Independent investigation into the care and treatment of Mr N

Case 14

Commissioned by NHS London

NHS London

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Executive Summary

1. Introduction to the incident

This Independent Investigation was asked to examine a set of circumstances associated with the death of a member of public, Mr X, on the 23rd April 2004. Mr N was subsequently arrested and convicted as the perpetrator of this offence.

Mr N received care and treatment for his mental health condition from the North East London Mental Health Trust (the Trust) now a Foundation Trust. It is the care and treatment that Mr N 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

Following the incident the Trust set up an internal investigation. The internal investigation was led by a single investigator from within the Trust.

The Trust did not liaise with either the victim or perpetrator families.

The report from this investigation did not contain Terms of Reference but stated that the purpose of the investigation was to examine the evidence and make recommendations.

While the recommendations recognise that there were gaps in the care given to Mr N, the report does not consider the potential impact that the failures in Mr N's care could have had nor does it comment on how his care could have been managed differently

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 single investigator, supported by a peer reviewer, that examines an identified aspect of an individual's care and treatment that requires in depth scrutiny. The particular theme for this case was homelessness, 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 the services involved i.e. homelessness, drugs and alcohol. This type of Investigation is conducted by a single investigator supported by a peer reviewer, with access to expert advice as necessary.

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'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, 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 peer reviewers and quality assurance provided by the Health Advisory Social Care Advisory Service as required

4.5 Independent Investigation start date

The Independent Investigation started its work in October 2007.

5. Summary of the incident

Mr N, at the time of the incident, was a 34 year old white male who had had very limited contact with mental health services in the 2 years prior to the offence.

Very little information was available in regard to Mr N's history. It was known that he had a tendency to get into fights. He had been released from prison in 2001 having served a 10 year prison sentence for armed robbery. He was not followed up by the probation service on his release from prison and there was no information available regarding his mental state in prison.

Mr N had a long history of being in care and reported suffering from both physical and sexual abuse. His brother had committed suicide but there is no record of when this occurred. It was recorded that he had limited contact with his family. It was recorded that there was also a possible history of head injuries which might lead him to be vulnerable to violence and aggression in adulthood.

Mr N's first contact with the local mental health services was in July 2002 when his GP referred him to the Community Mental Health Team (CMHT) for an assessment. The Community Psychiatric Nurse (CPN) assessing him recorded that he had poor sleep, poor appetite and low mood. The CMHT records note that he was mostly concerned with problems associated with his flat. He was referred for psychotherapy. Several further CMHT appointments were offered but Mr N failed to attend these and his case was closed by the Mental Health Duty team in February 2003.

In January 2003 the CMHT were informed by a housing officer that Mr N had been involved in a serious assault resulting in him needing 41 stitches.

Mr N's next contact with mental health services was in January 2004 when he was referred by his GP as he was reported to be depressed, paranoid and having suicidal thoughts. Mr N was assessed and accepted for an informal admission to hospital on 9th January 2004. During the course of his admission, it was determined that Mr N did not have a major depressive or psychotic disorder. He was on no medication. It was considered that his difficulties were as a result of his substance misuse and social problems rather than any underlying mental illness.

Mr N left the ward on 12th January 2004 and was reported as a missing person. When he failed to return he was discharged in his absence on 13th January 2004. The discharge plan stated that Mr N required no further follow up on the grounds of the absence of mental illness. However on the day of his discharge, the Ward did make contact with the CMHT and asked the team to follow him up in the community for a substance misuse screen.

6. Findings

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

- **Quality of clinical documentation**
  Whilst the clinical notes state that this individual had no major mental illness the clinical documents do not record why this clinical view was held. This level of practice leaves the service user, the health care professional and the Trust vulnerable.

- **Quality of Clinical Assessment**
  Mr N was a vulnerable individual who found it very difficult to cope. It is the conclusion of the Independent Investigation that an individual with Mr N's background and diagnosis should have received a comprehensive clinical assessment.

- **Clinical Management/CPA**

It is the view of the Independent Investigation that there was a failure to manage this case effectively, by not allocating a named worker as care co-ordinator.

7. Notable practice

No areas of notable practice were found.

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

The role of this Independent Investigation was to review the Trust's internal investigation and assess its findings and recommendations and the progress made in their implementation. This included an evaluation of the internal investigation Action Plan.

The quality of the internal investigation was considered to be poor when reviewed by the Independent Team. The information available to the internal investigator appeared to have been incomplete. No conclusions were drawn in such a way to ensure that meaningful recommendations were developed. The recommendations did not lend themselves to an action plan that could be implemented in an operational service context.

As the action plan is based on the recommendations from the initial review these are very process focused but do not address the wider issue of how the Trust could manage the care of someone who does not have a diagnosable mental illness and whose primary problem is substance misuse but nonetheless is quite vulnerable and has a number of risk factors

A review of the action plan which appears to have taken place around December 2005 indicated that many actions have been completed. There is no evidence of further review.

9. Recommendations

While there are lessons to be learnt from this tragic case it is clear that Mr N was not suffering from a major mental health problem and it is unlikely that secondary mental health services could have predicted or prevented this tragic event.

The Investigation Team found that there were areas that the Trust could improve. The following recommendations are made:

1. It is recommended that the Trust review its Internal Investigation procedures against its latest SUI policy to ensure that it is meeting the standards that have been set, including ensuring that staff undertaking investigations have been trained in Root Cause Analysis.

2. It is recommended that the Trust set minimum standards for completing Clinical Assessments and audit these on a regular basis.

3. It is recommended that an audit should take place to ensure that the Trust's record keeping is of an acceptable standard that meets both local and national guidance.

4. It is recommended that all staff should receive training in case management and that this should be audited in line with CPA and other local and national guidance.

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.