VERITA

INVESTIGATIONS – REVIEWS – INQUIRIES

Thematic review of four independent investigations

A report for
NHS East of England

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1. Introduction

Introduction

1.1 In 2009 NHS East of England commissioned Verita to undertake four independent investigations. These were commissioned in accordance with guidance published by the Department of Health in HSG 94(27) *Guidance on the discharge of mentally disordered people and their continuity of care in the community* and the updated paragraphs 33-36 issued in June 2005.

1.2 The aim of the independent investigations is to investigate the mental health care and treatment of a group of cases that have been drawn together with particular themes.

1.3 The investigations followed a homicide committed by a patient in 2003, two further homicides committed by patients in 2005 and a fourth homicide committed by a patient in 2006. All four of the patients concerned were under the care and treatment of the North Essex Partnership NHS Trust[1] (the trust).

1.4 Three of the patients were receiving services from the drug and alcohol services.

1.5 The four investigations were into the care and treatment of H, J, K and L.

1.6 In agreement with NHS East of England these independent investigations were assessed as requiring two investigators, with access to expert advice as necessary. The investigators. Liz Howes and Amber Sargent were chosen because their expert experience matched the themes of the investigations. Biographies of the investigators are attached at the end of the report.

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[1] North Essex Mental Health Partnership NHS Trust was created in 2001 from the merger of several other trusts and part of Essex social services. In 2007 the trust became North Essex Partnership NHS Foundation Trust.

1.7 Terms of reference for the four investigations are included in the individual reports. The terms included the provision of a report of each investigation and an overview report focusing on the common themes of the investigations.

1.8 The common themes arising from two or more of the four independent investigations are:

- Non compliance with care programme approach policy
- Lack of risk assessment and management
- Poor communication/information sharing
- Lack of services for people with a personality disorder
- Failure to learn lessons from serious untoward Incidents

1.9 We are aware that there has been some other work within the East of England region relating to themes arising from serious incidents. Where appropriate we have therefore tried to make recommendations with similar wording in order to assist the SHA and the trust that needs to implement the recommendations.

The four cases

1.10 On 16 August 2003 H fatally wounded a 20 year old male following a violent dispute. On 10 August 2004 H was found guilty of murder and sentenced to life imprisonment with a recommendation that he serve a minimum of 15 years in prison. His three associates were found guilty of violent disorder. Two of them were sentenced to two years imprisonment and the third received a one year custodial sentence.

1.11 On 23 July 2005 J killed his friend in a street in Colchester following a violent argument. J produced a knife when his friend attacked him and he then stabbed him. J was found guilty of manslaughter and sentenced to five years in prison.

1.12 On 2 December 2005 K was arrested after an acquaintance of his had been strangled to death. K had previously told staff that he had suffered harassment and

sexual abuse from the victim. K stood trial at Basildon Crown Court and was found guilty of manslaughter and sentenced to three and a half years in prison.

1.13 On 23 March 2006 L fatally wounded a 19 year old male following a violent dispute. On 2 April 2007, following a six week trial at Chelmsford Crown Court, L and his co-defendant were found guilty of manslaughter and attempted robbery, but acquitted of murder. On 19 April 2007 L was given an indeterminate public protection sentence with a six year minimum period of detention before consideration of release.

The trust's reports

1.14 The trust conducted an internal investigation into the care and treatment of each patient and found that in all four cases there were issues surrounding CPA, risk management, information sharing and in two cases issues around services for people with a personality disorder.

1.15 The terms of reference for the four independent investigations include the following:

Stage one

- Conduct the review of the progress that the Trust has made in implementing the action plan from their internal investigation.

Stage two

- Review the care, treatment and services provided to the service user by the NHS and the local authority from the service user's first contact with services to the time of the offence.

1.16 A copy of the full terms of reference can be found in appendix A.

2. Methodology

Preparation

2.1 We wrote to the four perpetrators to ask their permission for us to access their clinical records. In three cases we either had no reply or they declined consent. K did provide consent but in respect of H, J and L consent was gained via the trust Caldicott Guardian[2].

2.2 The investigation team made efforts to make contact with the victims' relatives to explain the nature and process of the investigation and to discuss how they could be supported while the investigation was taking place.

2.3 In the case of K we asked Essex Police if they were able to help us contact the relatives of his victim. However, the investigators, the police and the Strategic Health Authority agreed that given that the victim's only known relative had little contact with him, was elderly, physically unwell and given the time lapse between the incident and our investigation it was inappropriate to pursue any contact.

