Strictly Confidential

Report into a Serious Incident that took Place at the Bill Yule Adolescent Unit On 26th February 2012

January 2013

Acknowledgements

The members of the independent review panel in this case were commissioned by South London and Maudsley NHS Foundation Trust to examine the care and treatment of four young people and their subsequent absconsion from the Bill Yule Adolescent Unit on 26th February 2012. The unit is based at the Bethlem Royal Hospital and managed by South London and Maudsley NHS Foundation Trust.

The method undertaken by the independent review revisits the circumstances relating to the absconsion from the unit and the care and treatment that was provided to each of the young people who absconded. The independent review panel acknowledges that this causes all those involved to re-examine often difficult and sometimes disturbing experiences as well as the discomfort caused by the process itself.

The independent review has a responsibility to ensure that processes are properly conducted in order to maximise learning with the aim of improving services to individuals thus reducing inappropriate risk.

Those who attended for interview were asked to account for their roles and provide information to the independent review. All did so in accordance with expectations and frank openness for which they must be commended. We are grateful to all of those who granted access to facilities and individuals throughout this process. This has allowed the independent review panel to reach an informed position from which we have been able to draw conclusions in order to set out recommendations.

Grateful thanks are also extended to the independent panel of experts who so diligently examined the documentation, participated in the interviews, considered the evidence and contributed to the report.

Executive Summary

Introduction

On the 26th February 2012, between 13.10 and 13.15 hours four young people escaped from an Adolescent Medium Secure Unit, the Bill Yule Adolescent Unit, based at the Bethlem Royal Hospital. The four had removed one of the young people's bedroom windows, climbed out and then escaped over the perimeter wooden fence outside that part of the unit.

One young person returned later that day of his own volition, a second handed himself into the police on 27th February 2012. A third was apprehended by the police at Dover port on 28th February 2012, and the fourth came back to the unit on 3rd March 2012.

The Bill Yule Adolescent Unit, (BYAU), a service provided by South London and Maudsley NHS Foundation Trust, (the Trust) is a national specialist service that is commissioned by the National Specialist Commissioning Team, (NSCT). The unit is one of seven similar units that are based across the country and provide this highly specialist service for adolescents who meet specialist criteria. The BYAU provides care for up to ten young male people although some of the units in other parts of the country do provide a service for both male and female young people.

The Board of Directors of the Trust met on the 28th February 2012, two days after the incident, and decided to suspend the service. This was agreed and confirmed in writing to the NSCT who supported this decision. The BYAU closed on the 12th March 2012.

An absconsion from any medium secure setting constitutes an extremely serious incident, therefore it was agreed to set up an external independent investigation into this.

The Trust commissioned the investigation on 14th March 2012, in partnership with the NSCT, in order that the NSCT can share learning with other adolescent forensic services.

The first part of the investigation was to examine the care and treatment provided to the four young people and the circumstances of the escape from the unit. The second part was to undertake a review of the service being provided and make recommendations for the future service provision.

The independent review was undertaken by three different cohorts of professionals independent of the services provided by South London and

Maudsley NHS Foundation Trust in accordance of the Terms of Reference.

Consent to access the young peoples' case notes was delayed as the legal aspects were complex due to parental and care responsibilities. Consent to examine the final young person's case records was obtained in July 2012. Once the records had been received and indexed with a timeline of the person's contact with services, arrangements were made to commence interviews.

Evidence was received from a total of 31 individual witnesses over a period of nine days during, July, September, October and November 2012. One witness was recalled for a second interview.

Short profiles of the four young people who absconded on 26th February 2012 were compiled together with a timeline of the events that took place that afternoon. Their ages are below;

- Patient A, aged 18 years
- Patient B, aged 16 years,
- Patient C, aged 17 years,
- Patient D, aged 14 years,

The independent review panel's analysis and findings were based on the evidence, both written and oral, that had been provided to them during the course of the review. The analysis sets out the background to the BYAU and consideration of the issues raised within the review.

Findings and Recommendations

This review has been made more complex by the BYAU service having been suspended since the end of February 2012. The consideration of the evidence provided would normally produce recommendations that would be made to ensure that the likelihood of similar events would be minimised in an ongoing service.

