Independent investigation into the care and treatment of Ms B

Case 2

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 member of public on the 3rd November 2003. Ms B was subsequently arrested and convicted as the perpetrator of this offence.

Ms B received care and treatment for her mental health condition from the Barnet, Enfield and Haringey Mental Health Trust (the Trust). It is the care and treatment that Ms B 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

A comprehensive Board Level Inquiry Panel was undertaken into the care and treatment of Ms B. The Panel was chaired by a Non Executive Director of the Trust and was supported by a consultant psychiatrist, a senior nurse and senior social work staff. The Board Level Inquiry Panel met with witnesses from within the Trust and from external agencies. Each witness was provided with the opportunity to be accompanied by a colleague or representative. Ms B's GP was unable to attend the Inquiry, however he did make contact with the Trust and provided a written statement.

The Board Level Inquiry Panel noted that the Trust 'Management of Serious Incidents Policy' was not followed in respect to Ms B 's case. No local internal investigation was conducted by the Haringey Directorate in relation to this serious incident. The lack of local investigation does not appear to have been investigated by the Haringey Directorate: there were no records of the reasons why an internal investigation was not conducted. Furthermore this was not explored by the Board Level Inquiry Panel.

The Board Level Inquiry Panel was robust and comprehensive. The inquiry addressed all the areas identified in the terms of reference. It also addressed all the care and service delivery problems in the recommendations.

The Board Level Inquiry Panel also met with members of Ms B's family and they found this meeting very useful in understanding the circumstances in which Ms B lived. Ms B's family welcomed the opportunity to meet with the Chair of the Board Level Inquiry Panel and be involved in the Inquiry process. The Board Level Inquiry Panel did not meet with the victim's family.

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 indepth scrutiny. The particular theme for this case was the management, organisation and delivery of mental health services at the Barnet, Enfield and Haringey 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 i.e. child protection, Care Programme Approach, 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:
    - 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 three investigators with expert advice 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

At the time of the incident Ms B was a 40 year old woman who had been in contact with mental health services on and off since 1986. From 1995 Ms B was under the care of a Consultant Psychiatrist and was mainly seen in the outpatient department. Ms B was described as having a difficult and violent childhood, which included a history of sexual abuse. Ms B had three children. After splitting up with the father of her children Ms B had a number of relationships with men who were violent and who also used alcohol to excess.

Ms B was prescribed Oxazepam (a Benzodiazepine which is indicated for the short term relief of anxiety) from 1995 and health professionals, in particular her GP, was concerned about her over-use. Ms B was diagnosed with depression, anxiety, depression within the context of a borderline personality disorder and latterly alcohol dependence.

From 1999 Ms B began drinking mainly at night. As the years continued her drinking increased. In June 2000 the Children and Families Services became involved with Ms B's family following a complaint, a police notification and an anonymous referral. By November 2000 Ms B's children were placed on the 'At Risk Register' (for actual neglect) and taken into care to live with her sister and mother. Ms B made numerous attempts at self harm often under the influence of alcohol and regularly presented in crisis at A&E or the Emergency Reception Centre at St. Ann's Hospital (Mental Health Unit). She was known to become violent when drunk. Three episodes of violence whilst intoxicated were noted.

During Ms B's contact with the mental health services she was encouraged to self refer to the Haringey Advisory Group on Alcohol (HAGA) on numerous occasions. This is a voluntary sector agency for motivated clients. In 2001 Ms B was described as engaging with HAGA and beginning to show small ways of attempting to improve her life.

In 2003 Ms B had three admissions to hospital for detoxification and for her own safety. Risk assessments undertaken in March and May 2003 identified her risk as medium. She was placed on enhanced Care Programme Approach (CPA) prior to discharge in May 2003. A Community Psychiatric Nurse (CPN) was allocated as her Care Co-ordinator.

Ms B was not seen by the CPN or Dual Diagnosis Team due to her frequent non attendance for appointments (DNAs) and staff sickness, but was seen in outpatients in September 2003. The plan following this appointment included follow up by HAGA and the Care Co-ordinator. An appointment had been made for early November 2003 at the GP surgery for Ms B to be seen and assessed by her Care Co-ordinator, GP and dual diagnosis worker. This appointment was scheduled for three days after the incident and was made as it was known that Ms B regularly attended the surgery.

