

6 https://www.cqc.org.uk/sites/default/files/new_reports/AAAD0109.pdf
7 https://www.cqc.org.uk/sites/default/files/new_reports/AAAE1332.pdf

'inadequate'. Almost seven years after Mr R's death, its inspection report highlights concerns about whether NEP is learning from incidents and if it is taking action to prevent them from reoccurring. For example, it notes that the Trust, *'had a high percentage of delayed incident investigations. This meant that there was a potential delay in identifying the learning from these. For example, 51% of the serious incident investigations were ongoing and of these, 86% were overdue at July 2015. The oldest serious incident ongoing had been open for over 12 months created on 24th April 2014 and was a 'suicide by outpatient'.'*

- **December 2016** – Eight years after Mr R's death, CQC's Chief Inspector of Hospitals takes enforcement action against NEP to force improvement in the quality of care it provides. The enforcement action is in the form of a warning notice[8] following a further inspection[9] of NEP in September 2016. This highlights that its inspection found that, *'improvements were needed in a number of areas ...* [including] *the trust's assessment and management of risks for fixed ligature points on wards ... and learning from incidents need to be shared with staff.'*
- **January 2017** – Essex Police and the Health and Safety Executive (HSE) begin a scoping exercise to determine whether they should launch an investigation into a number of deaths at NEP, including Mr R's and Matthew's.
- **February 2017** – PHSO concludes its investigation into Mr R's death, finding a number of failings and recommending that within three months (by May 2017), *'the Trust should explain the action taken; set out the evidence gathered that demonstrates change has happened and explain how improvements in its service will be monitored.'*
- **April 2017** – Merger takes place creating a new Trust, EPUT, in place of NEP.
- **August 2017** – Following the scoping exercise, a joint Essex Police and Health and Safety Executive (HSE) investigation begins into a number of deaths at NEP, including Mr R's and Matthew's.
- **July 2018** – CQC publishes its first comprehensive inspection report[10] into the new EPUT. This establishes that it has, *'increased the pace of their work to improve patient safety'* and that, *'leaders had oversight of safeguarding and incident reporting and shared lessons learnt'*, leading to an overall rating of *'good'*. Despite that, however, the safety of services was still rated by CQC as *'requiring improvement'*.
- **November 2018** – Essex police announce[11] that they are unable to meet the threshold for corporate manslaughter charges. The statement from Detective Superintendent Stephen Jennings of the Kent and Essex Serious Crime Directorate notes, however, that, *'As part of our investigation we identified clear and basic failings which in our opinion should have been easily overcome. These, however, did not meet the evidential threshold to proceed for a charge of manslaughter.'*

8 https://www.cqc.org.uk/news/releases/chief-inspector-hospitals-takes-action-following-inspection-north-essex-partnership
9 https://www.cqc.org.uk/sites/default/files/new_reports/AAAF7969.pdf
10 https://www.cqc.org.uk/sites/default/files/new_reports/AAAH2752.pdf
11 https://www.essex.police.uk/news/news-and-features/2018/11nov/essex-police-investigation-into-management-of-nort/

- **June 2019** – PHSO concludes its investigation into Matthew's death, setting out that it had found, *'significant failings ... including [in] key elements of care ... [and] NEP's investigations were not robust enough'*. It also noted that, *'NEP was not open and honest [with the complainant] ... about the steps being taken to improve safety at the Linden Centre'*.

Although our timeline concludes at this point, it should be noted that HSE's investigation is still underway and there remains a possibility of criminal charges being brought against the Trust once that investigation is concluded. We have taken this into account in forming our recommendations in the next chapter.

Our recommendations

We have only seen part of what has happened at NEP through our own investigations, which have looked at incidents that took place at single points in a much longer timeline. As a result, we are not best placed to look at the much broader issues of overall culture and leadership at the Trust over the ten year timeline which potentially stretches to several years before the death of Mr R depending on any findings made in the HSE investigation. But it is clear from CQC's inspection reports that NEP's acute adult inpatient services have not consistently demonstrated the learning culture and leadership that is essential to improving the quality and safety of care.