2.4 In the case of H we also asked Essex Police if they could help us contact the relatives of H's victim. We were provided with the contact details for the mother and stepfather of the victim and wrote to them explaining the purpose of our independent investigation. Having received our letter the victim's parents were keen to meet. During our meeting they told us they were unaware that H had any contact with mental health services as this was not raised during the trial. They were satisfied with the information we shared with them and were keen to be informed once this report has been concluded.

2.5 Essex Police were unable to locate the relatives of the victims of J and L.

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[2] A Caldicott Guardian is a senior person responsible for protecting confidentiality of patient and service user information and enabling appropriate information sharing.

2.6 We gathered a range of written evidence including:

- The perpetrators' mental health and primary care trust records
- Trust policies and procedures
- Statutory policy and guidance
- Previously completed incident and internal investigation reports
- Action plans resulting from the internal investigation reports.

2.7 Each investigation report consists of a chronology of events based on the documents gathered.

Interviews

2.8 We interviewed key people including:

- The family members of one of the four victims
- The area manager for adult services
- The trust lead for the internal investigations' action plans
- The operational services manager for the drug and alcohol services.

2.9 Each interview was transcribed and the transcription was subsequently sent to the interviewee for them to confirm its accuracy and to add any further information which they wished to make known to us.

Consideration and evaluation

2.10 The investigation team reviewed and analysed both written and verbal evidence.

Recommendations

2.11 Each report contains recommendations based on the evidence reviewed.

2.12 Section 2 of this overview report discusses the common themes arising from the four investigations. It also identifies the themes arising in each case (summarised in the table at Appendix B). Our recommendations are summarised in section 3. This report does not repeat the individual recommendations on issues such as risk assessment and risk management information sharing, personality disorder services, etc. that may have been made in each of the individual reports.

3. Common themes

Service Issues

Care programme approach (CPA)

Care planning and review

3.1 All four investigations highlighted some non-compliance with the trust CPA policy in terms of care planning and review.

3.2 Although H fitted the criteria for CPA and records show he was assessed as being on standard CPA, he did not have a care plan in his clinical notes, and therefore there is no evidence that he was assessed and managed under CPA in accordance with trust policy at the time.

3.3 J was assessed using CPA documentation but there is no evidence of a CPA level being recorded on his CPA forms or in the notes. He did not have a care plan until he was assessed in February 2005 despite being in contact with services since 2003. This was contrary to trust policy.

3.4 L was assessed using CPA documentation, but there is no evidence of a CPA level being recorded on the CPA forms or in the notes and this did not accord with trust policy.

3.5 K's care plan was last reviewed on 17 March 2005 a year before the incident. Again this is not in line with trust policy.

Risk assessment

3.6 All four of the internal investigations identified issues around risk assessment and risk management. In all cases there was some divergence between practice and

the trust's clinical risk assessment and management policy and there were no clear plans to manage these risks.

Comment

We have examined the current trust policy regarding CPA and risk assessment. It is now up to date and fit for purpose. The trust includes audit of compliance in its clinical audit programme. It is important that this process of assurance is continued. At the time of the offences the policy was not fit for purpose or fully embedded. This led to the policy not being adhered to by staff.

Managing patients who do not attend appointments (DNAs)

3.7 In all four cases we found that patients did not always attend appointments. There is evidence that on occasions this was managed and followed up appropriately but on some occasions there is no evidence that the decision to discharge patients (because of non attendance) was discussed with the team or the team manager as trust policy required.

3.8 In all four cases, reference was made in the internal investigation reports to a history of non engagement but no clear recommendations were made about this in any of the internal investigations.

3.9 The trust now has a clear policy for the management of patients who do not keep appointments or who disengage from services.

Comment

The SHA should assure itself that the current DNA policy is in line with best practice and that the policy is being complied with.

Information Sharing and Communication

3.10 In three cases substance misuse was identified in the case records and these three perpetrators were referred to local drug and alcohol services. Of these three, L and J were subject to a drug testing and a treatment order.

3.11 In the case of L there was a failure to communicate effectively in relation to the non compliance and lack of effectiveness of the treatment order but the order worked well in the case of J.

3.12 Information relating to L's health and non engagement was not shared with his GP and a discharge summary for K was sent to his GP some three months after discharge. In the case of H a specialist practitioner was not kept informed of his non engagement.

3.13 H, K and L received services from a number of agencies but there is no evidence that relevant information was shared or joint working took place in relation to risk assessment and CPA.

Comment

Without all those involved in the care and treatment of these patients being kept informed of their engagement and presentation it was extremely difficult for staff to make an informed decision about risks posed and future treatment.

