Independent investigation into the care and treatment of Mr F

Case 6

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 Mr F's brother on the 24 July 2004. Mr F was subsequently arrested and convicted of manslaughter as the perpetrator of this offence.

Mr F received care and treatment for his mental health condition from the Oxleas NHS Foundation Trust (the Trust) formerly the Oxleas NHS Trust. It is the care and treatment that Mr F 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 internal investigation predates current National Patient Safety Agency (NPSA) guidelines. At the time, it was classified as level 5 in accordance with the Trust Policy for Investigation of Adverse Incidents. The multi-disciplinary internal investigation was chaired by a non executive director. It had written terms of reference and ran from 15th October to 29th November 2004.

The Independent Investigation Team believed that the Trust attempted to sufficiently involve the perpetrator/victim's family and members of staff associated with Mr F's care. His parents were contacted by the Trust but did not respond and it was evidenced that the interview process followed by the Trust was in line with an open and fair approach to the management of incident investigations.

The internal investigation used root cause analysis and identified care and service delivery problems and made appropriate recommendations based on the evidence it collected.

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 Care Programme Approach (CPA) used by mental health services at 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, Care Programme Approach (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:
    - 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.
- Conduct interviews with key staff including managers.
- 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 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 quality assurance 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

Mr F had contact with the Trust's services between March 2000 and July 2004. A psychiatric diagnosis of "Mild depressive episode without somatic syndrome" (ICD 10) was made during Mr F's contact with services. Mr F was first referred to the Trust's services on 30 March 2000 by his GP, for assessment of his mental state and risk of suicide.

In the period up to July 2004, Mr F had contact with the Locality Primary Care Counselling Service (LPCC), Emergency Psychiatry at Queen Mary's Hospital, Community Assessment and Treatment Team (CATT), and Community Psychology services, and was an inpatient on Lesney Ward. The Trust's services identified that Mr F had issues with anger management relating to females, and suicidal ideation. Both issues were addressed during Mr F's contact with the Trust's services.

On 24 July 2004, Mr F fatally stabbed his brother at the flat they shared, following an argument and alleged physical assault by his brother. Mr F was arrested and subsequently convicted of manslaughter. At the time of his arrest Mr F was 36 year old.

On 26 July 2004, the Trust's Emergency Duty Team was notified that Mr F had been arrested and charged on 24 July 2004 with the murder of his brother. Following Mr F's conviction of manslaughter and eventual release from prison he

has been in contact with the Trust.

6. Findings

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

6.1 Care planning

A care coordinator should have been assigned to Mr F's case and a care plan should have been developed in November 2003 when Mr F was referred to the Trust's services. Multi-disciplinary discussions between Community Mental Health Teams may have helped to address the issue that Mr F remained under the 'duty' system.

The Investigation Team concluded that, although CPA guidelines were not fully followed by the Trust's services, it was not possible to judge that, if CPA had been followed, the victim's death would have been prevented. Mr F received care and assessment from community psychology, in-patient psychiatry and community assessment teams during his contact with services. Throughout this time the risk of harm to the eventual victim was not deemed to be significant, although the risk was not assessed strictly in the manner set out in the Trust's CPA. Indeed the main threats for Mr F were seen as suicide and also a risk of harm from his brother.

6.2 Case drift

The Investigation Team identified four separate incidences when appointments were delayed and not offered within the Trust's contemporaneous policy guidelines. The Trust should have followed local CPA guidelines when Mr F was referred to, or between, mental health teams.

However, the Investigation Team judged that even if all appointments had been offered in line with Trust policy time frames it would not be possible to conclude that the victim's death would have been avoided.

6.3 Record keeping

There were six occurrences in Mr F's care where the Investigation Team identified omissions in the care records. The Trust's mental health services should have ensured that all interventions of care were recorded as stipulated by national and local guidance. In particular, risk management and contingency plans should have been clearer and more detailed.

The Investigation Team judged that the deviations from good record keeping practice were not deemed to be a material omission in Mr F's care. If the omissions in record keeping had been addressed, the Investigation Team concluded that they would not have prevented the death of the victim.

7. Notable practice

As identified from the review of clinical records and compilation of the timeline:

1. Communications between the Trust's mental health services and the patient's GP were good, for example notification letters to the GP were promptly dispatched if Mr F did not attend an appointment.
2. The Duty CATT team were quick to respond on 27 November 2003 to the patient's needs at a time of crisis, and Mr F was seen within 24 hours.
3. Overall the Community Psychology services provided a large number of contacts to the patient with scheduled weekly appointments from 08 April 2004.

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

Responsible leads and timescales are given for each action*:*

8.1 Agree a Trust wide format of standard CPA letters

Lead: CPA group; Timescale: September 2005; *Progress:* Draft standard CPA letter developed by group. Guidance to be incorporated into the CPA policy.

8.2 Raise awareness of CPA policy via mandatory training

Timescale: January 2006; *Progress:* Training curriculum in planning; to be delivered from January 2006 by University of Greenwich

The Independent Investigation evidenced that all points in the Trust's action plans were completed.

The Trust was the first mental health trust in London to introduce the RiO electronic patient record system, which is being phased in across London. It is considered that other mental health Trusts that introduce RiO should be encouraged to use the Trust's experience to guide their implementation, particularly with regard to staff training and the use of CPA.
As identified from interviews:

1. The Trust has introduced competency-based training for staff using the electronic patient record system (RiO). Staff have to achieve required competencies before they are permitted to use the system.
2. The Trust has introduced practice development workshops around particular

elements of RiO, aimed at those who are finding the system more difficult to use.
3. The RiO system itself assists care planning by providing a single tool for recording care plans which in turn supports multi-disciplinary team working and improved communication.
4. The Trust now uses a pre-discharge planning tool within RiO, prior to patients' discharge from inpatient care.
5. The Trust has introduced folders for patients to hold copies of their own care plan. This initiative has been supported by advertising to encourage patients to ask for copies of their care plans.

9. Recommendations

Following the review of Mr F's care and treatment, the Investigation Team judged that no direct root causes could be identified that would have prevented the death of the victim on 24 July 2004. The Investigation Team believes that even if all the identified contributory factors had been addressed, this would not have prevented the homicide.

1. As per the Trust's recommendation in the Internal Investigation Report the format of care plans for patients on standard CPA should be developed. However, since the incident subsequent updates have been made to the Trust-wide CPA policy. The Independent Investigation Team reviewed these polices to ensure that they addressed the issues raised in this cases.
2. Specific aspects of the use of CPA should be examined in future Trust audits. Drawing upon the findings of this Investigation and internal CPA audits, we recommend audit of the following areas:
    - Supervision by team managers of the completion of care plans;
    - Timely completion of care plans;
    - Recording of details of care coordinator;
    - Recording of CPA level;
    - Organisation and recording of discharge summaries and multi-disciplinary CPA meetings.

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.