Curriculum Vitae

Geoffrey Ronald Ellison

MPhil, MSc, RMN, SRN, D.N (London Univ), Cert Ed, RNT.

113 Allithwaite Road.
Flookburgh
Grange over Sands
Cumbria
LA11 7JR
015395 58238
07719786355
28geoffre@gmail.com

Personal Profile

A Registered Mental Nurse/ Registered General Nurse with extensive clinical experience in caring for people living with mental and physical disorders and a proven record of achievement in both teaching and management.
An excellent role model possessing sound leadership arid communication skills, which enables me to work as part of a team, or independently, to local national and international guidance. I am able to maximise team potential and effectively manage change and I work well under pressure and am accustomed to the demands of a complex organisation

Employment History

Independent Nursing Consultant, Training and Expert Witness 2012-Present.
I serve as an expert witness in the specialist field of psychiatry in the areas of liability and quantum in nursing and healthcare services.

Programme Leader/ Senior Lecturer in Psychiatry (Mental Health)
University of Chester - School of Nursing & Midwifery Chester College, Cheyney Road, Chester. CH1 4BJ June 2005 – 2012

Audit Lead/Clinical Effectiveness (Secondment - senior management experience)
Warrington Primary Care Trust February 2005 to May 2005

Project Manager (Secondment - senior management experience)
Salford Primary Care Trust June 2004-January 2005

Acting Head of Department, Senior Lecturer in Psychiatry/Mental Health
Chester College - School of Nursing & Midwifery Chester College, Cheyney Road, Chester. CH1 4BJ June 2000 – June 2004

Nurse Tutor
Chester College - School of Nursing & Midwifery Chester College, Cheyney Road, Chester. CH1 4BJ June 1989 -June 2000

Charge Nurse
St Helens and Knowsley Health Authority, Rainhill Hospital – Merseyside Central Rehabilitation
May 1986- September 1988

Staff Nurse / Deputy Charge Nurse
Wigan Health Authority — General Surgery and Psychiatry April 1983 -May 1986

Professional Education

September 2017 Keele University, Stoke
MPhil in Medical Law and Ethics

July 1992 Liverpool University Liverpool
MSc in The Ethics and Law of Health Care

June1989 Bolton College Bolton
Certificate of Education/ Registered Nurse Tutor

1983— 1987 Stockport & Stoke Colleges London Univ
Diploma in Nursing (4 years' day release)

August 1982 Warrington D. C. H. Cheshire
State Registered Nurse.

October 1978 Rainhill Hospital Merseyside
Registered Mental Nurse

Summary of my Career

My career in the National Health Service and higher education spans an extensive period of time during which I have had experience at various levels in a range of clinical, managerial and education services. My background of dual qualification has facilitated my focus on the clinical governance agenda, person-centred care and the pursuit of improved outcomes for those who are service users and carers. I have been instrumental in the commissioning of trainee nurses and educational learning packages for Warrington/Halton School of Nursing and Midwifery and liaising with Directors of Nursing Services and Senior Managers to establish workable and effective academic links for students.

Key Achievements (Past)

- Leadership —as acting lead nurse in Mental health/Learning Disability team successfully led the nursing team through a government review helping the University obtain a very high rating of 21/24.
- Lead person for operational and strategic link/collaboration in prison hospitals, and medium secure units for mental health and learning disability and networking nationally and internationally.
- Registered by the Mental Health Act Commission to be the external investigation and complaints officer for Ashworth Hospital Merseyside
- Played a leading role in identifying the needs of clinicians to enable a positive outcome through a needs analysis exercise ensuring successful bid.
- Responsible for negotiating with outside training agencies to commission training and development packages and for the franchise and delivery of these packages
- Chaired the Cheshire and Merseyside Workforce Development Confederation (Nursing Sub-Group)

- Lead person on the university ethics committee advising on health-related issues in research proposals
- Represented the University of Chester at conferences both nationally and internationally.
- Led a two-year research study on implementing and managing the process of change within the clinical environment of two trusts. This involved overseeing the project, analysing complex data and cascading the results back to the clinical areas (accepted for publication).

Past Key Achievements

- Produced key business planning document which provided information on the costs of venues used for training, which was then used to develop the PCT's case for new training centre. This was an important document helping to save the PCT £50k and underpinned the partnership working with Greater Manchester Ambulance Service.
- Through a "Prince" work plan I have been able to identify and manage critical issues and prioritise eg – recommendations following Health Care Commission and timescales attached.
- Lead and Link person for supporting the Practice educators. This role relates directly to the implementation of the *Specialist Practitioner Qualification Programmes* specifically through support networks within district nursing and health visiting.
- Collected and collated evidence on Statutory and Mandatory training and this information was used to support the PEC and Executive Board Directors in setting key targets and objectives.
- Have now completely rewritten the policy for Statutory and Mandatory training.
- Have rewritten the Quality Assurance policy on delivery of education. Within the quality assurance framework I have identified trainers by creating a vision motivated them to look at delivering training in a different way ensuring high quality provision of care and creating a workforce which is "Fit for Purpose". Have delivered on national strategy/policy.
- The work I have done around E learning packages has positively started to motivate and develop trainers to achieve high performance by enabling innovation and creativity and facilitate new ways of a blended approach to working practices.
- Playing a leading role in the performance management of reports following CHI recommendations and for the advent of attaining Improving Working Lives plus in 2005
- Lead person for the Knowledge and Skills Framework. I am in the process of delivering training to senior personnel in the Trust.
- Created collaborated links with Social Services enabling positive working relationships across organisational boundaries developing a joint policy.
- Developed and maintained effective working relationships with professional groups and outside organisations (i.e. Universities Strategic Health Authority and Acute Trust).

Key Achievements (Present)

- Regular partnership working with senior management and through positive working gained valuable support for major reviews for NMC and CQC
- Linked with and cascaded information from major reviews to stakeholders strengthening the collaboration between the university and clinical practice.
- Lead link person/advisor to the senior management committee in the Five Boroughs NHS Trust (Mental Health and Learning Disability) to facilitate robust educational links between the university and clinical practice.
- Involved in ensuring standards of assessment, teaching and learning are met as laid down in benchmarks set by the Quality Assurance Agency and the Nursing and Midwifery Council as a member of the Programme Management.
- Member of the Programme Planning Team for the revalidation of the nursing curriculum 2012.

