Independent investigation into the care and treatment of Ms M

Case 13

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 gentleman known to her on the 22nd August 2004. Ms M was subsequently arrested and convicted as the perpetrator of this offence.

Ms M received care and treatment for her mental health condition from the North East London Mental Health Trust (the Trust) now a Foundation Trust. It is the care and treatment that Ms M received from this organization 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 commissioned an internal investigation team into the care and management of Ms M following the aforementioned homicide in line with the Trust's Serious Untoward Incident policy. The report of this Internal Investigation Team was completed in November 2006.

The terms of reference of the internal investigation team included examining the quality and scope of Ms M's health and social care and any assessment of risk undertaken, and examining the appropriateness, quality and adequacy of any assessment, care plan, treatment or supervision provided to Ms M.

Following reviewing documentary evidence and interviewing several members of staff involved in the care of Ms M the internal investigation team found no evidence of serious failures of care and identified no evidence to indicate that the actions or omissions of mental health services had led to Ms M committing the homicide. A number of issues surrounding the practice arrangements in place at the time of the incident were identified.

The internal investigation team concluded that the care and treatment provided to Ms M was well delivered. The Intensive Care Management Team (ICMT) had been the main provider of such care. The panel noted the considerable efforts made by the ICMT to engage Ms M and help her with her various social difficulties, including housing. The panel also noted the responsive and flexible approach adopted by the team to meet Ms M's needs, including at times crisis.

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 C Independent Investigation. A Type C Independent Investigation is a narrowly focused Investigation conducted by a a single investigator that examines an identified aspect of an individual's care and treatment that requires in depth scrutiny. The particular theme for this case was, drugs and alcohol issues at the North East London Mental Health 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. The investigation will be undertaken by a single investigator with peer support. 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 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

Ms M is a forty two year old single Caucasian woman who in July 2004 assaulted a male friend. At the time of the incident Ms M was thirty-six years old. The victim died approximately one month later as a result of the injuries he had sustained. Ms M was subsequently convicted of manslaughter in relation to this assault following initially being charged with murder.

At the time of the incident community mental health services in Dagenham were attempting to re-engage Ms M following her case being re-referred to services earlier in the year whilst she was a prisoner in HMP Holloway. Ms M was initially referred to community mental health services in August 2002 by her

GP who requested that she be seen for counseling as she had been suffering from anxiety and stress for a number of months. She was then managed by the Dagenham Community Mental Health Team before being referred to the Intensive Care Management Team. She was eventually discharged from that Team's caseload in September 2003. At the time of the homicide she had been re-referred to community mental health services following release from prison.

During the evening of 16th July 2004 she visited the home of a male friend. During the course of the evening it is documented that both parties consumed a significant amount of alcohol. It would appear that Ms M became intoxicated as a result. At some point during the evening Ms M and the victim argued. The victim then left his home and visited a local public house where he consumed further alcohol. On his return Ms M is reported as having been abusive towards him and to have thrown hot tea in his face. Ms M was then observed by the victim's parents head butting their son before kicking him in the face whilst wearing stiletto heeled boots. The victim attempted to crawl out of the room but was pursued by Ms M who continued to kick and stamp on him.

Following the assault, the victim did not call an ambulance and appears to have underestimated the severity of the injuries he had sustained. He subsequently consulted his general practitioner in Dagenham who recommended that a wound near his eye required sutures. Assessment later revealed that the victim's right orbit was fractured and a splinter of bone had entered his brain. He underwent neurosurgery at Old Church Hospital and was discharged on 22nd July. He subsequently developed orbital cellulitis and on 17th August was referred to the Queen's Square Hospital for Neurology. A CT scan of his brain then revealed the presence of a cerebral abscess. Following further neurosurgery he was placed on a life support machine. On 22nd August life support was terminated and he was pronounced dead. The victim was thirty-eight years old and appears to have been a friend of Ms M for a number of years.

Ms M was initially arrested on 20th July 2004 when she gave a 'no comment' interview in the presence of an appropriate adult. She was initially charged with assault occasioning actual bodily harm. However, following the victim's death this was changed to a charge of murder. Ms M subsequently pleaded guilty to a charge of manslaughter. However, it is unclear from the records available as to what grounds there were for this.

Ms M expressed considerable remorse for her actions that led to the death of her friend in 2004. She adamantly denied having had any intention of causing him serious harm. Instead she stated that her actions were precipitated by the victim's behaviour towards her. She believed that she was about to be assaulted by him and this triggered memories of the rape she reported in 2000. She continues to fear being attacked, and as such sleeps with a baseball bat beside her bed.

