Independent investigation into the care and treatment of Mr P

Case 16

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 an incident that occurred on 3rd October 2006 that resulted in the death of Mr P's father. Mr P was subsequently arrested and convicted as the perpetrator of this offence.

Mr P received care and treatment for his mental health condition from the South London and Maudsley Mental Health Trust (Trust A) now a Foundation Trust and the Hertfordshire Partnership NHS Foundation Trust (Trust B). It is the care and treatment that Mr P received from these organisations that is the subject of this Investigation.

2. Condolences

The Investigation Team would like to extend their condolences to the family and friends of the victim. 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

It is the view of the Independent Investigation Team that the internal investigation reports from both trusts were robust in process and addressed the main care service delivery concerns in their recommendations.

The Independent Investigation team found that Trust A had not sufficiently addressed the issue of seamless care between Trust B and its own Assessment and Treatment Team (team C) with regard to the inpatient admission and the discharge into community services. The focus of the investigation was primarily internal. The decision to establish separate terms of reference and separate internal investigations in each Trust is likely to have contributed to gaps in analysis. The joint Board Level Inquiry recognised the difficulty of conducting separate investigations and recommended that the decision to undertake joint investigations should be made at the commissioning stage with joint terms of reference, report and panel.

It is unfortunate that Trust A were not permitted by the police to have earlier contact with Mr P's mother to inform the investigation, as valuable information was held by her with regard to changes in Mr P's behaviour and mental state.

The Investigation Team found that in the case of Trust B limited information was provided to Mr P's mother as the main relative affected by the events. The Trust's Learning form Adverse Events Policy incorporates the NPSA principles on '*Being Open*', however the specific application of the procedure which resulted in initially not sharing the internal investigation with Mr P's mother, did not leave Mr P's mother with the impression of a culture of openness. This was compounded by a more open approach taken at the same time by Trust A.

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 merited an independent review and that this review would consist of a Type C Independent Investigation. A Type C Independent Investigation is a narrowly focused Investigation conducted by a single investigator who examines an identified aspect of an individual's care and treatment that requires in depth scrutiny.

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 e.g. child protection, Care Programme Approach (CPA), management organisation and delivery of adult mental health services (including CPA and risk assessment). The Investigation will be undertaken by a single investigator with peer support provided by team of two or three people. 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:
   - To ascertain progress with implementing the Action Plans.
   - Evaluate the Trust's mechanisms for embedding the lessons learnt for each case.
   - To 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 a single investigator with support from peer reviewers and 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 P, a known service user, was arrested on 3rd October 2006, charged with the murder of his father on the same day. He attended Crown Court and pleaded guilty to the manslaughter of his father on grounds of diminished responsibility. He was convicted of manslaughter in June 2007 and placed on Section 37/41 of the Mental Health Act, 1983. Mr P was transferred to hospital from prison in August 2007. He was 28 years old at the time of sentencing.

Mr P had been known to services in Trust A from 2001 when he attended with symptoms of paranoia and delusional beliefs combined with cannabis use.

In October 2006, Mr P was under the care of the Sector Assessment and Treatment Team in a borough wide service in Trust A. He had a diagnosis of paranoid schizophrenia and was on Standard Care Plan Approach (CPA). He attended outpatient appointments with the Staff Grade psychiatrist. Mr. P's care had transferred from another Sector Assessment and Treatment Team in January 2006 following a service reorganization based on aligning teams with GP practices. He had recently been discharged from 14 months of specialist psychology intervention from a psychology service for people with psychosis which was part of the Specialist Directorate of the Trust.

In the period leading up to the homicide, Mr P presented with a fluctuating mental state and he had failed to attend some of his outpatient appointments. He had had periods of non-compliance with medication. Mr P had also had a brief inpatient admission (three days in September 2006) at a Mental Health Unit, in Trust B. Mr P had not had any other inpatient admissions for psychiatric care and had only one forensic offence where he had attempted to steal from a shop but the owner had dropped the charges (date unknown).

In the weeks before the index offence, Mr P was spending increasing amounts of time sleeping in his car near his parents' home. He stated that he felt too afraid to enter at his parents' house as he was concerned that they were involved with a paedophile ring. On the day of the offence, he entered the house to confront his father about this belief.

On 4th October 2006, Mr P arrived at his parent's house and stabbed his father who was sleeping downstairs, with a kitchen knife. Mr P's father was alive at this point and his mother called the police. His father died on the way to or shortly after arriving at hospital.

Mr P is currently detained on a Section 37/41 of the Mental Health Act, 1983 in a medium secure setting.

6. Findings

The Investigation Team has identified six care and service delivery problems which for Mr P, led to care that fell below the standards expected under the Care Programme Approach in the period leading up to the homicide.

1. Inadequate clinical risk assessment of Mr P
   The Investigation Team found that there was a failure to act on indications of increasing risk behaviours and a failure to sufficiently communicate both internally and with the relevant external people who expressed concern. There

was a clear failure to carry out risk assessments and formulate risk management plans in line with Trust policy.

2. Clinical communication between the Specialist Psychology Service and the Assessment & Treatment Team

   The Investigation Team found that there was inadequate communication of clinical information between the Specialist Psychology Service and the Assessment & Treatment Team, in particular a failure to address increasing psychotic symptoms during 2006.

3. Reviewing the level of CPA
   The Investigation Team found that opportunities to review Mr P's level of CPA were missed. In addition, there was a lack of clarity in the minds of staff, on the extent of integration between outpatient services and the assessment and treatment team, such that it was not clear if the team policy on review covered those seen solely in an outpatient setting.