Personal Details

DOB 28 3.55
License: Car owner/driver with full clean driving license

Hobbies/Interests

Qualified amateur football league referee, learning to speak Spanish fluently, Walking football.

Referees

Mrs. Maureen Benbow
Independent Nursing Consultant
CQC Specialist Advisor
20 Cloverfields
Haslington
Education
Crewe
Carlisle
Cheshire

CW1 5AL
01270 251833

Mrs. E Maloney
Head of Education Centre
Learning and Development
North Cumbria University Hospital
NHS Trust
The Cumberland Infirmary
Newtown Road
Cumbria
CA2 7HY
Carlisle
01228 814828

Dr. Janet Barton
Senior Lecturer
Faculty of Health
and Social Care
Nursing
University of
Chester
Crab Lane
Warrington CW
Cheshire
WA2 0DB
01925 534226

*****MAINTAINING CLINICAL CREDABILITY*****.
(**2012 TO PRESENT DAY)**

To maintain my skills and standards for the subjects I teach and report upon as an expert witness I have always worked within various psychiatric clinical areas every year. There is a professional expectation that every three years the Nursing and Midwifery Council will demand clinicians to prove and give evidence that they have completed the 450 clinical hours and are up to date with their Continuing Professional Development. Without this evidence which has to be checked and signed off by another senior professional you will not be able to maintain your registration. I revalidate with the Nursing and Midwifery Council in December 2017 and to date have completed 910 teaching and clinical hours and all of my Continuing Professional Development is current .

Additional Roles
As a Union steward representing the Royal College of Nursing, and also my role as a University Senior Lecturer monitoring learner nurses educational placements I have been involved in investigating allegations of professional malpractice, negligence and abuse, safeguarding, bullying and harassment, accountability, confidentiality and dignity breaches, unsafe staffing levels in hospitals and care homes. The investigations have specifically focused on physical, mental and financial abuse, medication abuse and misuse, a lack of basic understanding of the needs of people living with different forms of dementia and challenging behaviour.
The skills I have developed are recognition of malpractice, working with various professional disciplines, leading and reporting on a number of issues. Being able to monitor, evaluate and promote the health and safety, comfort and rights of residents in Long-Term Care homes through the educational inspection program. Ensure compliance with relevant legislation and policies. Analyze information to inform care and service improvements, particularly in the areas of nursing and utilize skills to evaluate and assess the provision of clinical care of complex Long-Term Care home residents.
Being able to give constructive feedback to improve and develop the NHS services to positively move forward, develop and improve patient care.
My long-term experience as a member of the University Ethics Committee helped to develop my decision-making skills by working as part of a multidisciplinary team.

As a member of University Professional Suitability Panel which considers the professional suitability of students following breaches of protocol. My participation enabled me to work with colleagues from other faculties. Issues such as violence on campus, inappropriate material on social media sites, alcohol and drug abuse, child pornography were investigated and recommendations made to the university board.
Cheshire Police

- Advised and undertook the role of teaching of mental health education to the above **police force** when dealing with people with learning disabilities and mental health problems within the general population. Gave numerous lectures to cadets being prepared to go out on their various communities. Also assessed

the training police officers when delivering Mental Health law which involved sections of the Mental Health Act (1983)[2007 revised].

As a University Senior Lecturer one of the units I was over was The Delph Hospital which was run by the private firm Partnerships in Care. I was the lead input for the student's educational needs and training progress and yearly I audited the whole hospital which needed to be carried out for NMC requirements. A second unit I also was the lead educationalist at was the Priory in Altrincham in Cheshire again fulfilling the requirements I have just laid out for the Delph.

Secondly and more importantly when I finished playing football at weekends I decided to go back onto the clinical area and keep my clinical skills up to date. I was invited by a Director of Nursing to work in a medium secure unit dealing with forensic psychiatric medicine.
I worked for a private company called Craegmoor Healthcare in Manchester where we took prisoners but were patients with serious mental health problems from Ashworth in Liverpool and from Broadmoor in Kent who were considered not to need high secure care. (Craegmoor Healthcare later sold out the franchise to the Priory Group).
On many occasions I was the lead nurse over both wards at weekends as there was no senior management present but they were contactable by telephone should the need arise. On some occasions I was asked to take charge from 5pm till 8pm. So as soon as I had finished teaching I went straight to the hospital and took charge so that the senior management could go home at 5pm.

The two wards were composed of 12 patients on each ward with a ratio of 12 patients to 5 staff. I attach a testimonial which I had done in 2012 when I was thinking of returning to senior management within the NHS but decided to stay in Education. (I do believe that the manager who wrote this report has been displaced and no longer works for the Priory Group ad that sadly Charles House Hospital has closed.)
However it gives an insight into some of what I did and I hope it clarifies some of the anomalies not found in the CV.

2012-Present . Freelance Health Educationalist and Expert Witness
In the last three years, I have been working for the North Cumbria NHS Trust which involves the West Cumberland Hospital and Carlisle Infirmary as a freelance health educator. Following two CQC reviews it was identified that there was a deficit area in the knowledge of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. It was also to meet the Commissioning for Quality and Innovation (CQUIN) 2015/16 targets. I developed a teaching package and have delivered to a wide target audience from the newly qualified band six to the most senior personnel including top level consultants and members of the executive board. I also delivered on 'Prevention of Suicide' training.

I serve as an expert witness in the specialist field of psychiatry in the areas of liability and quantum in nursing and healthcare services.

TO THE COURT:

LIABILITY REPORT

CONCERNING THE INJURIES SUFFERED

by

XXXXX

(born xxxxxxxx)

following care received between 11 – 31 December 2012

at

XXXXX

Report Prepared By :

Geoffrey Ronald Ellison
MPhil, MSc, RMN, SRN, DN(London Univ), Cert Ed, RNT

Report prepared for the Court on the instructions of :

XXXXX
XXXXX

Date of Report: **14 April 2017**

H:LEGAL2017/ GE/

C O N T E N T S

INTRODUCTION

1.1 Formal Details

1.1.1 The following is the proof of evidence of Geoffrey Ellison of AMG Consultancy Services Limited.

1.1.2 I am a Registered Mental Nurse and State Registered Nurse with 37 years' experience as a Clinician and University Senior Lecturer in Nursing

1.1.3 I serve as an expert witness in the specialist field of psychiatry in the areas of liability and quantum in nursing and healthcare services.

