Independent investigation into the care and treatment of Mr C

Case 4

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 the public on 2 July 2005. Mr C was subsequently arrested and convicted of manslaughter on the basis of diminished responsibility.

Mr C briefly received care and treatment from the then Oxleas NHS Trust (the Trust) now Oxleas NHS Foundation Trust, before the incident. It is the care and treatment that Mr C received from this organisation that is the subject of this investigation.

2. Condolences

The Investigation Team would like to extend their condolences to the victim's family and friends. The Investigation Team 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 investigation was coded as a Serious Untoward Incident and a full trust internal inquiry was undertaken. The internal inquiry had written terms of reference. It was chaired by the Director for Human Resources and Organisational Development, and involved multi-disciplinary team, including a Non-Executive Director of the Trust.

The Trust investigation used a modified version of root cause analysis and made a set of recommendations based on the evidence collected during the investigation.

4. Commissioner, Terms of Reference and Approach

This particular case was subject to an independent audit, carried out by Verita and Capsticks, 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 theme for this case was the application of the Care Programme Approach (CPA) by the Trust.

4.1 Commissioner

This Independent Investigation was commissioned by NHS London. The Investigation was 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 33-36 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. Safeguarding Children, Care Programme Approach (CPA), the organisation and delivery of adult mental health services (including CPA and Risk Assessment). The Investigation will be undertaken by a team of two to four people with expert advice. The work will include a review of the key issues identified and focus on learning lessons

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:
- Ascertain progress with implementing the Action Plans.
- Evaluate the Trust mechanisms for embedding the lessons learnt for each case.
- 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.

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 identifies 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 four investigators and expert advice provided by the Health and Social Care Advisory Service.

4.5 Independent Investigation start date

The Independent Investigation started its work in December 2007.

5. Summary of the incident

Mr C was in contact with mental health services for just over two months from 1st May 2005 to 5th July 2005.

Mr C's mother contacted her GP on 31st March 2005 as her son was not sleeping nor communicating with his family in the normal way. Mr C admitted he was taking cannabis and had been in trouble with the police. The GP referred Mr C, whom he had not known previously, to the local Community Mental Health Team (CMHT) with a request for urgent review. His referral was discussed within the CMHT. He was contacted by letter within ten days and given an outpatient appointment for 31st May 2005.

On 30th April 2005, Mr C was arrested in Camden for carrying drugs and a putty knife. A Mental Health Act Assessment was carried out at Kentish Town Police Station.

Mr C was subsequently detained under Section 2 of the Mental Health Act 1983 and was transferred to Avery Ward in Greenwich where a core assessment and the brief risk indicator checklist were completed. At this early stage, the assessment noted persecutory, paranoid and obsessional delusions and identified risks of substance abuse, neglect and moderately high risk to others. The plan was to carry out a drug screen, physical examination and keep Mr C under 15 minute observations. He was also identified as having a high risk of absconding and aggression. He was seen by an SHO and prescribed lorazepam and haloperidol.

Over the following week Mr C made several attempts to abscond from the ward including breaking a window with a fire extinguisher. He succeeded twice and was returned in restraint. He was physically aggressive and verbally abusive and was sometimes sexually inappropriate with staff. A drug screen was positive for cocaine, cannabis and methamphetamine. On review there was an impression of mental and behavioural disorder due to use of psychoactive substances. His GP was contacted. His mother visited twice. On her second visit, she told the

SHO that Mr C had threatened to kill a person who owed him money. A CPN from the CMHT attended the ward round and assessed him for a Mental Health Review Tribunal, which was held the week after.

The Tribunal upheld Mr C's detention under section 2. He was prescribed clonazepam and a referral was completed for the psychiatric intensive care unit, although he was not admitted there. He had another drug screen which was positive for cannabis. Relatives visited. By the beginning of the third week he presented with no prominent delusions, no suicidal or homicidal behaviour and the impression was of transient or brief psychotic episode in remission. He was encouraged to seek help from the local drugs services, including the Beresford Project and Substance Misuse East Team, which assessed him on the ward. His haloperidol was reduced.

Mr C was doing well and the ward staff contacted his mother about him having home leave. She was unhappy about this, and asked for Mr C to remain on the ward until she had spoken to the Associate Specialist (a senior doctor) on the ward. Mr C's clonazepam was stopped. After speaking with the Associate Specialist, his mother agreed to have him home for three days from 27th May 2005. He was taken off section 2 and was assessed and accepted by the home treatment team prior to home leave.

