Independent investigation into the care and treatment of Mr K

Case 11

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 the death of a member of public on 22nd May 2003. Mr K was subsequently arrested and convicted as the perpetrator of this offence.

Mr K received care and treatment for his mental health condition from the Central and North West London Mental Health Trust (the Trust) now a Foundation Trust. It is the care and treatment that Mr K received from this organisation that is the subject of this investigation. The victim was also in receipt of mental health services from the Trust.

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

In line with the local Trust Serious Untoward Incident policy a serious incident investigation commenced on the 23 May 2003 and was completed on 19 June 2003. An internal review was undertaken by the Trust, the panel of inquiry was set up in June 2003 and completed their report on 20 December 2004. An action plan was in place by June 2005 and completed in July 2005.

The Investigation Team felt that the internal review report was comprehensive, thorough and covered most of the salient points within the body of the report. We are of the opinion that it should have been completed in a more timely fashion. There were areas however where we felt there was room for improvement.

The terms of reference include the objective to examine the overall care provided to the victim and to Mr K by the Trust, particularly focussing on the one year period prior to the incident. Whilst the care provided for Mr K was examined in some detail there was little reference to the care provided to the victim. This will not be commented on further as it is not the subject of this report.

It is difficult to ascertain from the report what, if any, support was provided to the Trust's staff and the families of the victim and perpetrator.

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 post-discharge placement 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 an appropriately knowledgeable investigator. 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 or Caldicott Guardian approval).
3. Review the Trust's 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 and set out 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 an appropriately knowledgeable investigator, with a peer reviewer 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 K was 43 years old at the time of the incident. He had a diagnosis of paranoid schizophrenia and a long history of substance misuse. He was a patient with Brent Mental Health Services East Sector Community Mental Health Team (CMHT) and was living in a Hostel in Willesden which is a high care 24 hour supported housing scheme for people with mental health problems and substance misuse provided by Brent MIND.

Mr K was first diagnosed as having mental health problems in 1977. For most of the time since then Mr K's care was institutional. He had 4 admissions to the local psychiatric hospital in the 1970's, he spent 7 years as an inpatient at Broadmoor hospital in the 1980's, moving on to the Three Bridges Unit Regional Secure Unit and then local psychiatric services. He was discharged into the community in the early 1990's but this placement broke down and he was re-admitted to hospital under the Mental Health Act in 1993. He remained in a variety of in-patient hospital placements until his discharge into supported accommodation in the community in March 2000. He was re-admitted to hospital

under the Mental Health Act again in July 2002, he was discharged in February 2003 back to the same hostel accommodation where he was resident, although under an eviction notice, at the time of the incident.

A Mental Health Act assessment was arranged to take place at the Hostel on the 21st May 2003 but due to Mr K not being present it was re-scheduled for the 27th May 2003.

On the evening of Thursday 22nd May 2003 Mr K visited the flat of a known acquaintance who also had mental health problems. At approximately 22.30 neighbours heard the sound of fighting coming from the flat, then from the hallway, continuing down two flights of stairs to the ground floor. Mr K was heard to threaten to kill the flat occupier, and then make several stabbing movements with his arm towards the victim who had fallen to the ground. The police were called and they found the victim with a knife sticking out of his back. He was taken to hospital by ambulance and pronounced dead at 23.15. The post mortem found that the victim had multiple stab wounds and that the cause of death was a single stab wound to the heart.

Mr K was arrested the following morning at 6.15am. He was examined by the Forensic Medical Examiner who found him fit for interview. Mr K was subsequently charged with murder and remanded into custody. His mental state deteriorated while he was in prison and he was transferred to the Three Bridges Regional Secure Unit on 4 December 2003 under Sections 48 and 49 of the Mental Health Act 1983.

The case went to trial in February 2004 and Mr K was found guilty of manslaughter on the grounds of diminished responsibility on the 1st March 2004. His detention was continued at the Three Bridges Regional Secure Unit under Sections 37 and 41 of the Mental Health Act 1983 and he remained in secure psychiatric provision until his death on the 21st August 2007.

6. Findings

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

6.1 Care Planning and Risk Assessment

There were no clear care plans and no clear contingency plan. No action had been taken with regard to Mr K's housing issues. The risk assessment had picked up on all of the risk factors but there was no appropriate follow up that took these factors into account. CPA is a process which is supposed to ensure that mental health service users do not fall through the safety net of care. Mr K was on enhanced CPA and as such should have had a more robust and coherent clinical management plan.

6.2 Mental Health Act Assessment

A Mental Health Act assessment was arranged to take place at the Hostel on the 21st May 2003 but due to Mr K not being present it was re-scheduled for the 27th May 2003 when his key worker would be available again..

This decision can be viewed in a number of ways. There was a desire to ensure that if and when a Mental Health Act assessment was undertaken, it should be done by staff who knew Mr K and were willing to take responsibility for his care and treatment – these sentiments are laudable. However asking unqualified support staff to take responsibility for calling out the emergency team given the amount of input and the controversy Mr K's care and placement had caused, can be viewed as a bad decision and an unfair shifting of responsibility. There is no documentation to demonstrate that the treatment team contacted the Emergency Duty Team co-ordinator to highlight and discuss Mr K's possible needs.