Synopsis

1.2.1 Mr XXXXXXX (I will use his first name for the purpose of this report), a patient with mental health problems, was admitted through the emergency department (ED) on the 11 December 2012 via a general practitioner (GP) referral. On admission at 21.05 on the 11 December 2012 he was referred to the psychiatric team for a psychiatric assessment. He was transferred to the Department of Psychiatry, XXXXXXXX on 12 December 2012 as an informal/voluntary patient. He had presented to his GP with symptoms of paranoia, auditory hallucinations and anxiety, secondary to cannabis use. XXXXX had a history of two previous suicide attempts at age 16 years by cutting his wrist and at 17 years when he attempted to jump off a bridge and was prevented from doing so by a friend; on both occasions, he was not assessed by mental health services.

1.2.2 Medication prior to admission to the in-patient unit of OLH. Efexor 125mg reduced to 75 mg and Zyprexia 10mg at night prescribed by his GP and had been using Cannabis three times a day for three weeks.

1.2.3 Whilst an inpatient in XXX, XXXXX attempted suicide on the 31 December 2012 by hanging and suffered a hypoxic brain injury. Following his suicide attempt he was admitted into the Intensive Care Unit (ICU) for intubation and ventilation where he stayed from the 31 December 2012 to the 10 January 2013. He was transferred to a medical ward for five days and transferred back to the psychiatric services on the 15 January 2013.

1.3 Summary of Conclusions

In summary, in light of documentation provided, I am of the opinion that nursing staff:

- Failed to document conclusively XXXXX care requirements.
- Failed to recognise vital indicators that XXXXX was contemplating suicide.
- Failed to follow their own policy guidelines and exposed XXXXX to an increased risk of injury.

2. INSTRUCTIONS

2.1 Instructions

I have been instructed in writing on 3 March 2017 by XXXX, acting on behalf of the Claimant, to review the evidence presented by the Claimant and Defendant, and to prepare a report that comments upon the nursing care provided to Mr XXXXXXXX at XXX on the dates identified within this report.

2.2 Issues to be addressed

This report comments on whether the nursing care provided to XXXX at XXXX, was responsible for the injuries sustained on the 31 December 2012 and was, therefore, not of a reasonable standard, with regard to:

- Failure to provide an appropriate level of nursing care and supervision
- Failure to take into consideration previous related clinical problems experienced and historically recorded by other clinical professionals

Appendix Two contains details of all documentation made available to me and which I have read and considered in the preparation of this report.

3. THE INVESTIGATION OF THE FACTS

3.1 Brief Social and Medical History

XXXXX was born in XXXX, XXXX, Ireland where he was described as a ‘happy-go-lucky’ child until he went to an all Irish school where he became troubled and uncomfortable. He had a teacher who shouted at him constantly, had difficulty expressing himself in Irish and became withdrawn. He started to suffer from constipation at a young age due to the effect of his early school years. At 9 years of age he was assessed by an educational psychologist who diagnosed dyslexia and difficulty relating to numbers. It was recommended that he attend an English speaking school where he made improvement and also attended evening support for dyslexia but felt that he was being labelled and expressed that he had issues with his self-esteem. He always suffered anxiety when going to school and displaying anger when returning home, being verbally aggressive towards parent’s. Bullied his mother (2006-2011).

His history also shows he did not have many friends and, did not engage in hobbies and started smoking cannabis at aged 15 and also abused ecstasy tablets. Admits to spending £80-£100 a week on cannabis, at the time of his admission to Department of Psychiatry. His mother and father divorced and he went to live with his father but often displayed poor personal hygiene, not wanting to wash daily. Vegetarian since the age of 14 but I can find no history of what brought him to this and he preferred to eat alone and never took meals with parents.

Became a social drinker then started binge drinking through teenage years where committed ‘Public Order’ offences –‘Mischief’ 15, 17 and 21 ordered to attend court was given fines for these offences. He had a history of depressive illness and his parents previously have expressed fears he could harm himself or others due to his physically impulsive behaviour. He had a history of suicidal attempts where he tried to slit his wrists at aged 16. At 17 went to jump off a bridge but stopped from doing so by friends. On neither occasion, he was not seen by psychiatric services.

He was in relationship for just over a year with XXXX his girlfriend who has a passive influence on him. Started to hear voices calling him names, he could hear the voices in his bedroom, both male and female voices. These voices are very critical of him telling him to do thing she did not want to do, and he believed these voices were of those of his neighbours.

3.2 Chronology of Events.

3.2.1 Pre-suicide attempt

10/12/2012. He was referred by Dr. XXXXX to the psychiatrist at XXXXX Hospital (79).

11/12/2012.He was admitted to the ED due to deterioration in his mental health state, assessment carried out by the ED medical staff who requested a psychiatric assessment.

11/12/2012. A psychiatric assessment started at 22.20 hours.
Gives history of his paranoid ideas which involved having issues with neighbours who were calling him child molester and 'paedo' and also hearing these comments in his parents' house. On admission, the ED staff failed to complete all sections of the admission document which included the following:

In the collateral history there is a mention of his past 'suicidal actions' but in the tick boxes section this has not been filled in and there are no comments of these past suicidal actions where staff are expected to elaborate (185).

In the family history section in the outline of the family tree there is mention of a maternal aunt being treated for depression but this has not been highlighted in the below section where it asks for family psychiatric history (187).

None of the sections on his Social history have been filled in which includes, Housing status, Housing amenities, Social supports and Financial status (191).
The recommendation was that he be admitted informally onto psychiatric unit. (Assessment completed at 00.10 12/12/2012) (193).

The Risk Assessment and Management Guide form was completed and in the specific section 'Risk to self' does identify that he had made previous attempts on his life but staff failed to elaborate further and highlight in the section below which requested further information. Commenced on level 3 observations (194). Level 3 observations are the patient is observed every 15 minutes and there is documentation proving this and the document is filled in and signed.

12/12/2012. He was admitted to the psychiatric ward at 01.00 hours. The Initial assessment noted his suicide attempt at age 16 by slitting his wrists but no mention of his second suicide attempt at aged 17 when his friend stopped him jumping off a bridge. He admitted to the psychiatrist that he smoked 1.5-2 grams of cannabis a day.

There is no evidence of a property list documentation sheet being completed on admission. The importance of this documentation would have included clothing which would have identified his belt (197).

His shoes, belt, jacket, pen and paper were returned to XXXX. My main concern here is why a patient with a history of self-harming and suicidal attempts was given back and allowed to keep his belt (216).

