Independent investigation into the care and treatment of Mr A

Case 1

Commissioned by NHS London

NHS London

Contents

Executive Summary

1. Introduction to the incident

This investigation was asked to examine a set of circumstances associated with the death of Mr A's wife on the 22nd February 2003. Mr A was subsequently arrested and charged as the perpetrator of this offence, but took his own life while on remand.

Mr A was a service user known to Barnet, Enfield and Haringey Mental Health Trust (the Trust). It is the care and treatment provided to Mr A that is the focus of this investigation.

2. Condolences

The investigation team would like to extend their condolences to the family and friends of Mrs A. The investigation team sincerely hope that this report will help to reassure family and friends that appropriate steps have been taken to identify all the care and treatment issues relevant to the incident, and that recommendations for action have been prioritised.

3. Trust internal investigation

The Trust internal investigation report includes findings under a series of issues, headings and recommendations. The Trust developed a separate Action Plan.

The findings of the internal investigation are included in the Trust's report. Although the findings do not include any relating to the examination of Mr A on the 8th and particularly the 9th October 2002, the other issues covered are directly relevant to an understanding of the incident and are appropriate.

The Trust internal investigation report recommendations are related directly to the issues examined. Not all issues attract recommendations and some recommendations are commentary on action the Trust was already taking.

4. Commissioner, Terms of Reference and Approach

This particular case was subject to an independent audit to ascertain its suitability for independent review. The independent audit decided that this case did merit an independent review and that this review would consist of a Type B independent investigation.

A Type B independent investigation is a narrowly focused investigation conducted by a team that examines an identified aspect of an individual's care and treatment that requires in depth scrutiny. The particular theme for this case

was the management, organisation and delivery of mental health services at the Barnet, Enfield and Haringey Mental Health Trust.

4.1 Commissioner

This independent investigation is commissioned by NHS London. The investigation is commissioned in accordance with guidance published by the Department of Health in circular HSG 94(27). The discharge of mentally disordered people and their continuing care in the community and the updated paragraphs 33-6 issued in June 2005.

4.2 Terms of Reference

The aim of the independent investigation is to evaluate the mental health care and treatment of the individual or where a group of cases have been drawn together that particular theme and/or the services involved i.e. Child protection, Care Programme Approach, management organisation and delivery of adult mental health services (including CPA and Risk Assessment). The investigation will be undertaken by a team of two or three people with expert advice. The work will include a review of the key issues identified and focus on learning lessons

The investigation team will:

1. Complete a chronology of the events to assist in the identification of any care and service delivery problems leading up to the incident
2. Review relevant documents, which may include medical records (with written patient consent).
3. Review the trust internal investigation and assess its findings and recommendations and the progress made in their implementation to include an evaluation of the internal investigation Action Plans for each case to:
    - ascertain progress with implementing the Action Plans.
    - evaluate the Trust mechanisms for embedding the lessons learnt for each case.
    - identify lessons learnt which can be shared across the sector.
4. Conduct interviews with key staff including managers.
5. Provide a written report utilising the agreed template, the report will include recommendations for the improvement of future mental health services.

4.3 Approach

The investigation team will conduct its work in private and will take as its starting point the trust's internal investigation supplemented as necessary by access to source documents and interviews with key staff as determined by the team.

The investigation team will follow established good practice in the conduct of interviews e.g. offering interviewees the opportunity to be accompanied and give them the opportunity to comment on the factual accuracy of their transcript of evidence.

If the investigation team identify a serious cause for concern then this will immediately be notified to NHS London and the Trust.

4.4 The investigation team

The investigation team will consist of three investigators with quality assurance provided by the Health and Social Care Advisory Service.

4.5 Independent Investigation start date

The independent investigation started its work in October 2007.

5. Summary of the incident

Mr A was a 29 year old man, born in Libya, with a poor command of English, resident in the United Kingdom since 1996. He had been married for 5 years and had a 3 year old child. His wife was from the Emirates ethnically but had been brought up in the UK and was a fluent English speaker. In October 2002 she was approximately 6 months pregnant. Mr A appears to have developed a paranoid psychotic illness in approximately April 2002, either a depressive psychosis or primary psychosis with depression. He was referred for psychiatric assessment on 17th September 2002 by his GP and an appointment offered for 14th October.

On 7th October he made a threat to kill his wife. He was assessed on 7th, 8th and in more detail on 9th October but for a number of reasons understanding of his mental state was incomplete. He was treated and followed up in outpatients on 14th and 24th October but did not attend a scheduled appointment for 25th November and was offered another for 20th March 2003. Perhaps as a result of the long intervals between planned appointments and communication problems with primary care, he did not receive regular prescribed medication although he made his first request for medication to his GP on 18th January 2003 and at about this time Mrs A gave birth to her second child.