Therefore the following recommendations are made taking into account that the service is not currently being provided and that decisions regarding a similar unit being re-commissioned or provided by South London and Maudsley NHS Foundation Trust have not been made by either the Trust or Commissioner.

The independent review panel have identified recommendations that also relate to the national services.

Notable practice

It is a normal process in investigations into serious incidents to set out areas of notable practice. In this case the independent review panel found several areas that they wanted to specifically single out as examples of good practice. These have been set out as follows:

The Service

The independent review team would like to commend the unit team on their energy and hard work in starting to formulate a robust service that would meet the required standards. The work they have done, and structures implemented, have brought about a reduction in the frequency of incidents.

Programme Board

The setting up of a Programme Board chaired by the Director of Nursing and Education was considered to be an initiative that if the incident had not taken place would have raised the profile of the service within the Trust and also encourage staff to continue with the service developments knowing that they had support from a Trust Executive Director. It was unfortunate that this group only had two meetings, the 18th January 2012 and 15th February 2012, before the unit was closed following the incident.

Forensic Liaison

The independent review panel heard that the BYAU clinical teams were forging links with the adult forensic services on the hospital site. It is considered that these links would have provided specialist support in particular to the unit's consultant and the issues in regard to security on the BYAU.

Escape Vulnerability Assessment

The independent review panel were impressed with the Escape Vulnerabilities Assessment process that has been developed by the adult forensic service and applied to the BYAU service. The resulting detailed report and action plan relating to the audits are to be commended.

Findings and Recommendations

Level of security

The independent review panel heard various terms that were used to describe the BYAU and the service provided there, in particular the level of security required.

Recommendation One – The Trust

It is recommended that if the service is re-commissioned for this client group that it meets the service specification for secure forensic mental health services for young people and that a jointly agreed definition for a medium secure forensic adolescent service is made.

Recommendation Two – NSCT

It is recommended that the commissioners should produce clear guidance for service providers on the timescale required for implementation of any changes to standards within their medium secure forensic adolescent service specification. In addition the NSCT must require service providers to provide detailed implementation plans and risk mitigation where standards are not met.

Recommendation Three – The Trust

It is recommended that a peer review framework is developed that audits and evaluates all three aspects of security (physical, relational and procedural) and reports on a regular basis to the Trust.

Specialist Expertise and Clinical Leadership

It was found that of the five consultant psychiatrists employed within the BYAU since it opened, only two of these had dual qualifications of Child and Adolescent and Forensic specialist expertise. The independent review panel consider that these qualifications are is vital to maintain the specialist clinical care required.

Recommendation Four – NSCT

It is recommended that standards for all medium secure forensic adolescent services ensure there is a medical lead who holds both

an Adolescent and Forensic qualification plus forensic psychiatry and that there should not be less than two consultants to each unit including when locum cover is required.

Psychology Service

Psychology services are vital within this specialism due to the relevance of developmental, clinical and forensic psychological theory and practice at all levels within forensic adolescent work. The independent review panel found that psychological services had not been given sufficient priority and had at times been completely absent. In addition, there was insufficient forensic psychological knowledge and experience.

Recommendation Five – The Trust

It is recommended that if the Trust has the service re-commissioned then psychological input to the service is reviewed and increased and that the service specification includes the need for relevant forensic qualifications and experience within the psychology team.

Clinical Care

The independent review panel heard and reviewed evidence that demonstrated significant shortfalls in the quality of clinical care, in particular in the quality of therapeutic engagement, observation and interaction, and shortfalls in the awareness and skills required for effective relational security at the time of the serious incident.

***Recommendation Six* – The Trust**

It is recommended that if the Trust has the service re-commissioned, that a review is undertaken to significantly improve new staff induction and continuing professional development training programme. These should be specific to the needs of an adolescent forensic medium secure service, including nursing leadership development. In particular it is recommended that the NSCT consider a Nurse Consultant post to develop the skills and knowledge required for this specialist service is considered.

Multi-disciplinary Team

The independent review panel found that the service did not present as one of a multi-disciplinary team with individual professionals often working in isolation on the unit and not specifically identified as clinicians important to the general service being provided to the young people.

