Independent investigation into the care and treatment of Ms V

Case 21

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 person known to Ms V on the 27th April 2003. Ms V was subsequently arrested and convicted as the perpetrator of this offence.

Ms V received care and treatment for her mental health condition from the Central and North West London Mental Health Trust. It is the care and treatment that Ms V 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 panel of inquiry was established to investigate the incident on 27 April 2003, its terms of reference and membership having been produced on 7 May 2003. Its report was dated 1st September 2004. The total time from constituting the panel to submission of the report was seventeen months which was substantially outside the Strategic Health Authority guidance of 60 days.

The Trust investigation was conducted at a level determined by the Chief Executive on the day of the incident. The panel was constituted of members of the two main statutory organisations responsible for the care of Ms V, Westminster City Council and CNWL NHS Trust. It was chaired by a non-executive director of the Trust.

The investigative process included gathering relevant information. This consisted of the patient's health and social care records and the records of St. Martin's-in-the-Fields Social Care Unit. Primary care records were sought but Ms V did not give consent to access her Primary Care Records. The report documents a meagre and misleading chronology which gives rise to three themes which are not compatible with the available evidence.

The original investigation predated the adoption of Root Cause Analysis methodology but followed the common process of investigations at that time. Much of the comment in the report relies heavily on the accounts given in interviews at the expense of the contemporaneous written record. This colours the tone of the report. This is not improved by numerous factual inaccuracies, and a style which makes it impossible to separate fact from opinion or to separate opinion of the panel from opinion of clinicians.

The recommendation of improving communication is not particularly well targeted in this case as communication was good, largely due to the industry of the CPN. However as the action plan addresses CPA practice within this recommendation, it focuses on one of the issues which the Independent Investigation Team believed could be improved:

communication which the panel of inquiry believed was deficient was communication between individual professionals within the case management of the individual patient. It is unclear to what extent this was addressed or improved by the recommendation or subsequent actions.

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 Central and North West 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 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.

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 expert advice provided by HASCAS as required.

4.5 Independent Investigation start date.

The Independent Investigation started its work in October 2007.

5 Summary of the incident

Late in the evening of the 26th or in the early hours of 27th April 2003 Ms V a 32 year old mother of one stabbed to death a person known to her, at a Hotel where she was then residing. Ms V was convicted of homicide on the grounds of diminished responsibility and imprisoned for four and a half years. During her prison sentence her deteriorating mental state occasioned her transfer to psychiatric care in conditions of medium security where she remains.

Ms V had lived with her daughter and her mother in central London until approximately one year before killing the victim. Apparently triggered by the death of her sister in June 2001, she drank alcohol increasingly heavily, became episodically depressed and repeatedly harmed herself by overdose of medication. She frequently presented to local Accident and Emergency Departments and was admitted to hospital on three occasions for acute psychiatric care and once for detoxification from alcohol.

Her father who may have abused her, physically and possibly sexually, during her childhood, died at Christmas 2002. Her daughter was taken into care (fostered) in August 2002 to be considered for either long-term fostering or adoption.

Ms V was born on 6/6/70, the second of non-identical twins. She, her twin brother and elder sister were brought up in the West End of London by her mother. Her father left the family when Ms V was three years old and he became street homeless. Ms V has alleged that she was sexually and physically abused by her father in childhood but maintained contact with him. She recalled being bullied at school. She obtained qualifications including an A-level in art. She worked in a supermarket until the birth of her daughter in 1990. The father of Ms V's daughter is alleged to have been physically abusive and had no access to his daughter.

Their daughter has moderate learning disability and was statemented in 1996. The children and families service in Westminster were aware of Ms V from 1993 after an anonymous referral by a neighbour citing Ms V's difficult relationship with her mother and violence from a male friend as the cause of their concern. In September of 1993 Ms V referred herself to social services complaining of violence and anger problems and alcohol abuse. She was offered therapeutic support and day care. In 1995 a child protection investigation was carried out into the allegation that Ms V's father had sexually abused her daughter. The findings of the investigation were inconclusive.

