Independent investigation into the care and treatment of Ms H

Case 8

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 baby on 28 March 2002. The baby's mother, Ms H was subsequently arrested and convicted as the perpetrator of this offence.

Ms H received care and treatment for her mental health condition from the South London and Maudsley NHS Trust (the Trust) now the South London and Maudsley NHS Foundation Trust. It is the care and treatment that Ms H 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 Baby H. 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 review was thorough and run jointly between the South London and the Maudsley NHS Trust and the London Borough of Lewisham. It worked to appropriate written terms of reference with a large and representative panel, using a clear methodology.

The overall internal investigation report was full, clear and comprehensive. Its recommendations were appropriate and to a large extent mirror those of this Independent Investigation.

In undertaking our Independent Investigation we were mindful of the recommendations of the internal investigation, and therefore limited ourselves to the six key recommendations.

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 themes for this case were child protection and the Care Programme Approach (CPA).

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 i.e. Child protection, Care Programme Approach, management organisation and delivery of adult mental health services (including CPA and Risk Assessment). The investigation will be undertaken by a team of two or three people with expert advice. 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 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 three investigators 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

Ms H is an Eritrean lady who came to England in 1994 aged 20. It is reported that she was a child soldier from the age of 12 to 18. None of her 5 siblings or parents lived in the UK. She married in 1994 and separated from her husband in 1998 after allegations of domestic violence. She was living in a homelessness hostel in Lewisham and became known to the Mental Health Services in Lewisham on 15th February 1999 when she was admitted to Ladywell Unit under the provisions of Mental Health Act 1983. It is reported that for 10 days prior to her admission, she was distressed and accused another resident of being "the devil". She was convinced that one resident was her mother and that another was calling evil on her. On admission she was psychotic, sexually disinhibited, physically aggressive, assaulted 2 patients and a member of staff. She reported hearing the Devil's voice and that the TV talked to her. She was therefore referred to the psychiatric intensive care unit. In a CPA meeting on 17.05.1999, she was diagnosed to be suffering from schizophrenia or crack cocaine psychosis and placed on Level 2 (enhanced) CPA.

Following discharge from hospital she was monitored by the local (Speedwell) Community Mental Health Team (CMHT) based at Speedwell Health Centre and was seen on a monthly basis and her depot injections (Piportil) was administered. She was not completely compliant with medication and often refused her monthly depot injection. In October 1999 Olanzapine was prescribed

and the depot injections were stopped. She became pregnant with her son who was born on 2nd September 2000. The baby's condition at birth was stated as good.

On 25th September 2000, Ms H took her son to the GP in Brixton as he was very ill after a ritual circumcision. She was referred urgently by the GP to the Accident & Emergency Department at St Thomas' Hospital. On arrival the child was seen by the paediatric Senior Registrar who found that there was a degree of shock. He was given treatment and transferred to Great Ormond Street Hospital. Following treatment, the baby was discharged home the next day with a follow up appointment in 6 weeks time. A CPA meeting was held on 29th September 2000 attended by CPN and Consultant Psychiatrist. Ms H was well and there was no evidence of depression or psychosis and Ms H seemed to be caring for her baby well. At this meeting Ms H did not tell the professionals of the difficulties following the circumcision.

Ms H continued to be seen monthly by her Community Psychiatric Nurse (CPN). On 21st January 2001 it was reported that at a CPN home visit Ms H complained of low mood, sleep problems and was hearing traditional music outside her ears. Again at a CPA meeting on 27th February 2001 attended by the CPN and the Specialist Registrar psychiatrist. Ms H reported that she had seen a vision of an animal in her room and had had a recurrence of auditory hallucinations. She was prescribed a low dose of Haloperidol.

Ms H was offered permanent housing in Sydenham and moved there on 11th June 2001. She complained to the CPN that she had seen a man or shadow in her room. Her Haloperidol was increased. Throughout June there are reports of Ms H continuing to see visions and that she had once had vacated her flat in a panic as a result of seeing someone in there. She reported feeling sad and tearful and felt 'stressed out' by her baby and in need of some space for herself.