Ms M has expressed dissatisfaction regarding the help she received from community mental health services both prior to the events of July 2004 and since her release from custody in February 2008. She has compared such support particularly unfavorably with that she received whilst in custody and described that whilst in prison, following being convicted of manslaughter, she was diagnosed as suffering from a form of epilepsy and also prescribed antipsychotic medication in the form of Chlorpromazine.

6. Findings

A detailed review of the case notes relating to Ms M's contact with community mental health services has revealed a number of care and service delivery problems.

6.1 Clinical Assessment

Ms M did not undergo a comprehensive psychiatric assessment and at no time was her history formulated and a formal diagnosis made. Instead it would appear that she acquired the diagnosis of personality disorder. This was largely based on her presentation and behaviour without the benefit of a comprehensive review of her past history. It is impossible to effectively address an individual's mental health needs without a full psychiatric evaluation and mental state examination.

Communication between community mental health services and Ms M's general practitioner was generally poor throughout the period she was managed by mental health services.

A detailed history was not completed in order to corroborate a patient's account. This is particularly important in cases where there is diagnostic uncertainty and where reported symptoms are intrinsically linked to apparent adverse life events.

6.2 Risk Assessment

In line with the failure to implement the Care Programme Approach the records indicate that a comprehensive risk assessment was never undertaken.

6.3 Care Delivery/CPA

The failure to implement the Care Programme Approach is likely to have contributed to the communication difficulties in this case and the problems co-ordinating Ms M's follow up in the community. The chaotic nature of Ms M's lifestyle was such that she would have benefited from a structured approach to managing her mental health difficulties, effective

implementation of the enhanced Care Programme Approach is likely to have helped provide such structure.

7. Notable practice

Considerable efforts were however, made by the intensive care management team to engage Ms M and it would appear that the team adopted a flexible approach in their dealings with Ms M in order to achieve this. It is noted further that the team typically responded promptly to Ms M presenting at times of crisis.

8. Recommendations

This Independent Investigation into the care and treatment of Ms M provided by the Trust has replicated many of the essential findings of the Verita/Capsticks review.

In particular it has highlighted that the initial assessment undertaken by the Dagenham CMHT of Ms M was inadequate. Her complex mental health difficulties required a detailed evaluation to be undertaken by an experienced psychiatrist in order to clarify her exact diagnosis and identify her ongoing treatment needs. No such evaluation took place following the initial screening assessment performed by a trainee psychologist.

The initial failure to comprehensively assess Ms M resulted in ineffective care planning and a failure to effectively address her mental health difficulties. Such problems were then exacerbated by a failure to manage Ms M according to the Care Programme Approach or to carry out a detailed risk assessment and thus implement a risk management plan. Such service delivery failures were further compounded by poor interagency communication both between Trust teams and Primary Care Services.

The Independent Investigation Team disputes the internal investigations finding that the care and treatment provided to Ms M was well delivered and that there is no evidence of serious failures of care. It is the opinion of the Investigation Team that there was a failure of the Trust to adequately assess and treat Ms M and that this is likely to have been a direct contributory factor to the incident.

It is therefore recommended that:

1. All referrals to CMHT services to be assessed by an experienced and registered mental health professional and when necessary are seen by a psychiatrist in order to confirm the service user's diagnosis and ongoing treatment needs. All services users presenting with complex needs should be seen by a consultant psychiatrist within two weeks of referral.

2. A comprehensive report is documented following all initial assessments by CMHTs. This should include the service user's differential diagnosis and an initial risk assessment. A copy of the report should be circulated to all relevant parties, including the referrer.

3. All patients on the caseload of CMHTs should be managed according to the Care Programme Approach.

4. A comprehensive risk assessment should be undertaken in the case of all service users being managed by CMHTs prior to their first Care Programme Approach meeting and the findings of this should inform the risk assessment plan. The risk assessment should use an evidence based and a reliable methodology. The assessment of risk should be dynamic and be reviewed on a regular basis including, in the event, of either a change in the service user's circumstances or any further information coming to light, for example details of the service user's offending history.

5. A copy of the risk assessment should be circulated to all relevant parties, including the service user's general practitioner.

6. Any significant changes in a service user's care plan should be communicated to all relevant parties involved in his/her care including the relevant general practitioner.

7. In the event of a service user who has been managed according to the Care Programme Approach being incarcerated all attempts should be made to facilitate a Care Programme Approach meeting prior to his/her release.

8. Service users with significant histories of offending and/or violent behavior should be referred to forensic psychiatry services in order to obtain advice regarding risk assessment and management

9. All internal investigation reports should be completed within 60 days of the incident occurring and root cause analysis or an appropriate alternative methodology used.

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.