Ms V's first contact with psychiatric services was in 2002. However in 1991 she presented to her GP with a number of physical symptoms, worrying that friends may have drugged her food. Dizziness, headaches and tingling of her fingers persisted for a number of years. In 1996 she described panic attacks and held the view that she had been poisoned by a relative several years earlier. She described panicking whenever she saw alcoholics or drug addicts in the street. In 1997 she was offered treatment by a psychologist (but there is no record of this having occurred)

In the year prior to the homicide she had frequent contact with two agencies; The West End Community Mental Health Team and the St. Martin's in the Fields Social Care Unit. She also received treatment and support from the Soho Alcohol Team. She had three hospital admissions for psychiatric care and one for detoxification from alcohol. She had no significant history of violence.

Ms V received a very high level of support from her Community Psychiatric Nurse, often being seen weekly. Her dysfunctional drinking behavior was reinforced by mixing with the clientele of the St. Martin's-in-the-Fields Social Care Unit, a voluntary sector service for the homeless, which largely supports street drinkers. However, she also received considerable support from that organisation.

There was frequent communication between her key worker at St. Martin's and her CPN. Further support and treatment was provided by the Soho Alcohol Service from the 10th December 2002 until she was taken into custody. She was seen every one to two months in the psychiatric clinic in the West End Community Health Centre. Her CPN attended many of these appointments and made in-reach contact with the wards on each of Ms V's admissions to hospital. Throughout the written record, Ms V is often described as only being willing to engage with services on her (own) terms. She resisted attending day services and declined to attend day-time sessions in a dual diagnosis service. When assessed she was found to be unmotivated by the prospect of residential rehabilitation for her alcohol problems. Instead she chose to spend her days with the street drinkers she met at St. Martin's, drinking large quantities of alcohol herself.

6 Findings

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

6.1 Lack of a clear process to direct senior oversight to care of a complex case

Within fourteen months Ms V had four inpatient stays, was seen monthly in the out patient clinic, was seen several times per month by her CPN, on occasions had daily contact with the team and was the subject of referral to a number of other services. Despite this the

consultant psychiatrist leading the team was unaware of her. Ms V's narrative history was not adequately reflected upon, rather than not known in sufficient depth.

Supervision and team meetings provide the conduit for seeking team and senior advice in the management of cases by team members. CPA reviews allow for a shared view of a service user's care to be formed by the different professionals involved. The care coordinator documented the role of both supervision and team meetings in Ms V's care.

A care coordinator or junior member of the team may present a service user for consideration at a team meeting or in supervision. However better practice is for the team to mandate presentation of each case for review within a given period.

6.2 Failure to collect and compile a narrative history

Despite Ms V disclosing her history in a piecemeal fashion, the service was in possession of all the key elements required to inform appropriate care planning. However these were at no point brought together into a high quality coherent narrative.

The staff grade doctor who saw Ms V formed an appropriate view of the issues in Ms V's care and recorded these adequately in the case record. The CPN/ care coordinator (commendably) attended a substantial number of Ms V's clinic appointments. However although a CPA meeting was held on the same day as one such appointment, the doctor did not attend the CPA meeting and their proposal for psychological referral or therapeutic community referral was not actioned. Hence in the midst of a lot of very good and committed practice a key strand seems to have been lost.

6.3 The lack of a clear approach to treating personality disorder

The diagnosis of Emotionally Unstable Personality Disorder, Borderline Type (Borderline PD) was first made at Ms V's discharge from St. Charles Hospital on 15.7.02. Although the inquiry report reflects that she had a number of diagnoses, suggesting uncertainty about these which the chair of the panel reflected at interview, Ms V's presentation with attendant alcohol misuse and mood change was entirely typical of the diagnosis of Emotionally Unstable Personality Disorder, Borderline Type. Inconsistent disclosure of childhood abuse is often made by those with Borderline PD.