Her psychiatrist saw her on 5th July 2001. Ms H was found to be more depressed than usual and drinking up to 2 bottles of wine 2 to 3 times a week. An antidepressant was prescribed. A referral went from the CPN to the health visitor service for support and a possible nursery placement for her son who was now 10 months old. During another visit by the CPN in July it was noted that her mood was low and that she heard strange noises after drinking alcohol. An application was made for her son to be placed with a child minder in July 2001. This was finally organized by the Early Years Service in February 2002.

In December 2001 Speedwell CMHT noted that Ms H was low in mood and she admitted to drinking a lot and feeling frightened on her own. On 21st January 2002 Ms H requested an urgent visit from her CPN saying she was feeling very paranoid and was unable to leave the house and felt surrounded by evil. She was visited by her CPN. Afterwards Ms H made an emergency appointment with the GP for medication and assessment but she failed to attend. Ms H failed to

attend numerous appointments either for herself or her son throughout February and March.

On 28th March 2002 Ms H failed to attend a church meeting. When members of the church visited her in her flat, they found the baby lying on the ground outside. The emergency services were called, but the child was found to be dead on arrival at hospital.

Ms H's son received routine immunization and developmental checks and except for the fact that his mother found it difficult to cope with him during the latter part of his life, the professionals involved in both case found that he was well, happy and cared for. He did however miss three appointments for scans relating to urinary tract infection investigations.

6. Findings

The Investigation Team identified the following care and service delivery problems:

6.1 Ms H's traumatic childhood background and its impact on her current mental health problems or parenting abilities was not investigated in detail

Clinicians were aware of the importance of Ms H's cultural background including her traumatic experiences as a child soldier and her religious beliefs. However they did not investigate in detail the impact of these experiences on her mental health problems, presentations and behaviour. This point would have also helped in assessing her parental ability had it been explored in detail.

Ms H's shift in religiosity from the beginning of her contact with the services and the time immediately prior to the murder of her child was not picked up

Ms H came from a specific African culture and had her own religious belief systems. Towards the end of 2001/beginning of 2002 she became more involved with her church and often described her religious views to her carers.

Ms H herself was a complex person due to her cultural and religious background and her traumatic later childhood as a child soldier. This combined with her being a single mother with mental health and substance misuse difficulties and her limited engagement with services was identified as the main contributory factor.

6.2 Communication between Child Health and Mental Health Services was poor

Ms H presented as very intelligent and capable. She was not straight forward or totally honest with the professionals caring for her, and at times deliberately

omitted significant information. In these circumstances the Team were sometimes not aware of the full situation, particularly regarding her child care abilities.

It appears that there was an assumption in both Child Health Services and Mental Health Services that their respective concerns been addressed by the other service. From the evidence we were given during our interviews, we were informed that had the Mental Health Services known about the circumcision they would have had more concerns about Ms H's parenting ability and would have put more pressure on the Children and Families Service to intervene.

The lack of meaningful and child-oriented communication between the CMHT and the Children and Families Department meant that child protection issues were never really to the forefront of the CMHT's thinking. This meant that their requests for child minding and nursery placements were not deemed urgent.

6.3 Patient was not always fully compliant with medication plan

Soon after her discharge from hospital Ms H decided to come off depot injections. She was prescribed oral antipsychotic medication which she took for a while but then stopped taking them. She remained well for a long period without any medication. The CMHT kept a close eye on her mental health and her functioning.

The emphasis on antipsychotic and antidepressant medication which was prescribed for her was not strong enough and there does not appear that the team itself was convinced of the importance of Ms H taking medication. The Team knew that she was not compliant with medication, yet they did prescribe a small dose of antipsychotic medication, Haloperidol and then her lack of response was not addressed and there does not appear to have been any significant attempt to persuade her to take medication including antidepressants. The Team appeared not to be concerned when Ms H did not collect prescriptions for her psychiatric medication from her GP.

Non compliance with medication despite deterioration of the mental state was not addressed through the arrangement of a Mental Health Act Assessment. There was documented evidence that Ms H's mental state was deteriorating and that she was becoming more psychotic and yet there was no mention of consideration of other possible interventions such as the use of a Section of the Mental Health Act 1983.