What we have seen through the two investigations we have carried out paints a worrying picture. We acknowledge that there is evidence that some improvements were taking place at the Trust over some of the past decade. This was highlighted by CQC in the warning notice it issued in 2016, when the then Chief Inspector of Hospitals noted that, even following the inspection that led to the warning notice[12] being issued they, *'could see that much work had been done since our visit in August 2015 and that there were a number of areas of good practice at the trust. The majority of patients gave positive feedback about their care'.*

Despite these improvements it is also inescapable that year after year there was a repeated failure to recognise the seriousness of the ongoing risks to the safety of people using NEP's acute adult inpatient service. This is particularly true in relation to the assessment and management of risks for fixed ligature points and sharing the learning from mistakes with staff, as CQC's inspection reports highlight.

In light of what had happened in the cases we have investigated and the learning from the other inquiries, investigations and reviews over the years, NEP should have become a beacon of good practice for the NHS. The Trust's leadership should have been driving a culture of learning and improvement to address the serious problems that had been repeatedly highlighted to it and they should have been putting in place clear oversight of the changes that were needed to achieve this.

It does not appear this was the case. Instead serious repeat failings at NEP were still being identified in CQC's December 2016 inspection report. It appears that it was only when EPUT was created that a real grip of the issues began to emerge, many years after the deaths of Mr Leahy and Mr R.

The recently published NHS Long Term Plan notes that, *'while some parts of the NHS have created and sustained the leadership cultures necessary for outstanding performance and the big service changes set out in this Long Term Plan, this is not yet commonplace.'* In our view, there are questions to answer about why learning did not take place at NEP for so many years and how the leadership of the newly merged EPUT has now started to drive improvement.

NHS Improvement is uniquely well-placed to lead a review to answer these questions. Having recently come together with NHS England to operate as a single organisation, NHS Improvement supports service improvement and transformation both across local healthcare systems and within individual providers. NHS Improvement also has a system leadership role for patient safety across the English NHS. As part of this activity, it is leading on the development of a patient safety strategy[13] for the NHS, which identifies mental health as a priority area for reducing patient harm.

12 https://www.cqc.org.uk/news/releases/chief-inspector-hospitals-takes-action-following-inspection-north-essex-partnership

13 https://engage.improvement.nhs.uk/policy-strategy-and-delivery-management/patient-safety-strategy/user_uploads/developing-a-patient-safety-strategy-for-the-nhs-14-dec-2018-v2.pdf

Learning from a review of patient safety, culture and leadership at NEP and EPUT would be invaluable not only for the Trust itself and the patients, families and carers who use its services, but also for the wider NHS as it strives to strengthen the safety and quality of care for people with a mental health problem, and achieve equal status between mental and physical healthcare.

In addition to the recommendations we have made to remedy the injustices in the individual complaints we received, we also recommend that NHS Improvement should conduct a review of what went wrong at the North Essex Partnership University NHS Foundation Trust and establish what should have happened instead and the learning that can be taken from this.

In making this recommendation we recognise that the HSE investigation is yet to be completed and we also understand that the local Clinical Commissioning Group (North East Essex) is planning to undertake a Commissioner-led review into these cases. It is important that NHS Improvement's review is timely, does not duplicate other investigative work already underway and draws on the other completed reviews and investigations.

We therefore recommend that the review does not commence until the HSE investigation and any related activity is completed and that its Terms of Reference take into account the views of ourselves, CQC, the Trust and the families and carers affected, as well as HSE and Essex Police. It should also take account of the local Commissioner-led review's Terms of Reference to avoid unnecessary duplication.

We would expect NHS Improvement's review to consider the key features that have led to the apparent improvements recognised by CQC from when the Essex Partnership University NHS Foundation Trust was created.

Any good practice that can be identified from the merger should be widely disseminated.

It should also include an assessment of whether there is specific learning that could contribute to existing initiatives on mental health safety improvement, as identified in NHS Improvement's own consultation on the NHS safety strategy, including the ambition to prevent all inpatient suicides.

In addition to being shared with the Secretary of State for Health and Social Care, the families of the young men that died and NHS leaders, the review's report and any recommendations should be made public. It should also be shared directly with the Chairs of the Public Administration and Constitutional Affairs Select Committee and the Health and Social Care Select Committee so that Parliament can consider whether any further scrutiny is necessary.

We are also aware that there have been calls for a public inquiry into what happened at NEP, including from the complainants in the cases in this report. The review should consider whether the broader evidence it sees suggests that a public inquiry is necessary. If this is the case, the review should also make a recommendation in relation to this to the Secretary of State for Health and Social Care.