12/12/2012. (15.30) His history was reviewed by the psychiatrist. XXXX admitted to smoking 1.5-2 grams of cannabis a day and agreed that his paranoid thoughts could be to cannabis-related or illness-related.

12/12/2012. (19.00) The nursing notes instructed that XXX should be reduced from level 3 observations to level 4 following a risk assessment (214). The Risk screen assessment was completed correctly (436). Level 4 observations are the patient is observed every hour and the observation is documented and signed.

13/12/2012.XXXX wanted to leave the hospital and was persuaded to stay and hand back his shoes, belt and jacket to staff (216). There is no mention in this entry in the nursing kardex of his level of observation status even though staff felt it was necessary to remove the articles previously mentioned (216-217).

13/12/2012. The next entry reads 12/12/2012 (06.35) not 13/12/2012 (216).

13/12/2012. (19.15). During a visit by his mother he went absent without leave (AWOL). The nursing notes recorded that the AWOL procedure checklist was implemented (176-177). He returned to the ward at 20.15 explaining that he went to confront his neighbours. The nursing kardex notes reported there were obvious

signs of psychosis but there is no mention of the level of observation when he returned (222-223) and he was nursed in a single room.

He was reviewed by the medical officer, notes from medical officer and night nurse indicated that XXXX was willing to stay but there was no mention of the level of observations or in the night report (224).

14/12/2012. Seen by psychiatrist who reviews his management plan. Nursing notes from the review state XXXXX is again on level 3 observation's but I can find no evidence of when he was changed from level 4 (see notes 12/2012)(225).

16/12/2012. According to the nursing notes, XXXX expressed a wish to go home and requested a doctor be contacted so he can be discharged. However, in the weekly care plan evaluation review (211) this is not mentioned and his observation status is not mentioned in either entry (227). Ativan 1 mg prescribed and taken by XXXXX.

17/12/2012. He was reviewed by the psychiatrist and team. The notes stated that there was no clear indication of on-going risk. He had mentioned in the review that he inappropriately touched a 12 year old girl in the genital area. When she asked him to stop, he did. He stated she was fully clothed and said he misinterpreted her signal. He stated that she was resting her feet on his crotch and he became aroused.

The nursing notes stated that he requested time off the ward when his girlfriend visited and this was granted. On return he expressed that his time off the ward had been stressful and, when questioned, said 'well being called a convicted paedophile would do it' (229). He was offered medication on request which was given and accepted which the notes say with 'could affect' and should say with 'good effect'. There is no mention of observation status within this nursing kardex entry(229) but the observation sheet reflected that he was still on level 3 (450-451).

18/12/2012. The level of observations was reduced to level 4 and documented on a repeat risk assessment form. The Repeat Assessment From has been

completed but section 1 ‘Risk to self’ has not been filled in and reads ‘not applicable’ (452).
Prescribed Olanzapine 5 mg mane, 15 mg Nocte.

20/12/2012. XXXX absconded and, when questioned about how he got out of a ‘locked unit’ he informed that staff he climbed out of the toilet window. He had been to his flat nearby and collected a ‘razor’ and underwear. There is no evidence of senior nursing personal being informed regarding him absconding or an absconding documentation procedure checklist being completed. In addition, there is no evidence of him having had a risk assessment in regard to his previous history of cutting his wrist. The level of observation remained on level 4 despite him leaving the unit without permission (236).

20/12/2012 – 25/12/2012. Despite XXXX expressing paranoid thoughts about the staff and also wanting to take his discharge and leave the ward there is no mention of his level of observation (level 4) over a five day period being documented.

25/12/2012. (04.00) XXXXX was agitated and wishing to take his discharge, expressing paranoid ideations and declined medications. Took medication after speaking to doctor on the phone. Nursing staff nursed him in a side room but advised he would need to return to dormitory tomorrow. Re- commenced on level 3 observations and notes state the reason as increased risk of absconding. Nursing kardex notes (240) state repeat ‘Risk screen assessment, completed and nurse signed to this but the repeat Risk screen assessment’ is dated as 26/12/2012 not the 25/12/2012 which would correlate with the nursing notes Also on the Repeat Risk Assessment form Section 1 has not been filled in indicating his previous risk to self. Section 5 which specifically refers to Absconding risk has not been filled in or indicating he has a previous history of absconding.

There is no entry in the ‘Risk Categorisation’ section indication whether he is a high, medium or low risk. Level of observation identified is ticked as level 4 which should read level 3. (198)

25/12/2012. XXXXX goes on day leave with father and returns. Nursing kardex notes date is 24-25/12/2012 it should have read 25-26/12/2012 (240).

25/12/2012. XXXXX goes on leave in care of his father. (241). Returns as planned but there no mention of what level of observation he is on after returning from leave with the nursing kardex notes.(240). Level 3 observation sheet reads that XXXXX had no observations done after 11.15 am but he was not collected by his father till 13.55. So no level three observations were done on XXXX for a period of 2 hours 45 minutes. (461). There is no mention in the nursing kardex as to the reason why.

26/1/2012 XXXXX goes on day leave with father and returns as agreed early evening. Earlier father had phoned the unit requesting if XXXXX could stay with him overnight. Advised against this by staff and XXXXX returns to the ward. Nursing notes entry says 19.20 (241).

Level 3 observation sheet reads that XXXXX had no observations done after he returned and there is no documentation made available to me from 20.00 hours on this date (461).

Father rang at 21.30 to say XXXXX had absconded from the ward and was at father's house. When staff requested to speak with XXXXX he puts the phone down. 22.30. Psychiatrist speaks to father on phone and advises father to bring XXXXX back to the ward. Advised by psychiatrist that if they are concerned of any risk issues to themselves (parents) to contact the police.

23.10. Father rings again saying he will bring XXXXX back to the ward in 20 minutes. However, the next nursing kardex notes entry is 27/12/2012 at 06.20 with no actual time mentioned when XXXXX actually came back. It does mention that he did return with his father, refused medication and went to bed but without a definite time this occurred.

I can find evidence of the senior medical officer being informed of XXXXX absconding from the ward and speaking on the phone to the father. But no evidence of senior nursing personal being informed or A.W.O.L procedure checklist absconding documentation being completed. (243).

27/12/2012. At 13.55 father finds XXXXX in the hospital car-park smoking however level three observations indicate at 13.45 he was in sitting room (462). Documented in nursing kardex notes at 19.00. (245).Refusing to take prescribed medications but agrees to take test dose of Clopixol 50mg intramuscular.