Having the diagnosis did not lead to a fuller assessment and attempt to obtain collateral information, nor did it lead to a clear treatment approach directed toward the personality disorder per se. However, during the time that Ms V received care from CNWL their approach to her was typical in the lack of a specific approach to addressing her personality disorder.

6.4 Loss of clinical records (Gordon Hospital)

Within fourteen days of her discharge from the Gordon Hospital Ms V had killed the victim. Her inpatient notes were sought at that point and were not then or subsequently located. In the fullness of time the Trust's transition to electronic patient records will address this issue. The Trust has also adopted the practice of backing up records to micro-fiche. Whilst useful, this was loss of records whilst still in use (awaiting discharge summary) and hence may well

not be addressed by this approach. The Trust currently has adequate policy guidance on securing notes following a SUI.

7 Notable practice

The CPN/Care Coordinator provided a good standard of care. She ensured appropriate referral to other services, notably the Alcohol Service and made repeated attempts to engage Ms V in meaningful daytime activities. She liaised with and engaged others providing care in reviews of that care. She engaged in the childcare/child protection process supporting Ms V. Her interventions and responses were timely. She facilitated communication between professionals and services and provided in-reach support on each occasion that Ms V was admitted to hospital. She attended many of Ms V's clinic appointments with psychiatrists. Her recording of this was thorough.

The reviews of the incident by the CMHT manager are succinct and very informative. It suggests that she had a good understanding of Ms V's difficulties and the care provided to her, reflecting well on her role as the CPN's supervisor.

The practice of the Chair of the panel of inquiry meeting with the Team Manager and the Consultant to feed back the findings and recommendations are to be commended.

8 Independent Investigation review of the action plan

A number of processes can be identified within the Trust since the incident aimed at improving CPA practice. The Team have had sight of a CPA Project Brief, CPA Workshops, CPA and Risk Management Training Logs (from April 2004) and several subsequent CPA policies, the most recent responding to 'Refocusing the CPA: DOH 2008' The CPA is monitored in a number of ways.

With regard to the loss of records, within Westminster there are now integrated Health and Social Care records. There is also a microfiche facility that allows better management of multiple volumes of case files. The service is moving towards implementing the information system JADE which will contain the electronic patient records.

Whilst Trust-wide training registers exist, there is an expectation that Team Managers have oversight of the training for members of their team through supervision and Personal Development Plans. Personal Development Plans are part of Training & Development Plans.

GP alignment is a work stream of the Trust Modernisation Board. The CMHTs in South Westminster are GP aligned with GP Liaison posts. The process is going ahead in the north of the Borough.

The London Borough of Westminster now has a designated Housing Specialist Manager who works between the Housing Department and Mental Health Services. The person facilitates communication between the two organisations. There are also Mental Health Link Workers attached to the large hostels and supported housing providers.

The lack of attendance by medical staff at the community CPA does not appear to have been the ordinary practice throughout the trust at the time of the incident.

Dual Diagnosis services have been developed within the Trust. The panel had sight of the Westminster Dual Diagnosis Operational Policy (Sept 2007) and the Dual Diagnosis Action Plan (2008).

There is a Service Improvement Team within the Medical Director's Department. This will identify particular issues from an SUI and inform a working group often from other areas to conduct a Service Improvement Review of a service. This process has only recently started across the services in general but has been running for some time in the substance misuse service.

9 Recommendations

9.1 Trust

1. The Trust should implement as fully as possible the recommendations of Personality Disorder: No Longer a Diagnosis of Exclusion (As modified by the findings of various pilot sites/reviews).
2. The Trust should ensure that adequate narrative histories are compiled and summarised and that these form the basis of 'guided reflection'.
3. The Trust should ensure that consultant psychiatrists are involved in the care planning for the most complex cases under the care of their team.

9.2 National

1. Training bodies should ensure that curricula adequately cover and emphasize establishing and understanding the significance of narrative histories in psychiatric practice and understanding personality disorder, its care and treatment.

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.