Independent investigation into the care and treatment of Mr U

Case 20

Commissioned by NHS London

NHS
London

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Executive Summary

1. Introduction to the incident

This Investigation was asked to examine a set of circumstances associated with the death of Ms X, who was another service user of the Central and North West London NHS Foundation Trust on the 5th April 2005. Mr U was subsequently arrested and convicted of Ms X's murder.

Mr U received care and treatment for his mental health condition from the Central and North West London NHS Foundation Trust (the Trust) formerly known as Brent, Kensington and Chelsea and Westminster Mental Health NHS Trust. It is the care and treatment that Mr U received from this organisation that is the subject of this investigation.

2. Condolences

The Investigation Team would like to extend their condolences to the family and friends of Ms X. 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 conducted an internal investigation after the incident. The report from the panel was produced in July 2007.

The multi-agency panel was chaired by a non-Executive Director and had written Terms of Reference.

The panel met witnesses from within the Trust and also from external agencies. The panel met a cross section of clinicians, who were invited to give oral testimonies and were invited to be accompanied by a colleague or representative. The panel was provided with statements from witnesses as well as clinical case files and related polices. The investigation was conducted comprehensively and although efforts were made to contact both the families of the victim as well as perpetrator, the panel did not receive any feedback from either family.

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. The particular theme for this case was homelessness and the management, organisation and delivery of mental health services at the Central and North West London NHS Foundation 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 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 supported by a peer reviewer, with access to expert advice as necessary. 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 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 trusts 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 identifies 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 an appropriately knowledgeable investigator, with a peer reviewer and quality assurance provided by the Health and Social Care Advisory Service as required.

4.5 Independent Investigation start date

The Independent Investigation started its work in October 2007.

5. Summary of the incident

Mr U, a known service user at the Trust killed Ms X, another service user of the Trust on 5th April 2005 in her house.

At the time of incident Mr U was 28 years of age. He was reported to be homeless. He has a daughter who lives with his partner in New Zealand.

Mr U had a disruptive childhood and saw a psychiatrist at the age of 13 years for behavioural problems.

Mr U's first contact with mental health services was on 8th August 2000 when he was admitted to St Charles Hospital after taking an overdose at his mother's house. Mr U had reported feeling depressed since the cot death of his five month old daughter in January 2000. He had also reported to have ended the relationship with his girlfriend (his daughter's mother) three weeks previously. He was discharged on 22nd August and there was no further contact with the Trust until November 2004.

He was taken to Hillingdon A&E on 18th November 2004 by police under Section 136 of Mental Health Act 1983 after he was found in a toilet at Heathrow Airport having cut his wrists. He reported that after his previous discharge from hospital in August 2000 he had moved to the Republic of Ireland and met a female from New Zealand. He had a son with her and subsequently they moved to Australia. His partner then moved to New Zealand and after living alone in Australia he returned to England on 12th November 2004. He stayed with his mother initially but after he stole some money from her, he was no longer welcome. He could not find anywhere to live and spent a few nights at Heathrow.

The period starting from this admission leading up to the incident was characterised by attempts by staff to discharge Mr U and assist him in applying for the housing and income benefits, only to see him readmitted in the following days. He was not good at taking responsibility; he often took drugs while in hospital and once was accused of the rape of another service user. He was discharged on 11th December 2004 to be admitted the next day with threats of suicide due to homelessness. A similar pattern continued until 13th March 2005 when he was discharged following receipt of benefit money from the Department of Social Security (DSS). He again admitted himself on 14th March 2005 with suicidal threats and gestures due to homelessness. He discharged himself on 17th March 2005 saying that he was going to live in Dumil Backpackers (low price temporary accommodation).

On 5th April 2005, Ms X, a mental health service user was found dead in her flat after her sister and brother contacted police following their concerns that nobody had seen her for a number of days. Mr U, who was transferred from the Stonelea Unit, Langthorne Hospital (Mental Health Unit in NE London) on 7th April 2005, was taken into custody by police on 8th April 2005 in connection with this the serious offence. He was formally arrested on 12th April 2005 in relation to the death and was later convicted of her murder and sentenced to life imprisonment.

6. Findings

There were six care and service delivery problems identified.

6.1 Difficulty in managing Mr U's homelessness and his unwillingness to deal with this

There was failure in implementing the 'Safety First' Report's recommendations made by National Inquiry into Suicide and Homicide by People with Mental Illness.

The recommendations were that homeless persons admitted to hospital should be subject to enhanced CPA. The Investigation Team believe that if he had been placed on enhanced CPA his problems such as housing need and repeated self harm behaviour could have been managed more effectively. By subjecting him to

CPA he would have had access to a care coordinator who could have assessed his needs such as a housing, referral to drug and alcohol services or a personality disorder service, and engaged him in the recovery process. This would also have provided a more assertive follow up whilst in the community. There is no certainty that Mr U would have engaged or complied with the care coordinator.

The Investigation considered that the hospital services needed to have a clear link with housing and social services in order to effectively deal with his homelessness problem rather than leaving this to the inpatient staff. This would have avoided him spending so many days on a psychiatric unit purely for lack of accommodation.

By reading the clinical notes in their entirety it becomes clear that Mr U was not under CPA at any time during his contact with the mental health services. However, towards the end of his first admission the 'CPA' term was used loosely to describe a discharge meeting. This did not have any direct impact on his care but could be quite confusing about the level of care he received.

The Investigation found that Mr U had no motivation to solve his problems evidenced by not completing his benefits and accommodation application forms, not turning up on time for CAB and continuing to abuse drugs on the ward.

Mr U was unemployed and did not have enough money to rent accommodation. After being discharged from the hospital with £705 from DSS he did not make any efforts to seek any employment and spent his money on drugs and alcohol.