Requests to leave the unit but cannot because the ward door is locked and XXXXX is refused permission to leave the ward. Nursing notes state that nursing staff explain to XXXX 'he is to unwell to leave the ward'. Agrees to take test dose of Clopixol 50mg intramuscular (I.M) (245). Also the entry of 27/12/2012 at 20.10 calls the patient *'John'*.

From the 25/12/2012 (04.000) till the 28/12/2012 (15.35) there is no mention of the level of observations XXXXX is on despite constant entries as to his mental state describing disorders of perception and paranoid delusions. Family express that they want XXXXX to remain in hospital and are unwilling to take him home. (240-248).

28/12/2012. 18.30. Attempting to leave the ward, nursing notes state 'extremely agitated' Expressing paranoid delusions of being monitored on the ward by cameras. Rewritten for Ativan 1mg TDS which was given to XXXX at 19.05. Documented on the medicine sheet but there is no mention in the nursing kardex notes. Level 3 observations documented (248).

29/12/2012 (11.30) Father rings ward and states that he and his wife will be '*disengaging*' from XXXX over the weekend, but would be willing to visit XXXXX on Monday 31/12/2012. . When XXXXX is informed of this he is 'unhappy' according to nursing kardex notes. Entry in nursing Kardex saying 1-1 utilised with XXXXX but in the level 3 observation sheet it reads he is in the sitting room watching television. (250 and 465).

30/12/2012. (06.30) Nursing notes indicate that XXXX requests another single room which cannot be facilitated. Locked himself in the toilet and lies on the floor with his pillow. When requested by staff he does come out. (251). Documented in observations sheet at 23.30 (467).

XXXXX speaks to father on ward telephone, nursing kardex notes indicate XXXXX 'as distressed and upset' during phone call. Seen by SHO where XXXX requests that his level of observations be downgraded, this was not granted (251).

30/12/2012.Between 09.15 and 11.30 where he observed 10 times within his 15 minute level 3 observations checks, he was found to be in the bathroom area on 6 periods of that time (468). Nursing kardex entry at 18.28 reflects this behaviour (252).

31/12/2012. XXXXX is seen in the ward round where he is expressing 'very paranoid delusions' as per doctor's entry. (253) At 14.00 to 14.30 he was off the ward under the supervision of his father. At 16.00 hours he is seen to be at the window pulling at the curtains. Entry in nursing kardex notes reflects this (257) and observation sheet also reflects this behaviour (470).

At 16.25 XXXX had attempted suicide by using a belt as a ligature and was found by staff. CPR was performed until crash team arrived. XXXX was transferred to ICU after intubation. Seen in I.C.U and observe to be having 'anoxic seizures' condition described as critical by medical staff (255). C.T scan, Brain and cervical spine organised by medical team.

3.2.2 Post Suicidal Attempt

XXXXX was nursed in ICU from the 31/12/2012 till 10/1/2013.

10/1/2013. He was transferred from ICU to the medical ward (269).

(10.00) Family meeting with XXXX's parents. Both parents express concerns of XXXX trying again to commit suicide and absconding. Mother's opinion on observation of XXXX reads 'I feel it is a grey area when XXXX attempted to harm himself before, verbally he always says he does not have any self-harming thoughts. (266)

10/1/2013. (11.00) XXXX placed on nursing observations level 1 (Special 1-1) (267).

Level 1 observations are where the nurse is almost with touching distance of the patient and is never left alone under any circumstances.

Level 2 observations are where the nurse is in the same room or area and the patient is observed constantly at all times and is never left alone under any circumstances

There is no mention of any risk assessment being carried out and completed and documented in the nursing Kardex notes.

14/1/2013. Between 18.10 and 19.00 there is no entry as to XXXX being supervised on his special level 1-1 observations sheet. There is blank where an entry should be. Accordingly, this reads the patient was left unattended for a period of 50 minutes. There is also no mention in the nursing kardex as to the reason why also. (274-275/478)

15/1/2013 Transferred from medical ward back to Department of Psychiatry. Remains on nursing observations level 1 (Special 1-1) (277).

16/1/2013. Between 15.00 and 15.30 there is no entry as to XXXX being supervised on his special level 1-1 observations. There is blank where an entry should be. The patient was left unattended for a period of 30 minutes according to the observation sheet used. (482). The reason why on the observations sheet 'has not' been documented and there is also no mention in the nursing kardex as to the reason also. (278/279)

Later between the times of 17.20 till 18.00 there is no entry as to XXXX being supervised on his special level 1-1 observations. There is blank where an entry should be. The patient was left unattended for a period of 50 minutes according to the observation sheet used. There is also no mention in the nursing kardex as to the reason why also. (282/483).

17/1/2013. (19.15). In nursing kardex notes the report states that XXXX whilst he is on his special level 1-1 observations was shouting paranoid ideations and continually attempting to lock the bathroom door. When advised by nurse that his

level 1-1 won't be on for too long he responds "That's because I will be dead- ill kill myself" (282) . However, the special observations sheet for this time period does not reflect any of this incident but reads 19.00. 'Restless in and out of bed'. (484).
22/1/2017. 17.40 No mention of level 1-1 special observations mentioned in nursing kardex notes. (290)

23/1/2017 Entry at 10.50-11.20 is blank without explanation on the special 1-1 observation sheet. (494). In the nursing kardex notes there is an entry saying that XXXX was attending Occupational therapy without a time attached to this entry.(291). Therefore this entry does not reflect why there is a gap on the special observations 1-1 sheet.

(07.00. 26.1.2013). The date reads 23/1/2013 not 26/1/2013 (295).

26/1/2013. 03.30. The nursing observations sheet notes that XXXX had a fall (498) and this is reflected in an entry at 05.10 in the nursing kardex notes where it details the injury due to the fall and that XXXX had suffered a small laceration on his head. Wound has stopped bleeding and steri strips over wound. (294). What is not mentioned is that an Accident Report form has been filled in or the Risk Screen Assessment being used. In section 3 under the heading Vulnerability the first section is 'Risk due to mobility/wandering' identifies these risk areas that staff should adhere to and document where necessary.

