Independent investigation into the care and treatment of Mr J

Case 10

Commissioned by NHS London

NHS London

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Executive Summary

1. Introduction to the incident

This Investigation was asked to examine the circumstances associated with the homicide of a member of the public and the attempted homicide of another on Saturday 11 November 2006. Mr J was subsequently arrested and was convicted as the perpetrator of these offences on the 29 January 2007.

Mr J 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 J 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 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 an internal review was undertaken by the Trust which produced a report "Root Cause Analysis on Mr J". The report is dated 17 July 2007.

The Internal Investigation Team consisted of the two members, a consultant psychiatrist and an Assertive Outreach Team Manager.

The Terms of Reference are not explicitly outlined in the Trust's Root Cause Analysis report. The internal review team note that they had been asked to complete a Root Cause Analysis review on Mr J following an incident that occurred on Saturday 11th November 2006. The review focused on this one incident involving Mr J.

The review took the form of a narrative chronology. There is a brief summary with conclusions which makes note of some care delivery problems. An examination of contributory factors is not evident from the report.

The internal review report provided by the Trust does not indicate whether their team approached Mr J's family, or the victims' family with regard to participating in the investigation. It does not appear from the report that there was any input from relatives, carers or victims. The internal review report also does not make reference to whether or not staff had support available to them after the incident.

The Investigation Team felt that the internal review report was of value to some extent but left room for improvement. There were a number of areas that the internal investigation did not address as outlined previously. These included:

- the consideration of contributory factors;
- the inclusion of family and carers (or reasons for not including the family/carers);
- input from Mr J himself;
- the issue of staff support and,
- the process for ensuring that the recommendations made would be considered and moved forward.

We also felt that a number of the recommendations made 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 some of the issues raised could not be potential issues elsewhere within the Trust.

4. Commissioner, Terms of Reference and Approach

This particular case was subject to an independent audit to ascertain its suitability for independent review. The audit results confirmed 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 the management, organisation and delivery of mental health and social care services at the 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 a single person. 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 Trust's 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 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

On the 11th November 2006 Mr J went to a pub in Kilburn. It was reported that he left the pub and then tried to return but was not allowed to re-enter. He left again and went home where he prepared some food, using a knife. He then returned to the pub with the knife, stabbing one security officer, in the chest causing death. Mr J stabbed a second security officer twice in the face with the knife. The wounded officer was transferred to St Mary's Hospital for treatment and survived the attack.

Mr J did not know either victim prior to the incident. He was subsequently convicted of one count of manslaughter and one count of attempted manslaughter. Mr J was aged 51 years at the time of the incident.

Mr J was diagnosed with schizophrenia in 1973 and received treatment for his mental health problems from Central and North West London Mental Health NHS Trust. Over the following ten years he had a number of admissions to hospital, some of which included detention under the Mental Health Act 1983. His earlier presentation was characterised by aggression and threats of violence when he was psychotic, issues regarding compliance with medication and partial insight into his illness.

He improved markedly while on regular injections of antipsychotic medication and remained stable in the community for years, including being able to hold down part-time employment for some time in the 1980's.

In 1997 / 1998 he was given a trial on oral rather than an injectable antipsychotic medication but it was noted in March 1998 that he hadn't improved on two different medications and depot (injectable) medication was recommenced. He remained mentally well and on depot medication from that time until 2005 when, after discussion with Dr1 his depot was stopped again and he was given oral medication. He continued to be seen primarily as an outpatient in 2005-2006 by Dr1, who had known him over a number of years, and Brent Community Mental Health Trust (CMHT), until Dr1 left Brent in September 2006. Before he left Dr1 reviewed Mr J and noted that he was relapsing with evidence of some paranoid ideas and sleep disturbance. His medication was increased to Quetiepine 450mg. There is no indication as to whether or not re-commencing depot was considered at this time. Mr J's care was transferred to Paddington CMHT in October 2006. The change from depot to oral medication in 2005 is therefore significant to this case.

6. Findings

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

6.1 Care Planning

Mr J was on Standard level CPA and as such did not have any formal CPA documentation on file. Dr1 did write regularly to Mr J's GP to keep him updated on Mr J's progress when he was reviewed. Dr1 was Mr J's care co-ordinator and therefore primarily responsible for Mr J's care. When Dr1 left the Brent CMHT this role was not clearly re-assigned to another individual.

There was no evidence found of a regular formal 'needs assessment' having been conducted as required by the CPA Policy.

The Paddington CMHT did initiate a formal risk assessment document but this contained very little information and was not completed in conjunction with Mr J.

The issue of what constitutes an "open case" needs clarification. If a service user is on Standard CPA and is being seen by a member of the team, in this case the consultant on an out-patient clinic basis, this contact should be regarded as being a responsibility of the catchment area team.

6.2 Transfer of Care

In the Investigation Team's opinion there was a failure to fully implement the Trust's 'Transfer of Care' policy:

a. Mr J was not involved in the decision to transfer his care to another team, he was simply informed that it was happening;
b. There were no CPA arrangements in place to meet Mr J's needs. There was no written risk assessment document, assessment of needs, care plan, etc available on Mr J at the time of his referral to Paddington, nor was there a comprehensive clinical / medical summary. The transfer letter did not mention the fact that Mr J's mental state had relapsed, although this information was contained in the accompanying clinical letters;
c. No lead figure who took responsibility for Mr J's case was identifiable at the time of the incident, contributed to by the fact that the consultant psychiatrist who had known him for a number of years left the team without providing a formal handover or risk assessment.
d. The transferring team did not retain responsibility for Mr J until future care was agreed.

