Independent investigation into the care and treatment of Mr O

Case 15

Commissioned by NHS London

NHS London

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Executive Summary

1. Purpose

The purpose of an Independent Investigation after a serious untoward incident has occurred, is to thoroughly and comprehensively review the care and treatment received by a service user in order to establish the lessons which can be learned, to minimise the possibility of a recurrence of similar events, and to make recommendations for the effective delivery of mental health services in the future, incorporating the lessons which can be learned from a robust analysis of the individual case.

This particular case was subject to an independent audit to ascertain it's suitability for Independent Investigation. This audit decided that this case did merit Independent Investigation and that this investigation would be Type C. A Type C Independent Investigation is a narrowly focused Investigation conducted by a single investigator supported by a peer reviewer, with access to expert advice and support as necessary. The Investigation involves a small number of interviews along with a review of documents, including medical records (with patient consent although this can be dispensed with if deemed necessary in the public interest). Cases suitable for this type of Investigation are those where the facts of the case can easily be attained through the internal investigation report. This type of Investigation is also appropriate where the issues are not overly complex.

2. Introduction

The Investigation into the care and treatment of Mr O was commissioned by the NHS London Strategic Health Authority pursuant to HSG (94)27. The Investigation was asked to examine a set of circumstances associated with the death of Mr X at the hands of Mr O on the 27th February 2006. The victim was a neighbour but unknown to Mr O.
At the time of the incident Mr O was not in receipt of care and treatment for mental health problems. He had however been under the care of the South London and Maudsley NHS Trust mental health services between August 2005 and December 2005.

3. Incident Description and Consequences

On 27th February 2006, Mr O awoke from a nightmare feeling angry and frustrated. He left his flat with knives in his bag, and on meeting a neighbour, Mr X, in the hallway, he attacked him, first with his hands, and then stabbed him with

a knife. He then handed himself into police, he was not aware at that time that Mr X had died.

Mr O was remanded into custody and charged with Mr X's murder. His mental health deteriorated in prison and he was transferred to a medium secure psychiatric hospital under Sections 48/49 in July 2006. He was convicted of the homicide in November 2006 and his detention was continued at a medium secure hospital under Sections 37 / 41 of the Mental Health Act 1983.

3.1 Terms of Reference

The aim of the Independent Investigation is to evaluate the mental health care and treatment of the individual. Such Investigations should demonstrate and promote good practice by being open and honest in addressing any shortfall in service provision to service users and carers.

4. Findings

Mr O had brief contact with the mental health services prior to the incident of 27th February 2006. During the course of this Investigation eight care and service delivery problems were identified as were a number of influencing and causal contributory factors. The problems identified are dealt with in detail further on in the report. They relate to many key aspects of Mr O's care including assessment, engagement, risk and care planning.

No root cause was identified as it was recognised that while the combination of the care and service delivery problems and contributory factors may well have played a significant part in promoting the unique combination of circumstances that led up to the incident, it is not possible to say with certainty that any individual issue had a direct causal influence, and that had this issue been addressed, we could say with reasonable certainty that the incident would have been averted.

It is of concern that the themes that run through this case echo the findings of many other independent inquiries. We are however hopeful that because this inquiries findings will be included in NHS London's "Embedding the Learning" project, they can be addressed in a way which will maximise the possibility of embedding real and sustainable change in the way our mental health services operate, leading to services which are indeed safe, sound and supportive.

5. Recommendations

The Investigation Team concludes that there was no root cause in the case of Mr O. However, a significant number of care and service delivery problems as well as contributory factors were identified which give cause for concern regarding the overall care and treatment of Mr O by the mental health services.

We are aware that much work has been done by, and is on-going in South London and Maudsley NHS Trust to remedy this situation and we are confident that lessons have been learned. In light of these conclusions we would recommend that South London and Maudsley NHS Trust should ensure that all staff are aware of the lessons learned in this particular case as well as other similar cases in London, including the specific comments made by the investigating team in the body of this report, and that these are used to continually improve the way that mental health services are both operated and delivered.

This report concludes with the following formal recommendations for action:

- The Trust should continue to ensure best practice in the implementation of risk assessment and management procedures. Mandatory training should be provided on this. This should be regularly audited and the auditing process should include qualitative as well as quantitative measures.

- The Trust should ensure that all staff follow the guidance set out in the CPA policy regarding working with patients who do not engage with services. Mandatory training should be provided on this.

- The Trust should consider developing a mechanism to ensure that patients who do not engage with services are adequately monitored. They should ensure that all available resources have been used, and may include liaison with other non mental health organisations e.g. GP's, housing, social services, etc.

- The Trust should ensure that the assessment of patients is an on-going process, and that all staff are aware of the importance of, and mechanisms for getting corroborative information.

- The Trust should ensure that all clinical staff have skills in basic counseling, listening and as well as the ability to explore and challenge information in a non threatening way, that will allow them to more appropriately engage and work with patients
  Time should be made available for all patients to have dedicated time talking with a named member of staff. This should be monitored and audited on a regular basis.

- The Trust should ensure that the working diagnosis given to patients is regularly reviewed, and that the rationale and decisions made regarding care are properly recorded and communicated.

- The Trust should continue to review it's systems for monitoring and managing bed occupancy and inter-ward transfers.

- We recommend that the lessons learned from this Investigation should be disseminated to all staff in the Trust through the establishment of an action plan for implementation.

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.