Recommendation Seven – The Trust

It is recommended that if the Trust has the service re-commissioned that they regularly review the composition of the multi-disciplinary team taking into consideration the changes in the patient population base and case mix.

Zoning

The independent review panel remain concerned about the unique zoning model used on the BYAU, and it was apparent from evidence received from staff that there was a confusion of purpose and inconsistency of application by the clinical team. Evidence was provided that the model in use on the unit at the time of the incident was to be reviewed. This proposal is endorsed and should be a priority if the service is re-commissioned.

Recommendation Eight – The Trust

It is recommended that if the Trust has the service re-commissioned then the zoning process is fully reviewed together with the policy and procedure and properly implemented if it is determined to continue with this therapeutic model of care.

Staff Recruitment and Expertise – The Trust

The independent review panel had concerns in relation to staff competency and the level of specialist forensic adolescent expertise with this patient population. Conflicting information was heard in regard to recruitment with some staff reporting that they were slotted into posts on the unit. Senior managers appeared not to be aware of this practice and refute the use of this redeployment process.

Recommendation Nine – The Trust

It is recommended that if the Trust has the service re-commissioned that all staff should be recruited specifically to work in the medium secure service and be supported to gain the appropriate skills, experience and qualifications. Furthermore it is recommended that the Trust work with other similar NSCT units to develop a competency framework that includes a probationary period of one month for all staff.

Complex Service

The independent review panel found that generally the complexity of the service and those of the individual young people was not understood resulting in a service that was considered to be not well supported and remained somewhat isolated.

Recommendation Ten – The Trust

It is recommended that if the Trust has the service re-commissioned effective support structures are put in place which would also define the roles and responsibilities in relation to Ward to Board and performance management.

Inpatient Beds

The independent review panel heard differing opinions as to how many Adolescent Forensic beds are required nationally. Evidence was provided that indicated that specialist expertise provided earlier in the pathway of the young people might change the number of inpatient beds required.

Recommendation Eleven - NSCT

It is recommended that a patient pathway is developed by the NSCT that includes nationally commissioned Forensic Child and Adolescent Mental Health Service Outpatients.

Clinical Environment

The independent review panel consider that despite the efforts of the Trust to upgrade the environment and to provide a reasonable clinical environment it was considered that the BYAU unit did not meet the

standards required in terms of security and effective therapeutic space because of the limitations of the building in which the service was being provided.

Recommendation Twelve – The Trust

It is recommended that if the Trust has the service re-commissioned that it is provided within an environment that is fully fit for purpose and meets all of the security and therapeutic requirements of an adolescent forensic medium secure unit. This should include specifications regarding the school provision and a reasonable degree of separation between the ward and the school environments within the secure perimeter

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Effective Service Provision – The Trust

Whilst carrying out the Service Review the independent review panel accessed considerable information as detailed under a Service Review section. It is considered that if there had been a mechanism or system for systematically bringing this information together it would have raised awareness of a service not functioning well, for example the high staff vacancy levels, high staff sickness and high use of agency staff, along with knowledge that the team had serious gaps in the multi-disciplinary team such as psychology, family therapy and for a long time a suitably qualified Psychiatrist. The service was also running with unoccupied beds, which was raised as a concern at monthly performance meetings.

Recommendation Thirteen – The Trust

It is recommended that if the Trust has the service re-commissioned that they develop a formal audit process that recognises issues that need addressing and could be used to review, evaluate and identify when a service is not functioning to the required standard to ensure the safety of both patients and staff. This should apply especially to small services such as the BYAU where the balance of safety and expertise is easily disturbed.

Forensic Liaison

The independent review panel commended the service for forming closer links with the Adult Medium Secure Service on site. It was considered that

these informal working relationships should have been formulised and part of both services structures.

Recommendation Fourteen – The Trust

It is recommended that if the Trust has the service re-commissioned that a formal structure is in place that includes joint responsibility for security within the forensic or secure structure of the organisation.

In Conclusion

In order to support the independent review panel's recommendations it is suggested that larger services, which are divided into smaller units, are considered in future new services to ensure that the required capacity to support high quality services with the variety and numbers of specialist staff and service development is achieved.