The day after leave started, Mr C was found collapsed in the street by the police. He was taken to St Thomas's Hospital where he was assessed and the SHO there identified a significant risk to others. Mr C was readmitted to Avery Ward where he was initially agitated, aggressive and disruptive. He agreed to remain as an informal inpatient. Ward staff established he was not a British citizen with no right to residency or access to benefits. Police contacted the ward as they wanted to charge him with carrying an offensive weapon. He was sexually inappropriate with female patients.

By the end of the first week in June Mr C had no abnormal thoughts and he refused a drug screen. The possible diagnoses were either schizoaffective disorder or mental and behavioural disorders due to use of substances. His mother agreed to have him on home leave on 7th June 2005 for three days, which was the last time his consultant psychiatrist saw him.

Leave did not go well: Mr C reported that he was disturbed by neighbours but denied cannabis use. On his return to Avery Ward the treatment plan was for a urine drug screen and for him to remain ward bound. Escorted access to the garden was added later. He denied hearing voices and had no abnormal thoughts. His haloperidol was stopped, procyclidine reduced, and he started olanzapine. He was sexually inappropriate, disruptive, hostile and abusive, attempting to abscond several times, once when his mother visited. He was transferred between Avery and Shrewsbury Ward at least twice, ending up on Shrewsbury Ward.

On 1st July 2005, he was caught smoking in his bedroom and staff suspected cannabis. Next day he was caught smoking again, in the garden, and staff confiscated the substance and some alcohol. He left the ward to go to the garden at 6pm and did not return until 11.25 pm, smelling of cannabis. He attempted to abscond the next day and refused a drug screen test.

Mr C's father telephoned the ward on 4th July 2005 alleging Mr C was involved in a murder on 2nd July 2005, having been informed of this from friends/family in Gambia. His father urged staff to telephone the police. On 5th July 2005 police officers attended the ward and arrested Mr C.

Mr C was convicted of manslaughter on the basis of diminished responsibility and was sentenced to be detained under the Mental Health Act. He remains detained in a forensic mental health unit.

6. Findings

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

6.1 Care Programme Approach: planning for discharge from inpatient care

The Investigation Team felt that there was an absence of key individuals responsible for Mr C's care in the three weeks leading up to the incident. There was therefore no one person who had an overview of his recent care needs and behaviour, and who could therefore recognise deterioration in Mr C's mental state.

There was not a clear care pathway, nor treatment plan (and the review team recognises that this was partly due to Mr C not having a clear diagnosis), and this situation did not support staff in continuing to care for Mr C.

Given that Mr C did not have an allocated care co-ordinator and his transfer between wards meant that his primary nurse input was inconsistent, his consultant psychiatrist was the one person who could have been identified as having overall responsibility for his care. The consultant's role in discharge preparation is particularly important given his likely continuing role in Mr C's care in the community. In addition, the on-call rotation for junior doctors did not aid continuity of medical care in the absence of the consultant psychiatrist.

6.2 Care Programme Approach: use of clinical risk assessment and management tools

There was no written requirement within the Trust's policy or guidance for Mr C to have had a full risk assessment undertaken. However, on the basis of the information available to the review team within the clinical records, and the expectations – rather than requirements – of the Trust's guidance in this area, the risks identified in relation to Mr C (which included both the risk to others highlighted in two separate assessments, his behaviour on the ward, and his use of drugs) would have merited a full risk assessment being undertaken and an appropriate management plan developed.

6.3 Liaison with Mr C's family, and use of carer's assessment

His mother was closely involved in her son's care throughout his time in hospital, and provided staff with information about his history and the period leading up to his admission. Mr C had not been allocated to CPA. An assessment of his carers' needs ought to have been triggered once this had happened, and this may explain why one was not undertaken during his admission.

6.4 Recording of communication between different teams and between individual professionals involved in Mr C's care

The involvement of the different teams in Mr C's care during the period of his admission was appropriate and demonstrates that staff had recognised his needs and how they could be met at various points. However, the lack of information in the inpatient records about the outcome of assessments undertaken by professionals in other teams may have prevented key people from having an overview of Mr C's treatment plan

6.5 Availability of rapid drug screening to ward staff

The delay in receiving the results of drug screens and the continuing access that service users had to drugs whilst on the ward made management of their mental health problems difficult for staff. It may also have contributed to the difficulties the multi-disciplinary team appeared to have in reaching a diagnosis for Mr C, and making decisions about his discharge and future care, if they had been unable to rule out mental disorder secondary to substance misuse.

The Investigation Team thought that in 2005, the lack of an organisational approach towards the management of people with both substance misuse and mental health problems made it very difficult for inpatient staff to manage effectively certain groups of service users. There was no clear approach to preventing inpatients' access to alcohol and illegal drugs, whether they were informal or detained patients.

