Independent investigation into the care and treatment of Mr I

Case 9

Commissioned by NHS London

NHS London

Contents

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 22nd August 2004. Mr I was subsequently arrested and convicted as the perpetrator of this offence.

Mr I received care and treatment for his mental health condition from the South London and Maudsley NHS Trust (the Trust) now a Foundation Trust. It is the care and treatment that Mr I 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 treatment of Mr I although this did not follow the SUI reporting process. It was evident that the incident was logged on their incident reporting system nearly 11 months after the incident.

The Investigation Team consisted of a Consultant Child and Adolescent Mental Health Services (CAMHS) Psychiatrist & Lead Doctor for Child Protection, Southwark CAMHS and a Community CAMHS Nurse/Team Manager, Lead Nurse for Child Protection

The report was produced over 18 months after the incident (date of report 27th July 2006) and was not in the format of SUI reporting. It was found that it did not fully investigate the incident. The internal investigation had no material to support any interviews with staff at the time of incident, so these could not be referred to. No evidence was provided to support whether recommendations had been implemented or an action plan developed.

A single agency review produced a comprehensive action plan, attached as a recommendations monitoring form, which recorded a number of actions completed and/or ongoing or progressing.

No evidence was provided as to what involvement of Mr I, his carer or the family of the victim was offered at the time of the investigation for both the Trust and Single Agency Review.

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:

- 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.

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

On the 28th September 2005 Mr I was convicted of the murder of the Victim on 16th December 2004 outside his home. Mr I had been involved in the bullying of the Victim's stepson and when he tried to protect the child Mr I pulled out a knife and stabbed the Victim. He later died of his injury.

Just prior to the incident the Victim had been trying to contact the police by telephone to request help.

6. Findings

6.1 Lack of multi-agency working

Mr I was recorded as being a vulnerable child who was both materially and emotional deprived. He was one of five children, with a history of his mother having frequent hospital admissions leading to Mr I being cared for by various members of family during his formative years.

Mr I was first referred to the CAMHS service in January 1997 as his mother had concerns about all her children, but in particular Mr I. His mother had a history of manic depressive illness and frequent hospital admissions. She is reported to have stated that she was concerned about her anger towards Mr I and feelings of not being able to cope with him.

Mr I's mother also reported at that time that she was concerned that he was having difficulties at school.

From the initial contact with CAMHS Mr I was seen over a period of 7 years, being transferred between teams during this time. There was no evidence of a multi- agency working nor a case conference between those involved in Mr I's care to plan how the services could address his needs.

It would appear from the notes that there was initially good contact/involvement with Mr I, his mother and other family members. However, stronger concerns developed when a referral were made to the child and family social services department in June 1999 when his mother hit Mr I and during 2000 when he was charged with indecent assault which he had claimed he did under duress from another boy. It would have been good practice at this time to have reviewed Mr I's care.

There were many occasions where Mr I could have been referred for support and assessment for children in need given the repetition, duration and accumulation of concerns.

6.2 No Clear Management Plan for Care and Treatment

It was found that there was no evidence that a clear management or treatment plan was completed in the clinical records. Mr I and his mother would have benefited from having a comprehensive plan that articulated interventions for supporting families, promoting children's well-being, preventative methods and early interventions; such as anger management. His mother would have benefited from having an assessment for parenting and then parenting interventions. It was well known that Mr I's mother was often unwell but no evidence was found that this information was acted upon with additional support being provided at the times when her mental state had deteriorated.

6.3 Youth Offending Team (YOT) Access to Tier-3 CAMHS

The support provided to Mr I from YOT staff was well evidenced and his engagement was noted as good. However, a concern for the investigating team was what access the YOT staff had to a Tier-3 CAMHS service. In addition the health workers were agency staff and there had been some delays around recruitment of permanent staff. These concerns are also highlighted in the review undertaken in 2005 of the Lambeth YOT service.

7. Notable practice

The investigation team would like to commend the following notable good practice:

The YOT staff are to be commended for the excellent engagement and support that they offered to Mr I; including support for his mother as requested.

The single agency report was both comprehensive and offered an extensive chronology of events.

Good practice was identified in CAMHS, namely:

- Regular and effective CAMHS contact was maintained with Mr I until 2002 when he disengaged and strong efforts were made during 2004 by the CAMHS adolescent team to re-establish contact; including effective psychological interventions were provided for Mr I up to 2002.

8. Recommendations

The Investigation Team have made the following recommendations:

1. To have robust escalation processes in place when social services have concluded that an initial referral does not meet their criteria, but concerns remain with health staff, that there are mechanisms that can address this concerns at the appropriate level within both organisations.

2. That the Common Assessment Framework for Children to be implemented and used across the Trust, to improve the identification of support required for children and families affected by mental health.

3. That evidence is provided to the Chief Executive and the wider partnership officers that the recommendations from the review of the YOT (2005) have been fully implemented.

4. To develop effective joint working across CAMHS and adult mental health, which can be evidenced through regular audit and evaluation.

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.