VERITA

INVESTIGATIONS – REVIEWS – INQUIRIES

Overview report of seven independent investigations

A report for
NHS East of England

March 2010

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1. Introduction

1.1 In 2009 NHS East of England commissioned Verita to undertake seven independent investigations. They were to be undertaken in accordance with guidance published by the Department of Health in HSG 94(27) *Guidance on the discharge of mentally disordered people and their continuity of care in the community* and the updated paragraphs 33-6 issued in June 2005.

1.2 The investigations followed homicides committed by patients who were receiving care from secondary mental health and social care services in the East of England.

1.3 The seven investigations were into the care and treatment of A and B whose care and treatment was provided by Hertfordshire Partnership NHS Foundation Trust; C, D and E whose care and treatment was provided by North Essex Partnership NHS Foundation Trust; F whose care and treatment was provided by Cambridgeshire and Peterborough NHS Foundation Trust and G whose care and treatment was provided by Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust.

1.4 Terms of reference for each of the seven investigations were the same. A copy is included in appendix A.

1.5 This overview report discusses (in section two) the common themes arising from the seven investigations. It also identifies the individual themes arising in each case (summarised in the table at appendix B). Our recommendations, arising from the common themes are included in section two and summarised in section three. This report does not repeat the individual recommendations on issues including drug and alcohol services, risk assessment, carers' assessments that may have been made in each of the individual reports.

The seven cases

1.6 A had been engaged with mental health services since 1999. He had been referred because of anxiety and depression and had problems with substance misuse and binge drinking. On 25 December 2004 A struck in the face a man who was not known to him. The man fell backwards and struck his head. He sustained a fractured skull and died four days later. A pleaded guilty to manslaughter and was sentenced to four years and three months in prison.

1.7 B was engaged with mental health services from June 1998 until February 2005. He experienced personality, mood and behaviour problems and difficulties arising from use of alcohol. On 5 February 2005 B killed an elderly woman who was a friend of his. She died of multiple stab wounds. B was convicted at Crown Court of murder. He received a mandatory sentence of life imprisonment with a recommendation that he serve nineteen years and six months in prison.

1.8 C had a long and complex history of involvement with mental health services. He was not considered to suffer from a mental illness but did have issues with substance misuse and personality problems. On 12 July 2004 C killed his friend X who was found face down in his flat after sustaining ten blows to his head and face. He had a fractured skull. C was convicted of unlawfully killing X. He was sentenced to twelve years in prison and told he should serve at least eight years before being considered for parole.

1.9 D was referred to mental health services by his GP as he appeared to be depressed. He had been in contact with mental health services for less than three months when, on 16 June 2005, he killed Y, his ex-partner's new boyfriend, by beating and stabbing him. D also assaulted his ex-partner. At Crown Court he was found guilty of the murder of Y and of causing grievous bodily harm to his ex partner and sentenced to life imprisonment.

1.10 E had been in contact with the North Essex Drug and Alcohol Service between 1999 and June 2006. On 1 November 2006 E killed her boyfriend Z with a knife during an argument at their home. She was found guilty at Crown Court of the murder of Z and sentenced to fourteen years in prison.

1.11 F had been involved with mental health services since 1994 when he was admitted to hospital from prison showing signs of paranoid schizophrenia. He experienced further admissions to hospital on a number of occasions. From 2002 to 2006 he received regular visits from members of the community forensic psychiatric team. In February 2006 F punched W and left him unconscious in freezing temperatures. F subsequently died. F pleaded guilty at Crown Court to the charge of manslaughter. He was sentenced to a minimum of eighteen months in prison with a minimum ten year licence. The judge concluded that F posed a high risk of causing serious harm to the public.

1.12 G was in contact with mental health services for a period of 12 years between 1992 and 2004. He was referred following two overdoses and with difficulties in controlling his temper. During the night of 31 December 2004 or the morning of 1 January 2005 G killed his partner's three year old child at his partner's home. G was convicted at Crown Court of murder. He was sentenced to life imprisonment. The judge recommended that he should serve at least twenty years in prison. G was also found guilty of causing actual bodily harm to his partner and received an eighteen month prison sentence for that offence.

1.13 Verita's recommendations relating to each case are included in appendix C.

2. Common themes

Service issues

Services for people with personality disorder

2.1 Four of the seven perpetrators had diagnoses of personality disorder. Two had been diagnosed as having "*emotionally unstable personality disorder",* one with "*borderline personality disorder"* and one with "*sociopathic personality disorder".* Two of the internal investigations recommended reviews of services for people with personality disorders. In one trust a multi-disciplinary personality disorder team has since been established.