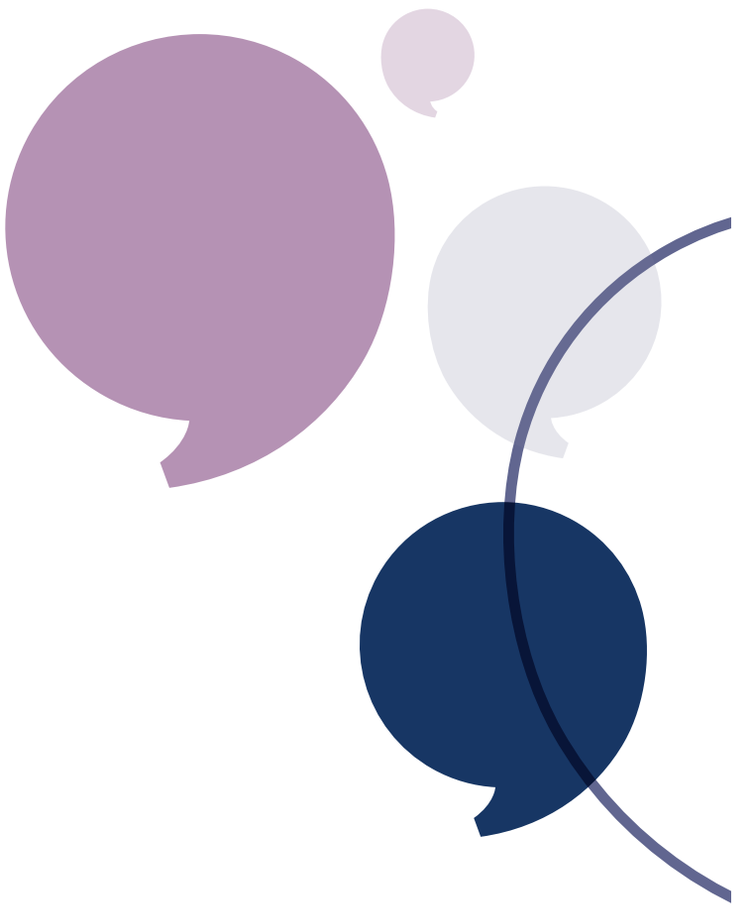
NHS Improvement should conduct a review of what went wrong at the North Essex Partnership University NHS Foundation Trust and establish what should have happened instead and the learning that can be taken from this.

Our investigations

Outlined overleaf are summaries of both of the cases we have investigated and that are referred to in this report. These focus on the key findings that are most likely to be relevant to the Review we have recommended, rather than setting out the full context and detail of the individual cases.

We have shared the full investigation reports with NHS Improvement so that they can be made available to the Review team, as well as CQC and HSE.

Following our investigation into the death of Mr Matthew Leahy, we have recommended that EPUT prepare an action plan to address any outstanding issues. We have said that this should be shared with ourselves, CQC and NHS Improvement so progress can be considered by the Review and as part of future regulatory inspections. We will publish this action plan once we have received it as part of our next relevant quarterly statistics report.



Mr R's case

On 8 December 2008 Mr R, aged 20, was admitted to NEP's Linden Centre as an informal patient.

Mr R had a history of substance misuse and anger issues, and had been tentatively diagnosed with ADHD and dissocial personality disorder.

On admission atomoxetine[14] was prescribed to treat ADHD. Lorazepam[15] and zopiclone[16] were also prescribed on an *'as needed'* basis. On 17 December the dose of atomoxetine was increased. The same day Mr R was granted ward leave.

On 25 December staff physically restrained Mr R. According to the care notes, his behaviour was hostile and aggressive that afternoon. On 26 December Mr R was granted ward leave.

On the evening of 28 December Mr R asked to be discharged. A short time later, he was found in an unresponsive state in his room. Attempts to resuscitate him were unsuccessful.

After Mr R's death, the Trust prepared a *7 day report*, followed by a Serious Incident Panel Inquiry which was completed in July 2009.

An inquest into Mr R's death, in February 2011, recorded a narrative conclusion: '[Mr R] ... *killed himself, while the balance of his mind was disturbed, before his illness was fully diagnosed to ensure a suitable care programme to be implemented to manage his condition. These factors more than minimally contributed to* [his] *death.'*

What we found

We found failings in the care and treatment provided to Mr R, which meant there were missed opportunities to mitigate the risk of him taking his own life. Ms R, his mother, suffers the ongoing injustice of knowing this, and also knowing that he did not receive the standard of care he should have done.