On 22nd February Mr A was charged with fatally stabbing his wife and remanded to prison. On 15th March 2003 Mr A was found dead in his prison cell and an inquest on 7th and 8th August 2003 at Milton Keynes Coroner's Court returned a verdict of suicide. His children left the UK to live with his wife's parents. The Trust carried out an internal investigation and made a number of recommendations.

6. Findings

The investigation team identified the following care and service delivery problems:

6.1 Limitations in understanding of Mr A's mental state

The detection and exploration of any psychotic beliefs that might be related to threats made by Mr A does not appear to have been explored with Mr A directly. If this had been accomplished it may have allowed the clinical professionals to understand the degree of threat that Mr A may have experienced due to the content of his persecutory beliefs and therefore provide some evidence as to the nature and seriousness of any action he might take in response to those beliefs.

6.2 Failure to ensure Mr A had regular prescriptions

In view of the long periods between the fortnightly prescriptions it is highly likely that Mr A either had long periods without treatment or took medication in quantities less than prescribed, and therefore was not receiving optimal treatment. It is possible that the incident itself resulted from a relapse in paranoid and/or depressive thinking after his prescription of the 18th January 2003 had run out.

6.3 Almost 5 Months between Outpatients Appointments

In view of the fact that he had only been under treatment on 24th October 2002 for 15 days, that his mental state was necessarily not that well understood and the threats to kill were known, this interval suggests an assessment of the risk Mr A posed as surprisingly low. Safety depended on informal monitoring by Mrs A, and by the GP.

6.4 Failure to obtain an independent interpreter for assessment interviews

Use of an independent interpreter might have enabled clinical staff to understand Mr A better and therefore understand and manage the risks better. The reason(s) for Mr A and his wife's refusal of an interpreter are not known.

6.5 Not referred for Enhanced Care Programme Approach (CPA)

Mr A had a number of characteristics known at the time of his treatment suggesting he was appropriate for enhanced care, and thus to have a Care Co-ordinator assigned to him.

6.6 Midwives and Health Visitors were not aware of psychiatric history

Mr A's psychiatric history and treatment was not communicated to midwives and health visitors. They would have had regular contact with Mrs A and her family in the immediate post partum period. This was a missed opportunity to enhance the monitoring of Mr As mental state and to reduce the possible risks to Mrs A.

6.7 Three separate routes into service before first treated

In an ideal health care system patients would gain access to the care they need in a timely manner through a single route, not the three routes which Mr A accessed.

7. Notable practice

The independent investigation found there was:

- an immediate engagement of interpreter for planned first assessment appointment at Cranborne Community Mental Health Team (CMHT);
- Full referral letter from GP with appropriate request for urgent assessment;
- Prompt Mental Health Act assessment;
- Prompt exchange of information between A&E and General Practitioner;
- Informal liaison meetings between CMHT and primary care;
- Joint assessments of patients;
- Transcription of interviews provided during Trust inquiry.

8. Independent investigation review of the internal investigation and action plan

The role of this independent investigation was to review the Trust's internal investigation and assess its findings and recommendations and the progress made in their implementation. This included an evaluation of the internal investigation Action Plan.

The Trust Action Plan follows the numeration of the issues and recommendations of the internal inquiry report in part but the focus on medication and consultants workloads appear to have been lost in the action plan. Nevertheless, the action plan deals with the following themes:

- Use of interpreter and working with diversity;
- Working with the police;
- Operation of the Care Programme Approach;
- Risk management;
- Adequacy of administrative support;

- Liaison with primary care.

Relevant areas were considered and findings adhere to what appears, from the point of view of the present investigation, to be the significant issues in Mr A's incident, although greater penetration on the issue of the clinical assessment of Mr A would have been appropriate.

The findings were adduced although they were not clearly labelled as such, but emerge under discussion of the 'Issues' the inquiry panel considered. The action plan deals relevantly with the findings though there are significant omissions (see above). However, the objective to be achieved under each "issue" is not always clearly focused or SMART so the actions relating to them suffer similarly.

The investigation has been provided with a copy of a joint action plan under the sponsorship of the Joint Strategy Implementation Group (JSIG) which deals with a wide range of issues in the provision of local Mental Health Services with the involvement of the Trust, Primary Care and Local Primary Care Trust. This is a living document which has gone through 10 versions since February 2007 as a part of ensuring actions take place.

9. Recommendations

The independent investigation makes two recommendations:

1. The Trust, in carrying out its work on working with 'difference', ensures that it specifically addresses ways to understand and, if possible, overcome objections that patients, carers and relatives may have to the use of independent interpreters.

2. In the joint work with primary care relating to prescribing that responsibility for prescribing for newly assessed patients in secondary care is clear and understood by both primary and secondary care.

The independent investigation requests that the Trust and NHS London consider the report and its recommendations and set out actions that will make a positive contribution to improving local mental health services.