   The absence of a well-defined medical care co-ordination role and the lack of consideration to the appointment of a non-medical care co-ordinator meant that at key points in the care, action was not taken. The lack of clear care co-ordination resulted in the failure to co-ordinate a response to increased risk and changes in mental state.

4. No evidence of Consultant Psychiatrist review of care during 2006.

   A consultant review may have revisited Mr P's needs, examined the multi-disciplinary inputs, reassessed treatment and risk and considered if his care was best placed in the A&T Team or in another specialist team.

5. Lack of seamless care between Trust B and A&T Team C with regard to the inpatient admission and the discharge into community services.

   The Investigation Team found that there was a failure of communication on the part of both Trusts to adequately pass on information with regard to the inpatient admission, particularly at the crucial point of discharge. Mr P was not seen by the Assessment and Treatment Team in the period post-discharge as would be expected by the seven day follow-up procedure.

   The admission was a response to a mental health crisis which was not then further assessed by Assessment & Treatment Team C.

6. The absence of a clinical assessment of the extent to which substance misuse may have contributed to Mr P's mental state.

Intermittent cannabis use is documented in the notes prior to August 2002 but there is no further reference to either the assessment or management of this as an issue in the period leading up to the offence. Mr P's mother reported to the Investigation Team that Mr P continued to smoke cannabis during this period. Mr P himself retrospectively substantiated this report along with the use of cocaine. Due to the lack of clinical history taking and absence of an assessment of the influence of substance misuse on Mr P's mental health in the period leading up to the offence, it is not possible to come to any conclusions about any causal relationship for Mr P between psychosis and substance use.

The Independent Investigation concluded that at the centre of these problems was the lack of allocation of an enhanced CPA care co-ordinator and the confusion around the role and responsibilities of a standard CPA care co-ordinator.

7. Notable practice

The Investigation Team identified the following areas of notable practice:

1. There is evidence of good therapeutic engagement and consistent care being provided by the CPN from referral and during 2001. This came to an end at the beginning of 2002 when the CPN left and Mr P had difficulty engaging with a new key worker and was therefore transferred to the out-patient clinic.

2. There is evidence of good engagement with the mother of Mr P by Trust A after the index offence occurred and of recent follow-up meetings with her. This is supported by the new Trust A policy, 'Being Open', September 2008.

3. The action planning process in Trust A was robust. The actions for service delivery improvements related to this homicide have been brought together with actions from other homicides and are being actively monitored by the borough Clinical Governance meetings. The action plan is a live document which is regularly updated. Actions are given a red, amber or green (RAG) status.

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

Trust A
The action plan is a live document which is monitored monthly and regularly updated by the Borough Clinical Governance Committee. This action plan has been brought together with action plans from other incidents in order to address common themes. Each action for implementation is assigned a RAG status. There is a local clinical governance advisor responsible for checking that actions are followed up.

Trust B
The Modern Matron, at Trust B is responsible for the co-ordination and implementation of the action plan. This is monitored by the Patient Safety Co-ordinator who tracks the action planning. The completed action plan is signed off by the Assistant Director of the Borough once the evidence of completion is presented.

The Independent Investigation Team endorses the recommendations made by the two Trusts and notes completion of these for Trust B and the progress towards completion of these in Trust A. It is clear that a robust local process exists through clinical governance structures for Trust A to continue to make improvements in the areas of concern that are outstanding.

9. Recommendations

The role of the Independent Investigation Team was to review the internal investigations of the two trusts and to assess their conclusions and recommendations. The Team reviewed progress in the implementation of action plans and reviewed the investigation process to evaluate the extent to which lessons had been learnt.

The Independent Investigation Team concurred with the view of the internal investigation team from Trust A that whilst there were significant failings in the standard of care provided, these did not directly contribute to the homicide. It is not likely that this level of risk would have been predicted even where full care co-ordination and risk assessment had been present.

The Independent Investigation Team recommends the following from its examination of the care service delivery problems:

Recommendations Trust A

1. Where separate outpatient clinics are still used, the Trust should have a system that ensures review and discussion in team or individual supervision of all outpatient cases. This should include periodic review of all cases, for example, annual review as a minimum and should remind practitioners to seek review in relation to triggers such as changes in risk.

2. Within the Care Programme Approach, each service user has a single named care co-ordinator. This must be clearly communicated to the service user, carers and other team members and documented to ensure there is no confusion. The Trust should ensure that the medical care co-ordination role is understood by medical practitioners.

3. The Trust should strengthen clinical practice so that changes in mental state, increasing risk behaviours or an increasing number of multi-disciplinary inputs, alert the care co-ordinator to review the CPA level.

4. The Trust should ensure implementation of the recent policy developed for the care and treatment of service users with dual diagnosis (co-morbid mental health and substance misuse problems), August 2008.

5. The Trust should explore with the Metropolitan Police, lessons learnt with regard to enabling timely Trust communication and information gathering from Mr P's mother.

Recommendations Trust B

1. The Trust should clarify and strengthen the policy on 'Follow-up After Discharge' from In-patient Units to incorporate the local responsibility for action where an in-patient is admitted from outside the Trust catchment area.

2. The Trust should review the 'Learning from Adverse Events' policy to ensure that its application has the intended effect of applying the 'Being Open' principles in relation to victims and relatives.

3. The Trust should ensure implementation of the draft policy for the identification and care and treatment of service users with dual diagnosis (co-morbid mental health and substance misuse problems) in in-patients setting.

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.