27/1/2013. There is no recordable entry on the level 2 observations sheet (500) between 17.00-18.00 there is no indication as to why this has occurred and there is no entry in the nursing kardex notes. (296/297)

28/1/2013. The observation sheet reads that at 06.30 level 2 observations were recorded (502) but the next entry is at 0.800 hours. 29/1/2013 (503). Therefore, there is a gap of 90 minutes indicating the patient was unsupervised. There is no indication as to why this has occurred and there is no entry in the nursing kardex notes to corroborate why.

29/1/2013.There is no recordable entry on the level 2 observations sheet (505) between 16.00-17.00. Therefore, there is a gap of 60 minutes indicating the

patient was unsupervised There is no indication as to why this has occurred and there is no entry in the nursing kardex notes to corroborate why (301/303).

29/1/2013. 08.00 There is a retrospective entry in the nursing kardex notes stating that XXXX was attempting to climb through windows on five occasions (x5) and open doors on two occasions (x2) on the 28/1/2013 (300).

I can find an entry at 03.00 for the 28/1/2013 on his observation sheet which reads “walking to door and trying handle”. (500) There is no mention on the observation sheet which reflects everything documented from the retrospective entry in the nursing kardex notes which states that he was also attempting to climb through a window on five occasions which would reflect this incident.

30/1/2013. Repeat Risk Assessment carried out. In the allocated boxes for information where it says Section 1. ‘An attempt on their life’, this has not been filled in. Below its says ‘Expressing high levels of distress’ this also has not been filled in. By not completing these sections it does not recognise the historical mental illness context of XXXX.

However, in the allocated space below which reads ‘please specify change’ there is a report of XXXX trying to get out of windows x5 and trying doors x2 on Monday 28/1/2013. Found with leg out of window in dormitory toilet. Rushing past staff x 2 and staff assisted to bring him back ‘. (506). This entry should be linked to the ‘Attempt on his life’ section

30/1/2013. There is no recordable entry on the level 2 observations sheet (504) between 09.00-10.00. There is no indication as to why this has occurred and there is no entry in the nursing kardex notes (296/297).

31/1/2013. (06.40) After being refused home leave and his father politely telling him on the phone he cannot pick him up and take him home XXXX says ‘You will have to collect me if I kill myself’ (304).

4/2/2013. There is no recordable entry on the level 2 observations sheet (515-516) between 07.00-08.00 and there is no indication as to why this has occurred and also there is no entry in the nursing kardex notes. (308/312).

4.2.7. 6/2/2013 Prescribed level 3 observations during the day and level 2 observations at night (314).

Repeat Risk Assessment carried out. In the allocated boxes for information where it requests specific concerns there is total omissions in the information sections 1-4 which have not been filled in.

In the risk management plan, he is indicated as level 2 at night and level 3 during the day but below at the bottom of the page in the risk categorisation he has been identified as 'Low' risk'. However, XXXX informed he is being reintroduced onto level 2 observations at night. This would then indicate that XXXX is a medium risk during the evening and throughout the night not a low risk and should be reflected on the Repeat risk assessment form (517-518).

16.2.13. Seen by Medical Officer where he admits to being paranoid about the nurses on the ward. The consultant questions him further where he says 'I would never hurt anyone else (nurses) 'I would rather hurt myself'. More clarification asked for by the Medical Officer and he says' I am upset hearing nurses voices calling me paedo I'd rather hurt myself'. Is immediately put on special nursing level 1-1 observations *day and night*. (328).

Repeat Risk Assessment form documented. Categorised as to high risk, but there is no date and no signature by person who completed the form. (549-550). There is no mention in the nursing kardex notes of a Repeat Risk Assessment form being completed (327-328).

17/2/2013. Nurse makes an entry in the nursing kardex notes that XXXX slept well and remains on level 2 observations. It should read level 1 observation's. See previous entry 4.2.8. If he has had his level of observation in the evening and throughout reduced to level 2 there is no documentation clarifying this. This was a Sunday so XXXX had not yet been seen by the review team.

Later seen later by Senior Registrar on call who documents in the nursing kardex notes 'Continue level 1 nursing observations till further review by team on Monday. (329).

18/2/2013. 06.40 Again this entry in the nursing kardex notes that XXXX is on level 2 observations (330). Has still not been seen by review team. And there is no recordable entry between 12.00 and 13.20 (551).

I can find no entry on this date in the nursing kardex notes that also states why there is an omission in his observation status for this time period.

18/2/2013. Seen by senior registrar in ward round who documents 'continue with level 2 observations (330).

18/2/2013. Seen by medical and nursing team. Decreased level of observations to level 3 observations day and night. (331).
21/2/2013. Level 3 observations reduced now to ward observations (334).

15/3/13. XXXX given overnight leave but no explanation given to him on his medication regime or to either one of his parents who could have supervised. He presents in the day hospital as being over sedated and needs to be escorted back to the ward. He reports to staff later that 'he may have mixed up his medication, taking an evening tablet this morning'.

Entry by a female medical Officer Dr. XXXX who says 'XXXX had T.T.A.s (To Take Away-leave medication) but this was not documented. He was not sure what meds he had last night and this morning'. (353)

4.3.1 XXXX was discharged to the care of his parents (370-371).

4. SUMMARY AND REASONS

From the documentary evidence made available to me I have formulated the following opinions:

4.1 Nursing Records.

Nursing kardex records were inadequate, not concise and omitted important information; for example, the prescribed level of observation was not always recorded.

The importance of the nursing observation level being reflected within the nursing kardex notes is that all levels of staff are made aware of this important aspect of care. This passing over of vital information is good practice and within protocol guidelines within trust policy standards and procedure. This then leads to high quality, safe and effective treatment delivered by capable teams. This was not the case on a number of occasions in the care of XXXX.

On one occasion there was an inaccurate entry calling the patient 'John', correct patient identification is an important criteria in good record keeping and is an important aspect of healthcare and social professions. Correct patient identification ensures that nurses and clinicians who access the patient's records can be sure that there are providing efficient and quality care to right individual. It facilitates continuity of care whilst informing and justifying decision making in manner that is clear to all. Calling the patient John when his name is XXXX clearly fails the standard set down by the Trust in their Records management protocol and other national standards and guidelines.