2.2 The needs of the four people with personality disorders were met to varying degrees with individual care programmes. Some concern was expressed by the internal investigation teams about the adequacy of resources to meet the needs of people with personality disorders but lack of resources was not identified in any case as a causal factor in the homicide. In at least one trust investment has since been made in developing a local specialist service to support community mental health teams and inpatient services in the management of people with a personality disorder.

Comment

It would be helpful for commissioners of mental health services (local primary care trusts) to have a clear picture of what specialist services are in place for people with personality disorders across the East of England. This could then be used to evaluate the effectiveness of services and build on best evidence based practice.

R1 Commissioners of secondary mental health services across the East of England (primary care trusts) should ask mental health and social care trusts to provide a profile of the spectrum of services they offer to people with personality disorders. A programme of evaluation of the effectiveness of such services should then be devised and implemented.

Managing patients who do not attend appointments (DNAs)

2.3 In four cases issues emerged around patients not keeping appointments. The three trusts concerned all now have clear policies for the management of patients who do not keep appointments or who disengage from services.

2.4 In two of the four cases recommendations about the management of DNAs were made in the internal investigation reports. In a third case, a reference was made to a history of non engagement but no clear recommendation was made about this. We have seen evidence in some trusts of improvement in DNA policies since these incidents.

Comment

It would be helpful to ensure that the DNA policies (and compliance with such policies) in all mental health and social care trusts across the East of England are in line with best practice.

R2 Primary care trusts should ask provider trusts to review their DNA policies and procedures to ensure they are fit for purpose. Trusts should include audits in their clinical audit programmes to assure compliance with DNA policies.

Drug and alcohol services

2.5 In six of the seven cases substance misuse was identified in the case records. One case involved solvent misuse. Alcohol and/or drug abuse featured in the remaining five cases.

2.6 Four of the perpetrators were referred to local drug and alcohol services. Another was subject to regular drug screening.

2.7 In one case a recommendation was made by the internal investigation team that "*consideration should be given to reviewing shared care arrangements between general psychiatry and substance misuse services".*

Comment

Our investigations confirm that while substance misuse was a common theme in these cases there was no evidence of service failure in this respect. There was also evidence that the liaison between drug and alcohol services in a number of trusts is well coordinated and effective.

Risk assessment

2.8 Four of the internal investigations identified issues around risk assessment. In one case the risk assessment process was found to be good. In two cases there was some divergence between practice and the trust's clinical risk assessment and management policy. In another case there was evidence of a poor quality risk assessment and non compliance with the trust policy.

Comment

We have examined the current policies in the three trusts where risk assessment was an issue. All are now updated and fit for purpose. All trusts include audit of compliance in their clinical audit programmes.

Care programme approach (CPA)

2.9 Three internal investigations considered the frequency of CPA reviews. In one case the level of CPA was considered and found to be appropriate. In another, compliance with CPA policy was found to be good.

Comment

We have examined the current CPA policies and procedures in all trusts. They are up to date and fit for purpose. We were assured that all trusts regularly audit compliance with their CPA policies.

Carers' assessments

2.10 In two cases issues around the assessments of carer's needs were identified. In one case the trust has since added a section to its clinical risk assessment policy about working in partnership with carers. It has also established a carers' council and new posts have been created to support engagement with carers. In the other case a carer's assessment was completed in accordance with trust policy.

Integration of records

2.11 Whilst not a common theme we were pleased to see that one trust has now fully integrated its medical, nursing and social work notes and has an electronic CPA *"repository"* in place to enable staff to access all CPA records.

Learning the lessons

Quality of internal investigations

2.12 We found three of the internal investigations to be of good quality. Two were adequate and two were weak. In two cases there were delays in starting the internal investigation process. In one trust there was significant variation in the quality of two internal investigations.

2.13 In two of the internal investigations there were no terms of reference provided.

Action plans

2.14 Action plans were developed and implemented in six cases. In the seventh, no action plan was required in view of the brevity of the perpetrator's involvement with services and the absence of concerns about his care and treatment.

2.15 We found four of the action plans to be of good quality and two were adequate. Four action plans have since been updated and in the other two cases there

was evidence of subsequent audits or update reports. Two of the original action plans were undated.

2.16 One trust has completed an internal audit of its untoward and serious untoward incident procedures. It included an examination of the follow up of serious untoward incident (SUI) reports.

Comment

The audit provided assurance that SUI policies and procedures were robust and that compliance was effective.

