

Independent investigation into
the care and treatment of Mr G
Case 7

Commissioned
by NHS London

Contents

	Page No
1. Introduction to the Incident	3
2. Condolences	3
3. Trust Internal Investigation	3
4. Commissioner, Terms of Reference and Approach	3
5. Summary of the incident	5
6. Findings	6
7. Notable Practice	7
8. Independent investigation review of the internal investigation and action plan	7
9. Recommendations	8

Executive Summary

1. Introduction to the incident

This Investigation was asked to examine a set of circumstances associated with an incident that occurred on 8th May 2006 that resulted in the death of his common-law father-in-law, his partner's father. Mr G was subsequently arrested and convicted as the perpetrator of this offence.

Mr G was receiving care from the Community Mental Health services at the Oxleas NHS Foundation Trust, (the Trust) formerly the Oxleas NHS Trust in the period leading up to this incident. It is the care that Mr G 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's Chief Executive commissioned an internal investigation into the incident. The incident was categorised as a "level 5" incident and a Trust Board enquiry panel was established to investigate the issues surrounding Mr G's care. The multi-professional panel including a non-executive director was chaired by the Director of Adult and Older Adults Mental Health Services.

The panel was given written terms of reference, used root cause analysis and made sound recommendations.

The Investigation Team considered that there was enough evidence to support overall the findings of the internal investigation and that their findings and recommendations are appropriate.

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 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) and child protection issues at the Trust.

A Type B Independent Investigation is a narrowly focused investigation conducted by a team, supported by a peer reviewers, that examines an identified aspect of an individual's care and treatment that requires in depth scrutiny. A Type B investigation would normally involve a small number of interviews along with a review of documents, including clinical records. Some Type B cases were also recommended to be grouped together around a common theme.

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 care and treatment of the individual or where a group of cases have been drawn together that particular theme and the services involved for example, application of the CPA and risk assessment. This type of investigation is conducted by an investigation team 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:
 - 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 four investigators with quality assurance provided by 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 G was 41 years old at the time of the incident. He lived with his long term partner of 20 years and two sons. His first contact with psychiatric services was 2nd April 2002 at the Hayes Grove Priory Private Hospital where he was seen by a private consultant psychiatrist and diagnosed as suffering a major depressive disorder.

He was referred to the Trust Mental Health Services by his GP on 4th April 2002 and assessed by a Community Psychiatric Nurse at his home. In mid 2002 he was made redundant and later that year it emerged that his wife planned to leave. He was seen by the local Community Mental Health Team (CMHT) and as an outpatient, but often did not attend. He started a business breeding reptiles.

Over the next 3 years he made two attempts at suicide and said he was willing to accept the offer of an appointment to see the consultant psychiatrist and psychological therapies team. In addition to his ongoing drug treatment and CMHT input he was assessed and took up the offer of art therapy in October 2004. His attendance record was variable at the beginning and he disclosed early sexual abuse. By the end of March 2006 his partner and children had left the home they had with him and gone to live with his wife's parents. From early 2006 he was seen regularly by the CMHT and the art therapist, and sometimes both. The records note that Mr G was often low in mood and angry. At one

session with his care co-ordinator he said he was convinced his sons would be abused and threatened to kill his father-in-law.

On 8th May 2006 Mr G's mother received a telephone call from her son who stated that he had killed his common-law father-in-law. She contacted the CMHT for advice who recommended that she rang the police. Mr G was arrested at his home and charged with the murder of his common-law father-in-law.

It was noted by the police that when Mr G was arrested he had apparently consumed a great deal of alcohol.

Mr G was found guilty of manslaughter on grounds of diminished responsibility and detained under the Mental Health Act 1983 in a psychiatric forensic inpatient unit.

6. Findings

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

6.1 Risk Assessment, including contact with Children and Families Services

In view of the serious allegations Mr G was making in relation to his partner's father the local Children and Families Service should have been alerted that the family were now living there. It is the view of the Investigation Team that the Safeguarding Children policy should have been implemented and that relying on other family members to keep the children safe was not sufficient.

6.2 CPA Care Co-ordination and Level

On examination of the case notes, oral evidence and other documents relating to Mr G's case it appeared that each professional worked in isolation and that a fully coordinated care plan was not developed, discussed and implemented and the level of input incongruent with a Standard CPA.

6.3 Treatment Planning

Although there was an ongoing and extensive art therapy service being provided this did not appear to have clear goals and timescales with measureable outcomes.

6.4 Personality Issues

The care records written in July 2003 indicate that Mr G had complex personality issues. There is no evidence that these were discussed further with the services

involved in his care. No referrals were made for additional assessments nor did the team consider the impact that these might have had on Mr G personally and his family's life.

7. Notable Practice

The Investigation Team supported the view of the internal investigation report in that the family were supported by the team and that there was evidence of good clinical practice and communication with Mr G's partner.

The Investigation Team found that in the initial phase of contact there was considerable input from the CPN, including regular home visits. This also applied to the Consultant Psychiatrist who saw Mr G on a regular basis despite him being only on Standard CPA. Generally, missed appointments were followed up and alternatives arranged. There was regular written communication with Mr G's GP.

During the periods of disengagement, in particular when the case was closed, self referrals from Mr G were accepted and acted on promptly.

The Investigation Team found clear record keeping and extensive input from the art therapist

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

In order to assess the progress made by the Trust in implementing the recommendations of the internal investigation, the Investigation Team reviewed the Trust's action plan.

Progress has been shown through:

- The Trust has arranged for CMHT staff to receive training on CPA which was commenced in April 2007. The Locality Managers are responsible for ensuring all staff attend.
- Supervision structures have been revised to ensure that a regular audit takes place of CPA and Client/Patient reviews.
- Community teams are reminded of the need to record contacts in RIO progress notes and this is audited on a regular basis by the Locality and Team managers.
- Child protection training has been in place since November 2006 and audited by the Locality Managers. A link worker has been in place since May 2007 to provide support between the CMHT and Children and Families Service.

9. Recommendations

9.1 Conclusions

1. That the initial phase of contact from the CMHT was of a good standard of care.
2. That the Trust has made considerable progress in the actions taken since the internal investigation was completed.
3. The Trust's overall performance and governance arrangements have improved since the time of the incident as recognised by the Trust's authorisation as a NHS Foundation Trust.

9.2 Recommendations

1. Specific aspects of the use of CPA should be examined in future in Trust audits. Drawing upon the findings of this Inquiry and internal CPA audits, we recommend audit of the following areas:
 - Supervision by team managers of the completion of care plans.
 - Timely completion of care plans.
 - Recording of details of care coordinator.
 - Recording of CPA level.
 - Organisation and recording of discharge CPA meetings.
 - Completion of risk indicator checklist and full risk assessments.
2. A Safeguarding Children strategy has been developed by the Named Nurse for Safeguarding children. It is recommended that there is a regular audit of the training, and progress against the strategy takes place.
3. Regular audit of the supervision arrangements for MDT and other staff covers care and treatment planning, and potential impact of underlying personality issues.

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.