National benchmarks for communication require that communication for professionals is key to patients receiving effective appropriate care. Information that is accessible, acceptable and accurate, and that meets patient's needs, should be shared actively and consistently. 'Staff should communicate effectively with each other to ensure quality of healthcare for all. (D.H 2010a). The Nursing and Midwifery Council (2015) emphasise in section 8.6 of Prioritising People that 'information is shared to identify and reduce risk'. I could find evidence that a number of specialist disciplines were making entries in the patient's nursing kardex notes. This highlighted that the Trust were using a multidisciplinary specialist patient approach better known as an integrated care pathway. Therefore, an integrated care pathway (or ICP) is a person-centred and evidence-based framework. It tells multidisciplinary and multi-agency care providers, people using services, and their carers what should be expected at any point along the journey of care. Nurses are continually risk assessing and reviewing the condition of our patients. It is important to ensure that problems,

progress or concerns are documented and action taken and this important information are made available to all those disciplines who are involved in the care of the patient.

4.2 Discrepancies in recording times on the observation sheets.

Nursing staff failed to record dates and times correctly on the observation document on a number of occasions.

Within the documents made available to me there was evidence on the patient observations sheets of missing staff names and signatures, lack of information for long periods of time, the times when observations were changed or reduced were not clearly documented, poor information regarding the patients mental state (waking hours) which bore no relevance to the patient's mental state (such as watching TV, settled or resting). Observation is an important skill for all nurses. It is recognised that patients may need varying degrees of observation, depending upon the patient's identified need, behavior or current clinical risk assessment. Principles of observation are that aassessment, engagement and intervention should be used to recognise, prevent and therapeutically manage: disturbed or violent behaviour; risk to self; risk of neglect; and abscondment. It must be noted that XXXX absconded on a number of occasions. The current level of observation must be clearly recorded in the patient's clinical notes and provides:

- Assisting in improving accountability.
- Showing how decisions related to patient care were made.
- Supporting the delivery of services.
- Supporting effective clinical judgements and decisions.
- Providing documentary evidence of services delivered.
- Promoting better communication and sharing of information between members of the multi-professional healthcare team.

4.3 Document Signing

Nursing staff failed to complete areas of a document in which was of high importance in the care of Mr. XXXX On a number of occasions there were signature omissions especially on the Risk Screen Repeat Assessment where the nursing staff did not follow the trust safety policy and trust procedure protocols. The signing of important documents is good practice and should never be underestimated and entries should be as detailed as possible The Nursing and Midwifery Council (NMC) sets out a nurse's obligation in the *'Code'* to keep clear and accurate records relevant to practice. The obligation is not limited to patient records but includes all records 'that are relevant to your scope of practice' (NMC 2015). It is important, therefore, that nurses keep abreast of legal requirements and best practice in record-keeping. It states that nurses 'must ensure that the health care record for the patient or client is an accurate account of treatment, care planning and delivery. Patient health records also have a function in improving accountability and in so doing have a legal purpose in providing evidence of the practitioners' involvement or interventions in relation to patients or clients. Absence in the clarity of the care delivered has a negative impact on the care delivery and decision making. Poor record keeping is often reflected in poor practice. The fact that record-keeping is integrated into all four professional standards in the new NMC Code of Conduct (prioritise people; practice effectively; preserve safety; promote professionalism and trust) (NMC, 2015), gives a clear indication as to 'If it's not written down; it didn't happen...'

Failure to Investigate Suicidal Attempt/Incident.

Nursing staff failed to investigate and document the suicidal attempt by XXXX on the 31/1/2012. By not doing this staff fell below the standards nationally laid down by the patient safety agency and therefore did not act reasonably in relation to the harm suffered by XXXX. The principal definition of a serious untoward incident (SUI) is any incident, on an NHS site, or elsewhere, whilst in NHS-funded or NHS regulated care. Involving: patients, relatives or visitors. And the new Serious Incident Framework as of 1st April 2016, Patient Safety is now part of NHS Improvement. The importance of completing serious untoward incident documentation (SUI) is to ensure incidents are properly investigated,

that action is taken to improve clinical quality and that lessons are learnt in order to minimise the risk of similar incidents occurring in the future. NHS organisations are responsible for identifying serious untoward incidents and taking effective action in each instance. They are expected to have clear policy and procedures so that all staff know how to identify and report a serious untoward incident.

To conclude, it is essential that patient's medical records are kept up to date appropriately recorded and documented. Nursing staff's failure to correctly document information and the numerous inconsistencies therefore failed to direct colleagues with patient care delivery and was a failure in following protocol.

4.4 Patient Property List

Within the documentation made available to me I can find no reference that nursing staff completed the property list documentation on initial admission on the 12/12/2012. It was the nurse's duty to make a detailed formal record of all property handed in by the patient, (which included his belt) or otherwise taken by the NHS organisation into safe custody, using the appropriate form as per the trust policy and standards.

They were in breach of that duty.

I can find evidence on the admissions checklist which included the property list being ticked off as completed but no actual property list documentation. By not completing this document they did not adhere to trust policy which is designed to ensure that appropriate measures are in place for the secure management of patients' property. Hospitals are responsible for the health, safety and security of all patients within its care and therefore has a statutory duty to provide a therapeutic and safe living and working environment for patients and staff and to protect the public. This includes not only protecting others from the consequences of a patient's activity but also protecting patients from their own actions (e.g., self-harm, drugs, illicit materials and fraud).

4.5. Absence without leave Policy

On two occasions the nurses did not follow Trust policy protocol when they should have implemented the 'Absence without leave Policy' (AWOL) guidelines.

The risk of an in-patient being absent or missing is that they may either actively or passively harm themselves or others, or be exploited by others, or suffer harm due to an inability to care for themselves whilst they are away from the in-patient environment. The purpose of the trust policy is to set out the arrangements for managing the risks associated with patients who are missing or AWOL. By not following the guidelines set down in the trust policy. The person in charge of the ward area at the time of absence is fully responsible for ensuring that:

- The process for managing the risk associated with patients who are absent without leave is correctly and efficiently implemented.
- Notifications are completed with timescales which includes senior nursing personnel on duty or on-call.
- Actions, decisions made/taken and outcomes are clearly, succinctly documented in healthcare records

Therefore, nursing staff on duty failed to correctly utilise the guidance laid down and expected of them by the Trust and within their own Clinical Governance guidelines and therefore did not recognise the risk and potential for injury. They also failed to provide guidance to other clinical staff of action necessary to ensure compliance with appropriate legislation in relation to missing service users.

4.6 Risk of Suicide

The Trust's approach to managing environmental risks for suicide and self-harm for in-patient and other relevant units and areas managed by the Trust are found within their policies. Nursing staff failed to correctly utilise information available and therefore failed to recognise the risk and potential for injury. Failure to follow their own policy guidelines and nationally recognised guidelines (in full N.I.C.E 2015, National Patient Safety Agency, 2004, University of Manchester, 2012). Department of Health, 2007) exposed Mr. XXXX to an increased risk of injury which represented a breach of their duty.