Medication

There was no issue with the dose of medication prescribed but NEP did not take specialist advice or carry out a full risk assessment before prescribing atomoxetine, and failed to properly monitor Mr R for side effects. Staff did not always record the rationale for giving lorazepam and its effect on Mr R.

Ward leave

NEP failed to manage Mr R's ward leave in line with its policy. Overnight leave was granted without any documented rationale or an appropriate risk assessment. Mr R was granted leave on the same day as the dose of his medication was increased, and on another occasion, the day after staff found it necessary to physically restrain him.

Physical restraint

Staff did not do enough to de-escalate the situation and behaved unprofessionally during the restraint, shouting at each other and using inappropriate language.

Care and treatment on 28 December 2008

Mr R's initial care plan had not been updated, and the assessment and management of risk was not adequate. Mr R had been admitted at

14 A drug used to treat ADHD.
15 A tranquiliser.
16 A drug to help people to sleep.

risk of suicide but there was no mitigation plan in place other than *'as needed'* lorazepam. NEP acknowledged through its own investigation that staff had not responded adequately when Mr R threatened to harm himself on 28 December.

Environmental risks were also not properly managed. An assessment in 2007 rated certain ligature points as low-risk. Before Mr R's death these environmental risks had changed but had not been identified or acted upon.

Matthew's case

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

On 7 November 2012 the police brought Matthew to NEP's Linden Centre as a place of safety. He had a formal assessment of his mental health and was detained for treatment under section 3 of the *Mental Health Act 1983* as amended in 2007 (the MHA).

On 8 November Matthew told staff he would hang himself if they gave him injectable medication.

On 9 November he alleged he had been raped during the night.

On 15 November staff found Matthew hanging in his room. After attempts to resuscitate him, he was taken to A&E at Broomfield Hospital where he died.

A number of investigations have been carried out into Matthew's death and the alleged failings in his care and treatment. In January 2013 NEP completed a Serious Incident Panel Investigation that concluded care and treatment was of a good standard.

In January 2015 an inquest was held that considered a report from an independent psychiatrist which concluded that overall NEP had provided an acceptable level of care. A police report commenting on the independent psychiatrist's findings said Matthew's care was appropriate at the time of his death. However, a report by a second independent psychiatrist said the treatment provided to Matthew, *'fell below the standard of a reasonably competent practitioner.'*

The inquest recorded a narrative conclusion which said Matthew, *'was subject to a series of multiple failings and missed opportunities over a prolonged period of time by those entrusted with his care....'*

What we found

We found that some aspects of Matthew's care and treatment were in line with relevant guidelines. But our investigation also identified a number of significant failings in key elements of care. Knowing Matthew did not receive adequate care has caused unimaginable distress to his family.

We also found that NEP's investigations were not robust enough and that NEP was not open and honest with his family about the steps being taken to improve safety at the Linden Centre. When his family came to us, NEP had not taken sufficient and timely action to put things right – this added to the distress and frustration as there was no reassurance that things had changed for the better.

Care planning

NEP did not ensure Matthew's care was adequately planned. Matthew had an initial care plan covering the first 72 hours of his admission but it was not updated to reflect all of his needs or address all of the risks present, for example, his reports of rape, substance abuse, aggression and non-compliance with prescribed medication. The failings were compounded by staff preparing a fuller care plan after Matthew's death. NEP identified this through its own investigation and took disciplinary action against the staff involved

and referred them to the Nursing and Midwifery Council.

Risk assessment and management

The assessment and management of risk during Matthew's admission was not rigorous enough. While the risk of *'suicidal ideas'* was recorded, this was not explored with Matthew in any detail, and no plan was put forward to manage this risk. NEP also failed to adequately manage environmental risks including a ligature point in his room. The failings in respect of the assessment and management of risk are all the more significant since Matthew was at the Linden Centre due to concerns about his welfare and the risks he posed to himself and others. Those risks should have been properly assessed and managed.

Matthew's physical health and nutrition

NEP did not take adequate care of Matthew's physical health. Matthew should have had a full medical assessment and examination on admission, or as soon as possible following admission. When Matthew refused a physical examination on admission, staff should have made at least one attempt to undertake a physical health assessment in each 24 hour period. There is no evidence this happened despite suitable opportunities arising. We saw no evidence that staff acted on Matthew's reports of cysts or bleeding from the anal area. We also saw no evidence that blood tests or an ECG were carried out, despite a plan for these being documented in Matthew's records.