Historical evidence of rapid deterioration of mental health and behaviour were not taken into consideration in taking a more proactive approach in medication management. With the benefit of hindsight it is clear that this deterioration was not observed by those working with Ms H.

6.4 Patient difficult to engage at times

Ms H was being quite difficult to engage with at times. She gave the impression that if it suited her, she would have contact and that she used the Mental Health Services more as a resource to obtain things that she wanted rather than as support for helping her manage her mental health issues. She was prepared to discuss how she felt but not willing to engage in any type of therapeutic work, and there were a high number of cancelled appointments and not being at home when visits had been arranged.

6.5 No CPA meeting for 14 months

CPA meetings were held in September 2000 and in February 2001 but there were no further meetings before the incident in April 2002. The long gap from the last CPA is a particular concern. Mental Health Services were waiting for a transfer to another team due to Ms H having changed her address and moved to another area. It was also during this period that Ms H's mental health deteriorated as did concern over her coping with her son. The clear deterioration in Ms H's mental state and behaviour in early 2002 and leading up to the death of her son clearly warranted a call for a CPA meeting and perhaps re-assessment of her urgent transfer to her locality CMHT despite their staffing problems.

It was, to say the least, unfortunate that during the period when Ms H's mental health was deteriorating her care was shared between 2 different Mental Health Teams. Whilst CPN 3 undertook home visits, any organisation of appointments to see a psychiatrist and other administrative matters were dealt with by CPN 2. It would appear that this arrangement meant that any childcare needs were not addressed and indeed Ms H did not want to be referred for family support. This is within the context of Ms H's mental health clearly deteriorating but CPN 2 was not sure she was psychotic or whether her descriptions of her church and her involvement with it were mainly cultural.

The lack of compliance with the Care Programme Approach procedures meant Ms H was not formally reviewed and assessed as frequently as she should have been, and other professionals from relevant agencies were not included in the CPA meetings. The transfer of care from the Speedwell CMHT to the Northover CMHT was confused with the care shared between the teams contributing to further communication problems.

6.6 Failure to recognise Ms H's deterioration which mirrored her relapse signature as described in the Risk Assessment

This combined with her history of non compliance with medication should have triggered consideration of an assessment under the Mental Health Act 1983.

7. Notable practice

Whilst there were failings in some processes and in communication between agencies, the overall handling of Ms H and her baby did have some notable good practice. These included:-

- The initial involvement of Mental Health Services in 1999 and the level of care whilst Ms H was an inpatient and the initial follow up services by the community mental health services.

- Ms H was referred to the addiction services immediately after discharge from hospital and her subsequent prompt assessment by the addiction services.

- CPN2 remaining involved with Ms H despite the difficulties in distance following Ms H's move to Sydenham (although this was also a failing in the formal transfer arrangements) but allowed the CPN to maintain a good relationship with Ms H.

- The referral of the child to the Children and Families Department for day nursery and general support (but this lacked any mention of the potential child protection issues and parenting skills).

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

The Trust has shown evidence that they:

- Actively tried to recruit staff;
- Reviewed CPA process and policies and developed new ones;
- Developed new policies regarding transfer of patients between sectors/ boroughs;
- Developed policies and protocols to manage patients with young children;
- Have in place new policies and protocols.

9. Recommendations

It is considered that there was no single root cause responsible for the death of the child. Numerous factors both independently and jointly contributed to his death. In short there were systematic failures of communication and process across agencies.

1. A full history should be compiled by clinicians and be verified from reliable third party sources.

2. There should be well publicised mechanisms for services to sharing information – it is understood that there is now a formal system called LISA which was spoken highly of by the interviewees.

3. It is vital that CPA is carried out in line with national and local requirements and that these are reflected in policies. Each CPA meeting should identify and address the specific needs of the individual patient. An audit of CPA compliance should be undertaken each year by the Trust.

4. The Trust should regularly audit the compliance of mental health services in following the Policy for The Care Programme Approach, and taking the requisite action should the audit demonstrate failures in practice.

5. The CPA Policy must be followed to the letter and be audited as detailed in Recommendation 4 above.

6. In all circumstances there should be only one care co-ordinator and one CMHT involved in a patient's care – either the current one or the new one but not both at the same time.

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.