R3 In view of the variable quality of these seven internal investigations mental health and social care trusts across the East of England should arrange internal audit of untoward and serious incident procedures and compliance with them.

Policy framework

2.17 All trusts had updated their policy and procedures for reporting adverse incidents (including SUI's) since these incidents.

Comment

The SUI policies in all of the trusts involved in these reviews are now comprehensive and fit for purpose. Internal audit should be used to assure that compliance continues in all cases.

Sharing and building on best practice

2.18 Our meetings with senior managers from the four mental health and social care trusts identified a range of ways in which trusts disseminate lessons arising from SUIs. The meetings also identified some excellent practice in developing and implementing

SUI policies and procedures. A number of managers commented on the need to share best practice in managing SUIs and learning the lessons arising from them.

R4 NHS East of England should share issues arising from these investigations to facilitate best practice in SUI policy development and the appropriate learning of lessons arising from such investigations. One way in which this could be achieved would be to hold a workshop for key senior managers from mental health and social care trusts and the commissioners of mental health and social care in the East of England.

3. Summary of overview report recommendations

R1 Commissioners of secondary mental health services across the East of England (primary care trusts) should ask mental health and social care trusts to provide a profile of the spectrum of services they offer to people with personality disorders. A programme of evaluation of the effectiveness of such services should then be devised and implemented.

R2 Primary care trusts should ask provider trusts to review their DNA policies and procedures to ensure they are fit for purpose. Trusts should include audits in their clinical audit programmes to assure compliance with DNA policies.

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Appendix A

Terms of reference, approach and methodology

Terms of reference

The terms of reference for this investigation were agreed as follows:

The aim of the independent investigation is to evaluate the mental health care and treatment given to A from the time of his first contact with mental health services to the time of the offence. The investigation will review the trust internal investigation and assess the progress made on the implementation of its recommendations.

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 Investigation action plans for each case to:*

    1. *ascertain progress with implementing the action plans;*
    2. *evaluate the trust mechanisms for embedding the lessons learnt for each case;*
    3. *identify lessons learnt which can be shared across the sector.*

- *Conduct interviews with a focus on managers rather than on front-line staff where required.*
- *Provide a written report utilising the agreed template.*

Appendix B

Key themes from East of England investigations

	A Herts	**B** Herts	**C** North Essex	**D** North Essex	**E** North Essex	**F** Cambridge & Peterborough	**G** Beds & Luton
Personality disorder		✓	✓		✓		✓
DNAs	✓		✓		✓		✓
Shared care – gen psych; substance misuse; forensic; PD services			✓				
Good internal investigation		✓	✓				
Good internal investigation after initial delay						✓	
Good action plan		✓	✓			✓	✓
Adequate action plan	✓				✓		
Good SUI policies			✓	✓	✓	✓	✓
Very short period of contact with service – adequate internal investigation				✓			
No action plan – (but not needed)				✓			
Drug and alcohol services	✓	✓			✓		
No terms of ref. for internal investigation; report undated					✓		

	A Herts	**B** Herts	**C** North Essex	**D** North Essex	**E** North Essex	**F** Cambridge & Peterborough	**G** Beds & Luton
Compliance with risk assessment policy		✓					
Carers' assessments		✓					
Quality of risk assessment & compliance with risk assessment policy	✓						
Good quality of risk assessments						✓	
Poor quality of risk assessment & compliance with risk assessment policy							✓
CPA reviews	✓						
CPA reviews & level							✓
Delay in internal investigation; no terms of ref.; little analysis of care and treatment; poorly framed recommendations	✓						
Lack of consistency in psychiatric care							✓
No formal internal investigation – contribution to child protection serious case review							✓
Incomplete chronology							✓
No interviews with staff							✓

	A Herts	**B** Herts	**C** North Essex	**D** North Essex	**E** North Essex	**F** Cambridge & Peterborough	**G** Beds & Luton
SUI policy for internal investigation not followed							✓
Forensic services; regular drug screening						✓	
Good compliance with CPA policy carers' assessments						✓	
Substance abuse							✓

Appendix C

Verita's individual report recommendations

Patient Key	Recommendation
A,B & G	The trust should consider commissioning an internal audit report to assure compliance with its untoward and serious untoward incident procedures. This could include an examination of the follow up of reports and action plans.
E	The medical director of the trust should commission an audit of the progress made on E's action plan to ensure that: • clients are seen individually • risk reviews are completed • clients with financial problems are appropriately referred to other support within the community.