Independent investigation into the care and treatment of Ms S and Mr T

Case 19

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 member of public on the 26th January 2005. Ms S and Mr T were subsequently arrested and convicted as the perpetrators of this offence receiving prison sentences of 14 and 16 years respectively.

Ms S and Mr T received care and treatment for their 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 T and Ms S 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 review to examine the care and treatment received by Ms S and Mr T prior to the homicide. The purpose of this was to learn any lessons and act on any identified shortcomings within the service.

The internal review was conducted by a multi-agency panel consisting of a non-executive director of the Trust, the medical director of the Trust, the interim director of nursing of the Trust, and an external lead nurse for professional development and innovation. The panel was chaired by a non-executive director of the North East London Mental Health Trust. The panel completed their report in November 2006.

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 the management, organization and delivery of mental health 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 care and treatment of the individual or where a group of cases have been drawn together that particular theme and the services involved. 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:

- Complete a chronology of the events to assist in the identification of any care and service delivery problems leading up to the incident
- Review relevant documents, which may include medical records (with written patient consent).
- 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.
- Conduct interviews with key staff including managers.
- Provide a written report utilising the agreed template, the report will include recommendations for future service improvements.

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 as required.

4.5 Independent Investigation start date

The Independent Investigation started its work in October 2007.

5. Summary of the incident

Ms S and Mr T were both patients of the Trust. They were convicted of murder in relation to a homicidal assault together with another co-defendant (not known to mental health services) that took place on 26th January 2005.

Ms S, at the time of the incident was 25 years old. She had had a disturbed childhood and it is reported that she was sexually abused by her father who also had an alcohol abuse problem. Most of her teenage years were spent in foster or care homes, at some times even sleeping rough. She has no contact with her mother and limited contact with her father and stepmother.

Mr T was 24 years old at the time of the incident. His parents separated when he was a teenager and he has two sisters and one brother but has no contact with any of his family. There is a reported history of both physical and sexual abuse from both parents and Mr T was taken into care aged 7 years. He has another daughter from a separate relationship as well as the three children by Ms S.

Ms S met Mr T when she was 15 years old and has had an 'on/off' relationship with him until the present time. It is reported that Mr T is the father of her three children, the first born when Ms S was 16 years old. All three children are in care.

From the information available, the homicide was unrelated to mental disorder. Consequently, it is believed there is little or nothing that could have been done by the Mental Health Services to avert this tragedy. It is important to state this clearly at the outset, and to hold it in mind when reading this report.

6. Findings

None of the difficulties identified below were thought by the Investigation Team to have contributed to the offence.

6.1 Assessment and Care Planning (CPA)

Mr T was a complicated patient and there is no evidence that the clinical team employed a clear assessment and care planning process. The team did not document their thinking about how to manage this case in a consistent manner. This was compounded by a lack of clinical management of the case which prevented appropriate identified follow through.

The Independent Investigation would observe that there appeared to be rather poor-quality clinical reasoning in Mr T's management. Some of this may reflect his highly chaotic and difficult presentation. Nonetheless, with the exception of Dr A at the Psychiatric Intensive Care Unit (PICU), there was little evidence of trying to obtain a history from Mr T and from collateral sources, to think about the nature of his problems, formulate a diagnosis and generate a thoughtful management plan.

6.2 Risk assessment and risk management

Risk assessment has to be applied thoughtfully, the Investigation Team acknowledges that drug and alcohol service are not the same as those of general adult psychiatry. Any new risk assessment tool that is introduced ought to be supported by an evidence-base. The current 'gold-standard' is the structured clinical judgement tool, the HCR-20. A first-rate risk assessment would not have added much in this case. Even if Mr T had been identified as being at high risk of committing violent assaults (as he actually was at points) there is little that could have been done to manage that risk given his primary diagnoses of drug dependence and dissocial personality disorder.

6.3 Communicating across agencies

The Trust has a policy and procedure regarding working with the police. The Investigation Team remains unclear as to how effective these policies are when implemented.

7. Notable practice

Ms S's key worker provided a sound standard of care and kept good, clear clinical records that evidenced good quality thinking about the management of the clinical case. Even though she was at times hard to engage, the key worker and the clinical team continued to work with her.

Dr A prepared an exemplary part 1 summary that was comprehensive and showed evidence that he sought collateral information.

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 Independent Investigation Team were of the view that the Trust's internal inquiry investigation and report was conducted appropriately and to a reasonable standard.

The Terms of Reference were appropriate and were addressed by the report.

The Panel was appropriately constituted, although it might usefully have included an external substance misuse specialist.

The methodology was clear and easy to follow. The recommendations less clearly followed from the analysis of the case, and this Investigation has highlighted these issues when relevant below.

The Trust's internal inquiry report makes a number of recommendations, most of which struck the Independent Investigation Team as being rather peripheral to the central difficulties of the case, but are nonetheless all largely reasonable.

9. Recommendations

It was the view of the Independent Investigation Team that the tragic homicidal assault that occurred on 26th January 2005 was neither predictable nor preventable by mental health services.

The Investigation Team make the following recommendations:

1. Regular and frequent clinical notes audit should be instituted, paying particular attention to the quality of the information recorded. For example, the presence or absence of part 1 admission summaries and CPA care

plans could be audited, together with an assessment of their quality (evidence of information collected from collateral sources, information available under every heading of a part 1 summary, evidence of a clinical formulation and synthesis of the case).

2. Clinical notes should be shared across clinical service areas.
3. Clinical risk assessment and management tools should be supported by an evidence-base and be validated for the clinical setting in which they are used.
4. Child Protection Case Conference procedures should be reviewed to ensure that there is a formal means of following-up plans made from one meeting to the next.
5. Robust arrangements for liaison with the local police need to be established, with clear policies and procedures for rapidly raising concerns. For example, the police's refusal to listen to Ms S's clinical team reporting that Mr T was in breach of his bail conditions ought to have been raised to a senior level with both the Trust and the police.
6. The Trust's Multi Agency Public Protection Agency arrangements should be reviewed with a view to involving senior clinical personnel.
7. Review of the interface between forensic and general adult mental health services within the Trust, with a view to establishing policies and procedures to quickly deal with difficulties at this interface.
8. Review of the interface between addiction and general adult mental health services within the Trust, with a view to establishing policies and procedures to quickly deal with difficulties at this interface.
9. The Trust's Dual Diagnosis Strategy is now complete and be should be implemented on a Trust wide basis with immediate effect. This Strategy must be audited six months from publication of this report and at six monthly intervals thereafter.

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.