The Investigation Team recognises the good practice of the staff caring for Mr C in referring him for assessment by the local substance misuse team, but the fact that there was no record of the outcome of that assessment in the inpatient records meant that staff were unaware of the long-term or short-term implications of Mr C's substance misuse.

7. Notable practice

The Investigation Team wished to highlight a number of areas where good practice was noted in relation to Mr C's care:

- the CMHT triaged the initial GP referral rapidly;
- at the point of Mr C's admission, he received an immediate and thorough medical assessment;
- there was evidence that staff persevered in ensuring that Mr C understood his rights as someone detained under the Mental Health Act;
- there was timely and appropriate referral from the inpatient ward to other services, e.g. Psychiatric Intensive Care Unit (PICU), Home Treatment and substance misuse;
- communication with Mr C's mother improved greatly after the first few weeks of his admission and there was evidence of regular contact from ward and medical staff.
- the internal investigation itself followed good practice.

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

After the incident, it was clear that a very thorough investigation, based on a root cause analysis approach, had been undertaken. It was clear that the investigators had recognised the limitations of a pure root cause analysis in relation to incidents in mental health services and had adapted their investigation accordingly. The recommendations made and the actions implemented were based on the issues identified during the investigation.

The Investigation Team was assured by the information received from the Trust that substantial work had been undertaken to improve systems and processes, particularly in relation to CPA, since summer 2005.

The Trust demonstrated to the Investigation Team all the changes which had been made to the Trust's management of care planning in the last three years. In particular, the implementation of RiO to replace all paper records across the Trust had significantly improved the Trust's ability to plan care appropriately and share information widely.

Since 2005, the Trust had developed a strategy for the management of dual diagnosis issues, had appointed a specialist nurse and had established training for all staff.

A carers' strategy had also been developed and published.

9. Recommendations

The Investigation Team discussed in some depth whether a change to any of the identified care and service delivery problems might have prevented the incident involving Mr C from occurring. It was agreed that there were no direct links between any of the Care and Service Delivery Problems or contributory factors and the incident itself.

The Investigation Team concluded that there were no root causes which would have prevented the incident occurring.

9.1 For the Trust

If it has not already done so, the Investigation Team recommends that the Trust updates its risk assessment policy and documentation to bring it in line with updated CPA guidance and practice and make it consistent with RiO. In particular we recommend that the Trust set specific time standards for staff to carry out risk assessments. An audit programme should be put in place to support implementation.

9.2 For NHS London

This case
The internal Trust investigation was timely, composed of the right people and produced a robust report with recommendations and action plan and NHS London accepted the conclusions and recommendations.

Commend the Trust for pursing the actions outlined in the investigation report and in maintaining an audit trail detailing the completion of the action points.

Thematic review: CPA
Since this Investigation Team was started, the Department of Health has published updated guidance on CPA. For those Trusts which have not already done so themselves, the London Development Centre for Mental Health is supporting the updating of local CPA policies.

NHS London could consider the development of a standardised audit tool for Trusts to use to examine and benchmark the effectiveness of their own use of CPA. The audit tool could contain reference to:

- The need for a named care co-ordinator and the need for formal multi disciplinary discharge planning for those on CPA.

- Risk assessment policy and documentation being in line with updated CPA guidance and practice and consistent with electronic service user information systems.

- Specific time standards for staff to carry out risk assessments.

- Formal carers' assessments.

- Local substance misuse services working with and being part of CPA where appropriate.

- A step-by-step procedure or flowchart which staff can use to ensure that all the appropriate steps for rapid assessment, allocation and application of CPA is achieved, no matter where a patient is first seen.

Future cases where an Independent Review is required

Using the collective experience gained from the current group of peer reviewers, NHS London should initiate a consultation process on the development of a transparent and evidence-based process for peer-based Independent Reviews of mental health serious untoward incidents so that Trusts have confidence in a method that has been widely agreed and disseminated before the Independent Review process starts.

Once the need for an independent peer investigation has been identified, NHS London should negotiate with each Trust to ensure that adequate staff time is allocated to the review process and that adequate timescales for completion are determined in advance

Obtain the consent of the service user whose care is being investigated before the review process starts.

Develop a training curriculum and a training programme aimed at supporting staff who undertake SUI investigations in all London mental health Trusts, in managing the investigation process, data collection, analysis, and in how to reach expected standards for reports.

Establish a mechanism for officers charged with managing SUIs to share their experiences and develop models of good practice through inter Trust SUI investigations.

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.