After discharge from hospital he chose to live with another service user and continued to use drugs at her home. When she objected to him using drugs and asked him to move out he again sought admission through self harming behaviour.

The Investigation is clear in their view that he made himself homeless and then got admitted to hospital through manipulative behaviour. It is clear from the above that Mr U only engaged with services when he needed a bed for the night or other assistance.

6.2 Initial problem due to no A&E assessment being sent with Mr U for his first admission

There was poor practice by the A&E doctor (referrer) in not sending the patient notes or a copy of them to the Inpatient Mental Health Unit. The implementation of Electronic Care Records (RiO) should resolve this problem.

The Investigation consider that there was a failure in adhering to good practice by not sharing care records with the Inpatient Unit. Electronic Care Records would have eliminated this mistake.

Mr U refused to co-operate fully on arrival at the Inpatient Unit and did not readily fill in any of the gaps in information. This meant that decisions had to be taken without all the necessary information.

6.3 Failure to follow up after discharge from hospital and to record non attendance at the arranged appointment

The Investigation considers that the Inpatient team failed to provide adequate follow up arrangements for Mr U after discharge. Although the patient's homelessness and lack of responsible behaviour made it difficult to follow him up, there was no documentation about any attempt to follow him up. It was felt that attempts should have been made to follow up Mr U and to check that he was addressing his accommodation and bereavement problems.

The Investigation feels that attempts should have been made to follow up Mr U after he failed to attend his appointment 3 weeks after discharge. The investigation also felt there should be a policy on follow up arrangements of patients under mental health services irrespective of their CPA status.

The Investigation considered that Mr U's continued homelessness and his lack of motivation to resolve his homelessness was a major contributory factor.

6.4 Failure to liaise consistently with police

Staff liaised with the police in an inconsistent way whilst he was bailed to the hospital address, and by not informing them when he was discharged.

The Investigation felt that there needs to be some policy or guidelines about better liaison between Mental Health Services and police when a person under the care of mental health services is arrested or bailed to a hospital address.

6.5 Referral to appropriate services

The Investigation feels that the referral to the specialist services should have been considered. He did display manipulative behaviour in order to get admission to hospital due to his lack of accommodation.

Mr U's illicit drug taking and his manipulative behaviour were of sufficient magnitude to warrant referral to a specialist service such as an addiction service and/or a Personality Disorder service.

6.6 Admission onto a locked unit whilst on 'informal' admission

Careful consideration was given to all these issues and the best decision in those circumstances was taken. Although Mr U felt he was treated unfairly, the circumstances and the alleged rape offence made it necessary for action to be taken to protect other people, particularly any females. In the event due to his self harming behaviour and reaction to the rape charge Mr U was detained under Section 5(2) of the Mental Health Act 1983 on 26th November 2004, which was later changed to Section 2 of the MHA 1983

7. Notable practice

The Investigation felt that the service provided to Mr U was generally of a high standard and various staff, especially in-patient team members who worked hard to support him.

Despite Mr U not being motivated to address his problems and presenting to A&E repeatedly, the inpatient team persistently encouraged him to apply for accommodation.

The Team also considered various risks to Mr U and others carefully when Mr U was considered for discharge from police custody after being interviewed in connection with rape allegations.

The Trust has also carried out an internal investigation, which was very comprehensive and took steps to implement the recommendations made by the internal investigation panel.

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

It is the view of conclusion of the Investigation that the internal investigation report undertaken in 2007 was robust and addressed the main service delivery concerns in its recommendations.

The Investigation reviewed the progress on the action plan dated 2008 and examined a number of documents to determine whether the recommendations were implemented. These included:

- A project undertaken within the trust recommended to examine the models for developing better links and communication between CMHTs, outpatients, specialist community services & primary care e.g. care co-ordinators linking with GP practices and links between PCLNs & CMHTs. The project report was signed off Jan/Feb 2008 and is in implementation stage.
- Case manager for homeless people – A pilot project has been proposed.

- Good practice meeting for CRT addressed some of the issues raised in the internal investigation report.
- Electronic Care Records System, JADE, has been implemented throughout the Trust to ensure better communication and access of health care records by health professions within the Trust at different places within the organisation.
- A project in the inpatient unit was being piloted which looked to increase CAB input to inpatient services with a specific focus on financial advice and support.

9. Recommendations

Whilst there were some gaps in the provision of care to Mr U (measured against recommendations made by the National Inquiry into Suicide and Homicide by People with Mental Illness published by the Department of Health April 2001) the Independent Investigation did not believe that this directly contributed to the incident.

Apart from the allegation of rape which was subsequently dropped, there was no evidence that Mr U was likely to be violent to other people. Most of the concern was that he often presented as homeless with suicidal behaviour.

1. People who are homeless, have been detained under the Mental Health Act and who have committed several acts of self harm, should be subject to enhanced CPA.

2. Appropriate arrangements should be in place to follow up patients discharged from inpatient wards in a timely fashion and to respond to their non-attendance at follow up.

3. All reasonable attempts should be made to obtain medical records from referring hospitals, including accident and emergency departments, for new admissions.

4. All the previous case notes should be made available to the assessing clinician in the Psychiatric Department as well as the A&E Department, preferably through electronic care records.

5. A link is generally available to providing housing support for people with severe and enduring mental illness (SMI). However work needs to be done to provide housing support to people with complex needs and yet not with SMI, such as people with no clear link with the Borough, unclear immigration status, or those with drugs and alcohol or personality difficulties.

6. Communication with external agencies such as the police needs to be improved, especially when discharging a patient who has the hospital as the bail address.

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.