Independent Investigation into the care and treatment of

Mr E

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 a member of public, on the 21st June 2003. Mr E was one of two men who were convicted of killing the victim at his home whilst committing a burglary.

Between November 2001 and December 2002, Mr E had been under the care of Oxleas Mental Health NHS Trust (the Trust) now the Oxleas NHS Foundation Trust. It is the care and treatment that Mr E 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 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

The Trust's internal investigation predated current guidelines on the processes of such investigations. As such it did not include a timeline and did not adopt root cause analysis techniques. The investigation did have written terms of reference. The multi-disciplinary internal investigation was chaired by a non Executive director. The internal investigation panel met on 10th October, 6th and 14th November, 8th and 19th December 2003. The report of the internal investigation was published on 3rd March 2004.

We judged that the investigation was conducted appropriately and reached pertinent conclusions, which were supported by background documentation, interviews with staff, and records of the discussions of the investigation panel. As in the independent audit and in our Investigation of Mr E's case, the internal investigation also highlighted concerns about Trust processes in relation to Care Programme Approach (CPA).

The internal investigation invited Mr E's family to contribute, but no reply was received. We are not aware of whether the victim's family were also contacted. However, we noted that the terms of reference of the internal investigation included the dissemination of a summary of the findings to relatives.

The records of the internal investigation detail interviews with staff members involved in the case. From these records we judged that the interviews were conducted appropriately and did not put staff under undue pressure.

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 application of the Care Programme Approach by the 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. Safeguarding Children, CPA, the organisation and delivery of mental health services (including CPA and Risk Assessment). The Investigation will be undertaken by a team of two to four people with expert advice. The work will include a review of the key issues identified and focus on learning lessons.

The Investigation Team will:

- Complete a chronology of the events to assist in the identification of any care and service delivery problems leading up to the incident
- Review relevant documents, which may include medical records (with written patient consent).
- 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.
- Conduct interviews with key staff including managers.
- Provide a written report utilising the agreed template, the report will include recommendations to feed into the overarching thematic review.

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 four investigators, with expert advice provided by 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

At the time of the incident Mr E was a 22-year-old single man. He was referred to Greenwich Locality Team, part of the Trust, on 14th November 2001 by Greenwich Housing Department Resettlement Team following concern about his behaviour.

After several attempts to meet Mr E at his home, he was assessed by a psychiatrist and the care coordinator, a social worker, in March 2002. He initially denied any forensic history, but subsequently reported a previous police caution for carrying a knife. He also reported that he had been charged with being drunk and disorderly, and being in a stolen car. A provisional diagnosis of mental disorder due to alcohol and/or drugs was made. The possible onset of a psychotic illness was also considered. A risk assessment was detailed in a letter to Mr E's GP, including identified risks of self-harm, self-neglect, harm to others and exploitation

In mid May 2002, Mr E was arrested and charged with burglary. He was detained in Belmarsh Prison and released on bail the next day. Mr E's flat was vandalised twice over the next few months. In June 2002 a home visit was made by Mr E's care co-ordinator and a colleague. A risk assessment was completed and risks were noted in Mr E's records. His housing needs were assessed. His mother was given a carer's pack.

In mid July Mr E's mother informed the Locality Team that her son had been detained in Belmarsh Prison, charged with burglary. Mental health staff contacted the prison to check. Mr E remained there until early November. Whilst in prison he received a forensic psychiatric assessment. "No clear evidence of mental illness" was identified in an addendum to the report, but concerns were raised that Mr E's previous history "may represent early stages of mental illness". On release, Mr E was offered an outpatient appointment with the care co-ordinator, which Mr E declined.

Mr E's care co-ordinator and the Locality Team manager discussed him. A decision was made to close the case. The care co-ordinator had been unable to meet with Mr E, although they had been in contact by phone. Mr E's case was closed on 19 December 2002. During this period of care no psychiatric diagnosis was made, although there was concern about Mr E's substance misuse.

On 22nd June 2003, the Locality Team was contacted by Social Services to inform them that Mr E had been arrested by the police on suspicion of burglary and murder. Mr E was one of two men who killed the victim during a burglary at the victim's home. Mr E and his accomplice subsequently mutilated and set fire to the victim's body. Following his arrest, Mr E was diagnosed with schizophrenia and was convicted of manslaughter. Mr E has since been detained in a secure forensic psychiatry inpatient unit.

6. Findings

There were five care and service delivery problems identified by the Investigation Team.

6.1 Initial care planning

The risk assessment and care plan were not completed by the Locality Team until five months after their first contact with Mr E. The care plan contained very little information, did not adequately draw upon previous assessments, had sections that were not completed, and was unsigned. Following completion of the care plan, there was no record of it having been discussed by the care coordinator and their supervisor.

We judged that multi-disciplinary discussion of Mr E's case and adherence to local CPA guidelines would have made adequate completion of the CPA documentation by Mr E's care coordinator more likely. Mr E's poor adherence to follow up contributed to the difficulties in collating the necessary information in a timely manner

6.2 Discharge planning

No CPA meeting was arranged prior to Mr E's discharge by the Locality Team. The internal investigation established that this should have occurred. There is no record of Mr E's mother being informed of his discharge, despite her role as a carer.

The absence of consideration of the need to hold a discharge meeting, or, if this was considered, the decision not to hold a discharge meeting was probably contributed to by the lack of evidence of Mr E having an ongoing mental health problem, and Mr E declining further contact with mental health services. However, local guidance indicated that a CPA meeting should have taken place. This may have prompted consideration of whether to discuss the discharge with Mr E's mother.

6.3 Allocation of patient

Following Mr E's referral to the Locality Team, his case was not allocated to a care coordinator for nearly three months.

