Independent investigation into the care and treatment of Mr Q

Case 17

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 an incident that occurred on 11th March 2004 that resulted in the death of a member of public on 11th March 2004. Mr Q was subsequently arrested and convicted of manslaughter by way of diminished responsibility as the perpetrator of this offence.

Mr Q received care and treatment for his mental health condition from the South London and Maudsley Mental Health Trust (the Trust) now a Foundation Trust. It is the care and treatment that Mr Q 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

The Trust initiated the Trust's Structured Investigation process and the report from this was presented to a Board Level Inquiry panel.

No written terms of reference are recorded. Staff interviewed during the Trust's investigation did not have their details recorded. No written details of these interviews were provided to the Independent Investigation, and it was not clear if any records of the interviews were taken.

The Independent Investigation found no evidence that Mr Q was interviewed. There was no evidence that any relatives were interviewed during the course of the Trust's investigation. It was noted that the care co-ordinator subsequently had contact with Mr Q's step-mother during the period he was on remand. Some details about the victim were recorded in the Trust's report but there was no available evidence about how, where or when this information was obtained. Apart from the care co-ordinator being debriefed and being given details of staff counselling services, there is no other record of staff support for those involved in the internal investigation.

The internal investigation identified 2 issues of concern:

1. The penultimate home visit to Mr Q of 7th January 2004;
2. Carbamazepine medication prescribed to Mr Q, its purpose and blood monitoring.

Recommendations were provided to address these issues.

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 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.

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 team of two or three people with expert advice. 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 future service improvements.

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 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

Mr Q was a 31-year-old Caucasian man at the time of the index offence on 11th March 2004. He had been known to adult psychiatric services since 1995, aged 22 years, and he had received a diagnosis of paranoid schizophrenia. He had a previous forensic history. It was variously recorded that he was charged having made two arson attacks by throwing petrol bombs at a mosque in 1997. The details of the conviction were not clearly recorded. However, he received a two-year probation order for the offence with the condition of attending outpatient psychiatric treatment. He subsequently remained under the care of the Community Mental Health Trust (CMHT) and he was in receipt of monthly reviews by his care co-ordinator at the time of the incident.

Mr Q formed a relationship with a 19-year-old woman in the summer of 2003. Having served a prison sentence in March 2004, this woman was met by Mr Q outside the prison and she returned to Mr Q's home and lived there for the next

two days. An argument ensued between Mr Q and the woman about her interaction with another man, and a physical altercation ensued. She received stab wounds to her neck area and defence wounds on her arms and chest area and died. Mr Q subsequently phoned his step-mother to ask if he could bring his dog round to her, which he then did. He told her that he was going to visit the mother of his daughter. However, he returned to the flat and called the police who arrived and arrested him. He was charged with the female victim's murder and he was remanded to prison. It was subsequently recorded that the victim was known to the Youth Justice Team in Southwark.

Mr Q was convicted of manslaughter on the grounds of diminished responsibility on 15th October 2004 at the Central Criminal Court. He was detained under a Hospital Order with Restrictions, Section 37/41, on 26th November 2004 and transferred to a medium secure hospital.

6. Findings

The Independent Investigation was unable to draw any conclusions about any Care and Service Delivery Problems because there has been a lack of contemporaneous clinical records. The Investigation notes the Trust's strenuous efforts to resolve the issue of lack of clinical records. The delay in producing the clinical records, the further delay in producing a Social Services file, and the ongoing failure to produce any non-computerised records for the period immediately prior to the index offence has seriously impeded the Investigation and made the use of Root Cause Analysis inapplicable.

7. Notable practice

The Investigation concluded that due to the lack of information it has not been possible to establish any notable practice nor the reliability of the statements regarding notable practice as recorded by the Trust.

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

The Investigation noted that the Trust's investigation did not recommend that written guidance about excess medication should be formulated and incorporated into CMHT/Trust policies. The Investigation considered that the Trust could clarify in writing the exact process and action that might be required in monitoring drug compliance in specific circumstances such as that of Mr RN.

The Investigation considered that the policy as described in *Interface Prescribing Policy* of the *Medicines Management Policy*, if adhered to, would appropriately resolve the issues raised with regard to the prescribing of medication and responsibility of monitoring therapeutic blood levels.

The Trust's internal investigation also highlighted the issue of a mechanism of recording the frequency of blood monitoring of relevant medication and feedback of the information between the mental health team and the GP. The Independent Investigation was unable to locate any details about this point in the Medicines Management Policy or the CMHT policy and the Chief Pharmacist confirmed that he was not aware of any policy about the communication of blood level results to the GP.

The Investigation suggests that further consideration might need to be given to the mechanisms by which recommendations from internal investigations are actioned locally and raised where appropriate at Trust level.

9. Recommendations

The Trust's internal investigation concluded that checking that clients comply with instructions about taking medication, and monitoring of blood levels of medication would not, if they had been implemented at the time of the incident, had any direct impact on the outcome of the incident.

Without access to the full set of contemporaneous clinical records, it is not possible for this Independent Investigation to either agree or disagree with this conclusion.

The Investigation recommends that:

1. NHS London and/or Department of Health clarify mental health trust obligations and responsibilities under, and sanctions for breach of, the Data Protection Act and disseminate these findings as soon as possible to all Chief Executives.

2. NHS London/Department of Health clarifies what should happen in cases where contemporaneous clinical or other records are not available for independent investigation.

3. The Trust urgently reviews its procedures concerning the safekeeping and retrieval of all contemporaneous clinical records for all serious untoward incidents, and ensures that these notes are available in their entirety for any future Independent Investigation.

4. The Trust urgently reviews its procedures concerning the recording and retrieval of oral evidence presented to internal serious untoward incident investigations, including Board level inquiries, for any future Independent Investigation.

5. The Trust clarifies the exact process and actions that are required of care co-ordinators in monitoring their clients' medication usage and concordance.

6. The Trust review and amend as appropriate any policy which addresses the communication of medication blood levels to GPs and CMHTs.

7. The Trust reviews the mechanisms by which recommendations from internal investigations are actioned locally and raised where appropriate at Trust level.

8. All mental health trusts should review the completeness of their record keeping and the processes used for accessing these records for all outstanding SUIs. Annual audits should be undertaken to ensure all clinical notes and notes and records of investigations have been indexed and filed.

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.