Safeguarding

3.14 Both J and K had children under the age of 18 and we could find no evidence in the clinical notes that any consideration had been given to the risks that substance misuse and offending may have posed to the children. In the case of J the trust was involved with child protection conferences about his child born in February 2005. H

was known to have younger siblings but there is no evidence that consideration was given to the risk of harm he may have posed.

3.15 We were told at interview with trust managers that there is now a mandatory training programme in place for safeguarding.

Services for people with personality disorder

3.16 One of the four perpetrators, J, was described as "*having a history of childhood abuse and difficulty in maintaining relationships which is consistent with a diagnosis of Personality Disorder".* There is no evidence in the clinical notes that this diagnosis was considered by the teams caring for him. This issue was raised in the internal investigation.

3.17 Another of the perpetrators was thought to have borderline personality disorder by his consultant.

3.18 Up until 2005 the trust did not provide specialist services for people with personality disorders. Since 2005 training has taken place across the trust but there has not been a consistent approach to this. We have made a recommendation about the development of a trust wide personality disorder strategy to support staff in the management of people with personality disorder.

Comment

In two of the individual reports we have made a recommendation about the development of a trust wide personality disorder strategy to support staff in the management of people with personality disorder.

It would be helpful for commissioners of mental health services (local primary care trusts) to have a clear picture of what specialist services are in place for people with personality disorders across the East of England. This could then be used to evaluate the effectiveness of services and build on best evidence based practice.

4. Learning the lessons

Quality of internal investigations

4.1 Three of the internal investigations were undertaken by a panel as outlined in the 2005 trust policy for the management of SUIs. In the case if H the internal investigation predated the 2005 policy and no policy was in place. In this case a single clinician report was completed.

4.2 The current incident and reporting policy now states that all serious incidents involving homicides should be investigated by a panel.

4.3 Only two of the investigations had terms of reference but we found all the internal investigations adequately addressed the issues although there was a delay in the completion of the final reports.

4.4 The reports for K and J were undated.

4.5 It has not been possible to determine the seniority or impartiality of the people who undertook the internal investigations as their role and position has not been made clear in all these investigations.

Comment

It is important that panel members are in a sufficiently senior position to interview staff and make recommendations and, in order to maintain impartiality it is important they are not part of the service being investigated.

The trust should ensure that all internal investigations have clear terms of reference in line with the incident reporting policy and procedure.

Action plans

4.6 Action plans were developed and implemented in all four cases. There was a delay in formulating the plans and three of them have not been signed off by the trust.

4.7 One action from the K report about improving access to the electronic case recording system for drug and alcohol staff, is still to be fully completed although some progress has been made. The POPPIE system is being installed on all computers across the trust and some training has taken place.

4.8 There were seven recommendations made in the case of J, three in the single clinician report and four in the panel investigation. The action plan makes no reference to any of the seven recommendations but identifies a further three unrelated actions.

4.9 There is now a Scrutiny Group that is responsible for signing off reports and ensuring that action plans are agreed. This group was established in May 2005.

Comment

It is of concern that some of the themes highlighted in the first internal investigation in 2003, in particular risk assessment, risk management and information sharing, were repeated in the other incidents which happened some two years later. This reflects a failure on behalf of the trust to learn lessons in order to prevent similar incidents re occurring.

Policy framework

4.10 Since these incidents the trust has updated its policy and procedures for reporting incidents.

Comment

The trust's incident reporting policy and procedure is now comprehensive and fit for purpose. Internal audit should be used to assure that compliance continues in all cases and to test the effectiveness of the current policy.

Sharing and building on best practice

4.11 Our meetings with senior managers from the mental health trust identified a range of ways in which the trust disseminates lessons arising from SUIs. However there is further work to be undertaken to ensure lessons are learnt across all services. Managers commented on the need to share best practice in managing SUIs and learning the lessons arising from these incidents.

Conclusion

In all four of the cases there were missed opportunities that may have improved the care and treatment of service users.

Risk assessments were not always carried out in a timely and consistent manner and records of risk assessments were sometimes poor.

Information was not always shared across services to ensure that the service user received a joined up approach to their care and treatment.

A particular failing in the case of L was the failure to communicate with probation services in relation to his non compliance with the DTTO.

In three of the four cases the trust had a recorded history of past offences and convictions of the perpetrators but in the case of L the nature of his offences and the convictions associated with them were not known by the trust and only limited attempts were made to obtain this information.