As a result Mr J's care fell between services.

6.3 Transfer of a service user in relapse

Dr 1 had left Brent and his leaving brought with it the necessity to transfer Mr J to a new consultant. In order to avoid a further disruption later on, it was felt to be appropriate to transfer Mr J to a consultant within his catchment area (Paddington), even though he was unwell.

Local policy does not expressly address this issue. In the Investigating Team's opinion service users should not be transferred between teams when their mental state is in relapse.

6.4 Medication and follow-up

Mr J was treated successfully in the community on depot antipsychotic medication for many years. He had had an unsuccessful trial on oral medication in the 1990's and in a clinic letter in 1998 Dr1 wrote that Mr J should stay on his depot indefinitely. It is unfortunate that Mr J's mental state relapsed at a time when Dr1 was leaving the service, as Dr1 had known Mr J on and off for a number of years.

There was confusion about follow up arrangements which proved to be a barrier to Mr J's transfer to another team.

6.5 Communication

There were a number of phone calls between Paddington and Brent teams, none of those staff knew Mr J very well. A conversation between Dr1 and his counterpart before he left the service may have heightened awareness of Mr J's needs and allowed appropriate intervention early, particularly as Mr J was going to need a mental state and medication review.

The medical review in early November 2006 is viewed by the Investigation Team as a lost opportunity to treat Mr J's psychosis.

6.6 Availability of Clinical Information and Risk Assessment

The limited amount of clinical information available to the teams appears to have been a reason that impeded Mr J's smooth transfer between services. There appeared to be a reluctance to accept Mr J without full information. While this may be an admirable aim in terms of ensuring that teams have complete information on any new service user, a more flexible approach to patient care is needed which is led by the patient's needs.

Many independent inquiries in the past have highlighted the issue that risk information was not available to services, thus compromising the quality of risk assessments made.

While it was emphasised that Mr J was settled for many years in the community, much of this due to him being on and responding well to depot medication. The presence / knowledge of this background information on his presentation when psychotic may have influenced clinicians thinking about Mr J's presentation on this occasion in relapse.

6.7 Response to Information received on 10 November 2006

On the 10th November 2006, Brent CMHT received information from a member of the public to say that Mr J had been observed acting aggressively in the street.

It is unclear to us why a member of the CMHT did not make arrangements to follow up this report by checking on Mr J's well being, particularly as it was known that Mr J had a diagnosis of schizophrenia and he was known to be mentally unwell.

7. Notable practice

Dr 1 maintained good communication with Mr J's GP throughout the time that he was being seen in outpatients. The investigation team noted that there were a number of letters to the GP outlining Mr J's progress and any changes to his medication.

At the point where Mr J first raised concerns with a social worker (SW1) about rent and council tax arrears, SW1 acted promptly by contacting Westminster Housing Department. During the interview, SW1 stated clearly his commitment to the resolution of Mr J's housing problems.

Although ultimately it proved problematic in Mr J's case, the fact that Paddington CMHT will not accept service users without a reasonable case history, if they have been in contact with services previously, was seen as good practice. It is recognised that ensuring that as much information as possible is passed over to the accepting team would serve to facilitate continuity of care.

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

At this time we are still unclear about the progress of the Trust in implementing the action plans agreed. In our view many of the issues described require a fundamental shift in thinking and practice. We have not seen the e-mails referred to in the action points but wonder if they have considered and cascaded to staff the rationale for their actions.

At the core of this case is the need for one person to take responsibility for a patient, that person being easily identifiable, focused on having a holistic view of that patients needs and ensuring they are addressed. That person should be the care co-ordinator.

The Investigation Team was assured that the recommendations of the Internal Review were completed by the end of July 2007. For Brent recommendations 1-3 were signed off by the Head of the Mental Health Service on 22 July 2007 with the comment that they were completed and that training was in place.

For Westminster the two recommendations were signed off as completed by the Head of Service on 30 July 2007.

9. Recommendations

The Independent Investigation Team conclude that there was no root cause evident in the case of Mr J. However a considerable number of care and service delivery problems as well as contributory factors were identified which give cause for concern regarding the overall care and treatment of Mr J by the mental health services.

We are aware that much work has been undertaken and some is ongoing by the Trust to remedy this situation and we are confident that lessons have been learned. In light of these conclusions we would recommend that the 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.

1. The Trust should as a matter of urgency commission a piece of work to look at possible gaps in governance around the management of service users being seen in outpatients alone.

2. The Trust should ensure that it regularly audits the implementation of the CPA policy. The auditing process should account for the quality of information available as well as quantitative measures.

3. The Trust should review its teaching and training relating to CPA to ensure that all staff have a clear understanding of the purpose of CPA, and their roles and responsibilities within the CPA framework.

4. The Trust must have procedures in place to guarantee staff have easy access to all service user files which have relevant background information included in a consistent and easy to find format.

5. The Trust should ensure that all staff are aware of the importance of service user involvement and the inclusion agenda. This is particularly the case when carrying out a needs assessment and formulating a care plan. Mandatory training should be provided on this.

6. The Trust should examine its systems for risk assessment and risk recording to ensure that staff have easy access to comprehensive information at any time. This process should be regularly audited. Again mandatory training should be provided on this.

7. The Trust should review their Patient Transfer policy. We would recommend that in such circumstances patients should not be transferred when in relapse unless absolutely essential, and that handover of care should be evidenced by care co-ordinators.

8. We recommend that the lessons learned from this investigation should be disseminated to all staff and put together into an action plan for implementation.

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.