These recognised policies and protocol form a component part of managing overall clinical risk and incorporates:

- Undertaking a review of the area to identify:

- Structures or fittings which could be used in suicide by hanging or -strangulation
- obstructions to observing high-risk patients
- identifying potential ligatures
- Identifying other risks for self-harm or suicide in the environment.

The environmental risk assessment for suicide and self-harm is a component part of comprehensive clinical risk assessment which includes service user risk assessment, formulation and care planning. Hanging is still the most frequent method of suicide in inpatient areas and the most common ligature points are doors and windows; the most common ligatures are belts, shoelaces, curtains, sheets and towels.

4.7. Management of prevention of suicide by hanging and asphyxiation

On 12 December 2012 XXXXX was given back his belt and other items.

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Environmental Suicide and Ligature Point Risk Assessment.

Most suicides in inpatient areas occur by hanging. (Appleby et al 2006 and 2010) Removing the means of hanging (ligature point and ligature) is the most important step towards prevention. Risks of self-strangulation - where the ligature point can be virtually any fixed or heavy structure – indicates the need to remove ligatures. By allowing a patient with a history of suicidal attempts to keep the potential means to be able to use a ligature clearly showed that management controls have not been implemented to manage any identified and residual risks in the correct manner. That nursing staff had failed in their duty of care to ensure that care environments were safe and did not demonstrate that it has identified, assessed and managed increased the risk of potential harm to Mr XXXX.

Warning Signs

Over the period from 12/12/2012 till 31/12/212 when he attempted suicide he is suffering from paranoid ideas on a number of issues mostly expressing extreme paranoia about nursing staff. Paranoia is strongly linked to a higher-than-normal

chance of suicide and suicide attempts. Nursing staff should have been alerted that the behaviour of Mr. XXXX which was reflected in the nursing kardex notes, matched those identified by numerous authors that:
Suicide is also more likely in someone who is:

- Suffering hopelessness
- Socially isolated
- Living in a hospital
- Abandonment
- Irritability
- Increased anxiety
- Agitation
- Impulsivity
- Decreased emotional reactivity
- Declining offers of medication
- Requesting early discharge

(Appleby et al. 2010). Department of Health (2012). National Institute for Health and Care Excellence (2012).

On the 30/12/2012 he is found on six occasions out of 10 on 15 minute observations within the bathroom area. Ongoing risk assessment is needed due to the fluctuations of risk factors and warning signs over time. These were risk indicators or red flag triggers that immediately should have alerted the nurses of Mr. XXXX heightened suicide risk, but these were critically missed. At this point the medical team should have been informed and his level of observations should have been increased to level 2.

At 16.00 on the 31/12/212 Mr. XXXX is observed pulling at the curtains. This behaviour should have immediately raised concerns, but was also critically missed. This was the behaviour of someone looking for something which binds or ties, which could potentially be used for self-strangulation. Every effort should have been made to reduce and manage environmental risk - by removing or making safe the most hazardous and obvious risks e.g. ligatures and the nursing staff failed to do this. Nursing staff had not been vigilant in their duty because they were aware that Mr. XXXX still had his belt in his possession. They should have removed it immediately which imminently Mr. XXXX used to try and commit

suicide. They should have stayed with the patient and not left him and an urgent risk assessment completed. Again at this point the medical team should have been informed and his level of observations should have been increased to level 2.

5. OPINION

The conclusions that I have reached from considering the written evidence suggest that Mr XXXX psychiatric problems were clearly noted during his admission on 12 December 2012.

He had presented with a history of;

- Previous suicide attempts
- Substance abuse (regular smoking of Cannabis)
- Agitation
- Severe paranoid ideas
- High state of anxiety
- History of depression
- On prescribed psychiatric medication
- Auditory hallucinations

The risk factors for his increased risk of suicide falls have been outlined in Section 5 of this Report.

Nursing staff failed to correctly utilise information available and therefore failed to recognise the risk and potential for injury. Additionally, nursing records were found to be contradictory. The NMC (2015) state that nurses have a responsibility to identify patients at risk.

In summary, in light of documentation provided for review, the care afforded to Mr. XXXX fell below the necessary standard in the following areas:

- Failure to recognise a sequence of events which brought about a greater risk of a suicide attempt
- Failure to document correctly which led to ineffective nursing assessment planning for care, implementation and evaluation.

- Failure to observe changes in the mental health of the patient and take appropriate action.
- Failure to complete risk assessments in full and plan care around the assessment findings.
- Ineffective care exhibited by lack of action when there is a duty to act therefore increasing the likelihood of error.
- Failure to follow standards of care owed to the patient
- Failure to follow their own policy guidelines and exposed Mr. XXXX to an increased risk of injury through a suicidal attempt.

6. STATEMENT OF COMPLIANCE

I, Geoffrey Ronald Ellison, declare that:

- I understand that my primary duty in written reports and in giving evidence is to the court and have complied with and will continue to comply with that duty;
- I am aware of the requirements of Part 35, Practice Direction 35, the Protocol and the Guidance for the Instruction of Experts in Civil Claims 2014.
- This report includes all matters relevant to the issues on which my expert evidence is given.
- I have given details in this report of any matters which might affect the validity of this report.
- I have indicated all the sources of information I have used;
- I have addressed this report to the court. I further understand that my duty to the court overrides any obligation to the party from whom I received instructions.
- I will notify those instructing me immediately and confirm in writing if for any reason my existing report requires correction or qualification;
- I understand that;

    (i) My report, subject to any corrections before swearing as to its correctness, will form the evidence to be given under oath or affirmation

    (ii) I may be cross-examined on my report by a cross-examiner

    (iii) I am likely to be the subject of public adverse criticism by the judge if the court concludes that I have not taken reasonable care in trying to meet the standards set out above

- I have abided by the Code of Conduct as laid out by the Nursing & Midwifery Council (2015) throughout the preparation of this report.

I confirm that I have not entered into any arrangement whereby the amount of payment of my fees is in anyway dependent upon the outcome of this case.

7.00 STATEMENT OF TRUTH

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

Geoffrey Ronald Ellison
M.Phil. MSc, RMN, SRN, DN (London Univ), Cert Ed, RNT

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