Summary of recommendations

R1 The trust should assure itself and commissioners that there is now a robust process in place for CPA which includes care planning, risk assessment, risk management planning and non attendance at appointments. The trust should also assure itself or the PCT that it has a robust policy on safeguarding.

R2 The Commissioners should ask provider trusts to review their DNA policies and procedures to ensure they are fit for purpose. Trusts should include audits in their clinical audit programmes to assure compliance with DNA policies.

R3 Commissioners of secondary mental health services across the East of England should ask mental health and social care trusts to provide a profile of the spectrum of services they offer to people with personality disorders. They should then devise and implement a programme of evaluation of the effectiveness of such services.

R4 NHS East of England should share issues arising from these investigations to ensure best practice in SUI policy development and the appropriate learning of lessons arising from such investigations. One way in which this could be achieved would be to hold a workshop for key senior managers from mental health and social care trusts and the commissioners of mental health and social care in the East of England.

Appendix A

Terms of reference

Independent investigation into the care and treatment of H, J, K and L.

Terms of reference

The purpose of the investigation is to review the care and treatment of the mental health service user and to establish the facts of the incident in 2005, leading to the death of their acquaintance. The investigation will be carried out in two stages and shall include:

Stage1 **Working from the SHA commissioned assessment of the Trust internal investigation, its findings, recommendations and action plan:**

- Conduct the review of the progress that the Trust has made in implementing the action plan
- Reach agreement with the Strategic Health Authority on any areas (beyond those listed below) that require further consideration

Stage 2 **Specifically address the areas identified in Stage 1 to:**

1. Review the care, treatment and services provided to the service user by the NHS and the local authority form the service user's first contact with services to the time of the offence

2. Compile a comprehensive chronology of events leading up to the homicide and establish the circumstances of the incident itself

3. Review the appropriateness of the treatment, care and supervision of the service user in the light of any identified health and social care needs with particular regard to the service user's forensic history and mixed diagnosis of borderline personality disorder and neurotic traits.[3]

4. Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming himself

[3] Point 3 was amended in agreement with NHS East of England to read:

Review the appropriateness of the treatment, care and supervision of the service user in the light of any identified health and social care needs with particular regard to the service user's forensic history and if appropriate diagnosis of personality disorder.

or others in particular the risk the service user posed to his partners or children (if applicable).

5. Comment on the adequacy of the communication and information sharing between the various agencies involved with the service user including the sharing of the service user's history of violence

6. Examine the effectiveness of the service user's care plan

7. Review compliance with local policies, national guidance and statutory obligations

8. Consider any other matters arising during the course of the investigation which are relevant to the occurrence of the incident or might prevent a recurrence

9. Provide a written report to the Strategic Health Authority that includes a review of progress against the internal investigation and if required further measurable and sustainable recommendations for the agencies involved.

Appendix B

Key themes from East of England reviews

Themes	H August 2003	J July 2005	K December 2005	L March 2006
CPA	●	●	●	●
Management of DNA's	●	●	●	●
Information Sharing	●		●	●
Risk assessment/management	●	●	●	●
Clinical records	●	●	●	●
Personality Disorder Services		●	●	
Management of DTTO				●
Safeguarding children and Vulnerable Adults	●	●	●	
Investigation report process	●	●	●	●
Action Plans	●	●	●	●
Learning Lessons	●	●	●	●

Appendix C

Biographies

Liz Howes

Liz has 20 years' experience of senior management in the NHS, specialising in mental health and learning disabilities. This is included the management of Drug and Alcohol services and Personality Disorder services at Director level and the management of Forensic services as a senior manager. Liz led on a service improvement project in mental health services as part of a national pilot with the National Institute for Mental Health in England, and was responsible for leading a multi-agency project plan for the reprovision of Health Homes in the Learning Disability Service. This involved providing alternative accommodation and ensuring provision of mainstream services for residents with Learning Disabilities to promote social inclusion and personalisation of the care provided. Her previous posts have included interim director of learning disabilities and specialist services and head of services redesign and information services at Leicestershire Partnership Trust, and director of mental health services at Leicestershire and Rutland Healthcare NHS Trust.

Amber Sargent

Amber joined Verita as a senior investigator in 2009. Amber previously worked at the Care Quality Commission (CQC) as an investigation officer where she led interventions into trusts where patient safety concerns were identified. She also worked on several major investigations that CQC were undertaking at the time. During her time at CQC Amber worked with many mental health and acute NHS trusts as well as strategic health authorities to identify patient safety concerns, governance issues and concerns around performance and to provide recommendations for improvement. Before this, Amber worked for London Probation as a probation officer for three years.