The decision in the end was a judgement call. One would however have to speculate that if the assessment had been carried out in a more timely manner, the outcome may have been different.

6.2 Medication Compliance

This issue was central to the management of Mr K's risk and the Independent Investigation found it surprising that this was not more clearly managed, particularly given that he had recently been discharged from hospital and there was concern about his mental health and deteriorating presentation. Mr K's non compliance with medication was a known and significant risk factor which contributed to the breakdown of his mental health.

6.3 Access to Psychiatric Intensive Care (PICU) beds

The Independent Investigation Team understands the concerns relating to admitting Mr K. However the Investigating Team felt that many of these issues should have been dealt with and resolved during Mr K previous admission and the formulation of contingency plans. If there had been a clearer route to access to a PICU bed Mr K's care and treatment would have been provided in a more timely fashion and his mental illness could have been treated more appropriately.

6.4 Dual Diagnosis

While his care plans refer to the MIND support workers doing some work with him around his drug abuse, and the appointeeship (a legal way of having a person's money managed by an appointee) was put in place by the Court of

Protection in June 2002 to help limit his access to money, and therefore drugs. Mr K did not have formal access to a dual diagnosis service from which he may have benefited. This was a missed opportunity. The Trust has a responsibility to deliver dual diagnosis services within mental health service provision and these should be supported by specialist substance misuse services where appropriate.

6.5 Communication and Relationships between the Trust and 'Brent MIND'

It appears an opportunity was lost to maximise communication and information. The resulting effects this had on the care and treatment that Mr K received focused mainly around his non compliance with medication and the subsequent deterioration in his mental state. The lack of focus and clear leadership resulted in key decisions being either delayed or not made, in particular the decision to assess Mr K under the Mental Health Act 1983.

6.6 The decision to discharge in February 2003

Discharge under Section 25 of the Mental Health Act 1983 would have allowed for three main things to happen:

- Mr K would have to reside at a particular location
- He would have had to allow mental health professionals access
- He would have to comply with an agreed care plan, which could include accepting medication as well as abstinence from illicit drugs.

If these conditions were not met Mr K could have been "conveyed to a place of safety" and then assessed by the Registered Medical Officier and readmitted to hospital under section of the Mental Health Act 1983, if it were felt necessary.

The effects of the decision to discharge in February 2003 without the use of section 25 of the Mental Health Act 1983 meant that in the event of Mr K's mental health deteriorating the boundaries necessary to manage his increasingly difficult behaviour were not in place or enforceable. Also in the event of re-admission to hospital being indicated a whole new Mental Health Act 1983 assessment process would need to start from scratch.

6.7 Access to money

The Investigating Team found that the processes for these decisions need to be reviewed to ensure that they consider the best interests of the service user, this Investigation is of the view that giving Mr K full access to large amounts of money was not in his best interests.

7. Notable practice

The original Trust internal inquiry report commended the care-coordinator for his continued support of Mr K after the incident and during his stay in secure accommodation.

The Trust has made some very real progress with raising the quality of risk assessment and CPA both with training and monitoring. The provision of dedicated PICU, low secure and step down beds is to be commended.

We would also like to commend the Brent MIND services for the sustained efforts they made in caring for Mr K over a long period of time.

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

The action plan left a lot of room for improvement, particularly given the number of very valuable issues raised within the conclusions of each section of the report. The resultant local action plan only deals with procedures for depot medication and the relationship with MIND. The opportunity to formally review issues relating to CPA, risk assessment, dual diagnosis services, access to PICU beds, for example were lost.

We also felt that a number of the issues raised by the report could and should apply to the Trust as a whole. None of the issues identified are likely to be specific to this particular case and service alone. There is nothing to suggest that the issues raised could not be potential issues elsewhere within the Trust.

The Trust Board adopted the recommendations specific to it and with an action plan for implementations. This was signed off as completed in July 2005.

We are aware that much work has been done and is on going by Central and North West London NHS Foundation Trust to remedy this situation and we are confident that lessons have been learned. We recognise that the Trust is a very different organisation now in 2009 to the one in place at the time of the incident in 2003.

9. Recommendations

The Investigating Team have considered very carefully whether a single root cause existed in this case and have come to the conclusion that there is no root cause identifiable. We have identified a number of care and service delivery

problems, and a number of contributory factors which led to a number of lost opportunities for intervention in Mr K's care that may have influenced the events of the 22nd May 2003.

We would recommend that Central and North West London NHS Foundation Trust should ensure that all staff are aware of the lessons learned in this particular case as well as other similar cases in London, including the specific comments made by the Investigating Team in the body of this report, and that these are used to continually improve the way that mental health services are both operated and delivered.

This report concludes with the following formal recommendations for action:

1. The Trust should continue to focus on CPA and risk assessment training and monitoring to ensure best practice is implemented.

2. The Trust should continue to monitor and ensure training and implementation of best practice in medication management.

3. The Trust should ensure that there are clear protocols available to all relevant staff regarding access to PICU and low secure beds where appropriate, and where admission is required, this need is met in a timely fashion.

4. The Trust should ensure that all patients who have co-existent mental health and substance misuse needs have access to specialist substance misuse services including dual diagnosis expertise.

5. The Trust should ensure that clear communication processes are in place with external bodies. In particular in this case we would highlight the relationship with the Benefits Agency and the processes relating to appointeeship.

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.