We judged it likely that the lack of objective and subjective symptoms of mental illness would have reduced the Locality Team's degree of concern about Mr E. In addition, Mr E's poor adherence to planned follow up by the Locality Team appears to have contributed to a fragmented and protracted assessment process and the delayed allocation of a care coordinator. However, we judged it reasonable to assume that local CPA guidelines at the time would have contained a time limit by which a case should have been allocated, if only provisionally, following an initial assessment.

6.4 Liaison with the prison forensic psychiatry service

There was no evidence of liaison between the prison forensic psychiatry service and the Locality Team during Mr E's detention between July and October 2002.

We noted that the prison forensic psychiatric service did not identify any clear evidence of mental illness in Mr E. However, we considered it appropriate that the forensic reports should have been copied to the Locality Team to inform their future management of Mr E. Such a measure would have been in line with standard clinical practice when a patient is simultaneously under the care of more than one mental health service.

6.5 Carer's pack

Mr E's mother was not initially sent a carer's self assessment pack, despite her involvement with her son's care. When a pack was sent, there was no follow-up by the Locality Team when the completed self-assessment was not returned.

This issue also highlighted a problem about the need for regular supervision, particularly as Mr E's first care coordinator was a locum member of staff who might not have been as knowledgeable about the Trust's policies and guidelines as a permanent staff member. We felt that this issue was adequately addressed by the internal investigation and did not warrant further investigation.

7. Notable practice

The following areas were identified from our review of Mr E's clinical records:

- The referral proforma from Greenwich Housing Department to the Locality Team provided detailed information regarding concerns about Mr E.
- Following the referral, the Locality Team obtained relevant background information about Mr E from his family and GP.
- An initial urgent visit was made to Mr E's home, in response to concerns raised by the Housing Department about the risk of fire setting.
- Cultural issues were considered in the allocation to Mr E's case of a psychiatrist of a similar cultural background to Mr E.
- After missing the first appointment, additional efforts were made to ensure that Mr E was aware of the next appointment by phoning and writing to him.
- Following the initial assessment of Mr E by the Locality Team, their letter to Mr E's GP included a clear risk assessment.
- The Locality Team made efforts to keep in contact with Mr E through his family, and by phone and letter.
- Following Mr E's arrest and detention in May 2002, the Locality Team informed the prison of their involvement with Mr E.
- Shortly after Mr E's release from Prison in October 2002, contact was established between the Locality Team and Mr E's Probation Officer.
- Prior to Mr E's discharge from the Locality Team, his care coordinator contacted Mr E's GP and Probation Officer to establish whether there were any concerns about Mr E's mental health.

The following areas were identified from interviews with Trust staff:

- The Trust has introduced competency-based training for staff using the electronic patient record system (RiO), which includes CPA

documentation. Staff have to achieve required competences before they are permitted to use the system.

- The Trust has introduced practice development workshops around particular elements of RiO, aimed at those who are finding difficulties in using the system.
- Prior to a patient's discharge from inpatient care, Trust staff complete a pre-discharge planning tool, which is included in RiO.
- The Trust has introduced folders for patients to hold copies of their own care plans. This initiative has been supported by advertising to encourage patients to ask for copies of their care plans.

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

We reviewed the Trust's action plan and subsequent report on its implementation. Where actions were reported as not yet completed, we sought further information on progress from additional information supplied by the Trust and interviews with staff members. We are satisfied that progress has been made, particularly with regard to CPA and its documentation.

In addition we sought to understand the evolution of CPA processes following the introduction of electronic patient records and to establish learning points for other London Trusts. Oxleas NHS Trust was the first Mental Health Trust in London to introduce the RiO electronic patient record system, which is being introduced elsewhere in London. Other mental health trusts that introduce RiO should consider using their experience to guide their implementation, particularly with regard to staff training and use of CPA .

9. Recommendations

Our opinion is also that of the internal investigation panel, which noted that, during Mr E's period of contact with mental health services, "no clear recognisable mental illness" had been diagnosed and concluded that, "from the available evidence … there was nothing that would lead to a conclusion that this man was likely to present a significant risk to others."

We concluded that no root causes had been identified that, if they had been addressed, would have been likely to prevent the death of the victim in June 2003. At the time of the victim's death, Mr E had not been under the care of mental health services during the previous six months.

Because this incident occurred five years before our Investigation, with the internal investigation report being published a year later, certain recommendations that we might otherwise have made have already been implemented (see specifically 1 & 3 below). We anticipate that future internal

investigations will be compliant with current guidelines using root cause analysis techniques.

Trust CPA guidelines should address the issues arising from this case and CPA should be embedded in Trust working practices. The Trust introduced a Trust-wide CPA policy in 2003, which has been updated since. We reviewed these policies to ensure that they addressed issues raised by this investigation.

Specific aspects of the use of CPA should be examined in Trust audits to ensure that CPA is embedded in working practices. Drawing upon the findings of this Investigation and internal CPA audits, we recommend audit of the following areas:

- Supervision by team mangers of the completion of care plans;
- Timely completion of care plans;
- Recording of the details of a patient's care coordinator;
- Recording of CPA level;
- Organisation and recording of discharge CPA meetings.

The lack of communication between the Locality Team and the prison forensic psychiatry services highlighted the need for information sharing protocols between services, which have since been introduced by the Trust. All Trust teams now share the same electronic patient information system (RiO), which should facilitate communication.

Additional areas were raised by this case, but were not judged to warrant further detailed investigation. These might form part of a London-wide review if they are also raised in investigations into cases from other Trusts:

a) Clinical management of patients with dual diagnosis, particularly those who are difficult to engage;
b) Improved communication between mental health services and alcohol/substance misuse services, particularly when these services are delivered by separate Trusts or organisations serving the same population;
c) Transfer of clinical information between prison forensic psychiatry services and community mental health services.

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.