Our investigation saw evidence of concerns about Matthew's nutrition and weight. Staff failed to act on these in line with NEP policy and did not calculate a nutrition risk score for him. Matthew's weight should have been checked every week and his food intake monitored and documented.

Medication

Doctors prescribed medication which was suitable for Matthew's needs and at the correct dose. On one occasion, Matthew was given a rapid tranquiliser to calm his agitation. There was no issue with the drugs prescribed but we saw no evidence that staff considered or used de-escalation techniques before administering rapid tranquilisation, which should have been used only as a last resort.

Observation and engagement

Matthew's observations were not properly managed. Staff did not always observe him at the prescribed level, and his observation level was reduced on 13 November without prior discussion with the multidisciplinary team. No rationale for the reduction was recorded. Although the daily care records provide some evidence that staff engaged positively with Matthew, the observation records often only state his location or observed behaviour. There is little evidence that staff used observation as an opportunity for meaningful engagement with Matthew.

Response to rape allegation

Staff did not take adequate action when Matthew reported being raped on 9 November. Their response indicates they felt his allegation was a symptom of his delusional disorder. We saw no evidence staff completed actions noted to be *'essential'* in NEP's policy on *Promoting Sexual Wellbeing with Service Users.* They did not complete an incident form or carry out a capacity assessment, and it is questionable whether the police would have been called, had Matthew not phoned them himself. In the event, the police decided not to take any further action. We saw no evidence that Matthew's reports of rape went on to be addressed through effective care planning and risk management.

Allocation of key worker

NEP failed to properly allocate a key worker to Matthew. At the inquest, the nurse who had been assigned to Matthew stated that she only discovered this by reading a white board on the evening of 13 November - six days after Matthew had been admitted. The nurse acknowledged going on annual leave shortly afterwards without taking any action.

Record keeping

NEP's record keeping was not always as robust as it should have been. Some paperwork was lost and Matthew's care plan was falsified. Nursing staff did not record the rationale for administering lorazepam - a tranquiliser which may be a drug of abuse - and its effect, on each occasion Matthew requested it.

NEP's Investigations

Overall the investigations into Matthew's death were not adequate. NEP's *Seven day report* contains inaccurate information about how Matthew's care plan was reviewed. It lacks credibility because it was written by a member of staff who was later found to have been involved in the falsification of Matthew's care plan.

NEP's subsequent Serious Incident Panel investigation did not fully meet its terms of reference and the make-up of the panel was not in line with NEP's policy. Matthew's family was not as involved in the investigation as they should have been.

The conclusion of the Serious Incident Panel's investigation report - which stated that overall care was of a good standard - does not reflect its findings, which identified problems in key areas of nursing practice during Matthew's final admission, including the management of his observations, care planning and keyworker allocation. The report stated the investigation had been based on the *'principles of root cause analysis'* yet it did not explicitly refer to any root causes or factors contributing to Matthew's death.

The recommendations NEP made were not sufficiently robust and comprehensive. NEP failed to assure its commissioners that it had learnt from Matthew's death and improved patient safety within an appropriate timeframe.

Lack of timely safety improvements

After Matthew's death, NEP reviewed some of its policies and practices but did not make substantive physical improvements to the Linden Centre until August 2015. A CQC inspection of NEP's acute psychiatric wards that month - almost three years after Matthew's death - indicates that it had not addressed all of the safety problems.

The CQC found there were still an, *'unacceptable number of ligature risks'* with self-ligature causing two deaths during the preceding 12 months and similar deaths in previous years. There had been numerous other incidents involving the use of a ligature on the acute admission wards, with one incident occurring during CQC's inspection. Risks were not being properly managed even though they had been highlighted during previous inspections. The CQC said NEP had given assurances that changes would be made but it had not fully addressed concerns.

The CQC also found that there was an over-reliance on bank and agency staff, patient risk assessments on one of NEP's wards lacked detail, and the majority of care plans were not personalised or holistic.

NEP sent letters to Matthew's family and MP in February 2015 stating that it had made changes

since his death to improve patient safety and prevent similar events in the future. The fact that the CQC was still finding problems later that year indicates that the changes NEP made had not led to timely, tangible and sustained improvements throughout its wards. This clear failure to learn from mistakes is inexcusable.

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