Ms B with another patient Ms D was responsible for the manslaughter of her (Ms B's) partner. The incident took place in front of Ms B's 14-year old daughter.

No local investigation was undertaken. A Board Level Panel Inquiry was held by the Trust in 2005 and a number of recommendations for improvements were made. Ms B was arrested and charged with manslaughter and was sentenced to nine years imprisonment in August 2004.

6. Findings

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

6.1 Failure to develop a coherent management plan via the Care Programme Approach

The Trust services failed to develop a robust management plan for Ms B whilst she was under their care. This was further exacerbated by their failure to follow Trust policies and place Ms B on the CPA when they had opportunities to do so and when her presentation and her deteriorating mental health indicated it.

6.2 Lack of consistency in the prescribing of Oxazepam

The Trust services were aware of Ms B's dependence on Oxazepam and had provided support and advice to the GP regarding reducing / withdrawing. However medical staff failed to follow national guidance with regard to benzodiazepine prescribing and they failed to maintain clear communication to ensure that a consistent dose of the medication was prescribed.

6.3 Lack of integrated working of statutory and voluntary services especially with regard to Ms B and her family

Interagency working provides opportunities to enable seamless care to individuals with mental health needs especially those of a complex nature. Services involved with Ms B failed to follow National and Local guidance with regard to joint working. In addition they lacked the appropriate systems and therefore failed to communicate effectively with regard to Ms B and her family.

6.4 Poor management of Ms B's increasing alcohol misuse and dependence

The Trust services failed to respond effectively to Ms B's increasing alcohol use. The services were under the impression that Ms B was engaged with HAGA but they did not take any action to verify whether this was the case. In addition Trust policies and national guidance was poorly implemented.

6.5 Inadequate CMHT response to Ms B's mental health needs / diagnosis

The CMHT's interpretation of the eligibility criteria prevented them from responding to Ms B's needs and offering a service. In addition the community services failure to place her on the CPA further impacted on the CMHT's lack of involvement.

6.6 Lack of effective follow up by mental health services following Ms B's discharge from hospital in May 2003

Mental health services failed to adequately follow up Ms B. In addition they appeared to lack the appropriate systems to ensure continuity of care following period of absence.

7. Notable practice

There was a prompt response from mental health services to Ms B's GP letter dated February 1995 requesting that Ms B's be seen and assessed. Ms B's GP provided ongoing and consistent input throughout Ms B's episode of care with secondary services. His input was particularly helpful in monitoring Ms B's mental health, medication and alcohol misuse. The practice was notable because in the absence of a clear management plan the GP acted as a care co-ordinator. He provided regular input, liaised with other involved services and sought advice on best courses of action when required. He demonstrated a genuine interest in Ms B's wellbeing and her recovery.

As early as October 1995 the GP highlighted Ms B's potential for Oxazepam addiction and requested advice to help her reduce this. The advice received from secondary services with regard to benzodiazepine withdrawal followed established benzodiazepine withdrawal guidance.

The local Children & Families Social Work Team's response to concerns about Ms B's family and the Child Protection Conferences undertaken were robust, timely and followed safeguarding child protection guidance.

The CPN took the initiative to organise a meeting at the GP surgery for GP, CPN and dual diagnosis worker to see and assess Ms B in November 2003 because she knew that Ms B was attending these regularly.

During Ms B's involvement with mental health services she received regular appointments to attend outpatients.

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

The Barnet Enfield Haringey Mental Health Trust approached the implementation and monitoring of recommendations from six serious untoward incidents in a pragmatic way (this includes the recommendations from the Ms B's case) by pulling them together and grouping them. These recommendations were then entered onto a large action plan. Out of the 63 recommendations made since 2004, 39 (62%) related to the following areas CPA, audit, organisation of CMHTs, support for carers , risk management, record keeping and release off report to the family. The other recommendations related to Ms B's case were not themed or grouped in this way.

All of the recommendations and action plans related to the Ms B case were monitored by an internal High Level Serious Untoward Inquiry meeting chaired by the Director of Nursing. In addition, since 2007 the recommendations have been monitored by a Joint Mental Health Clinical Services Improvement Group (JMHCSIG), established jointly with the local PCT. This Group works to address risk issues in relation to those serious incidents which cross the mental health and primary care interface.

All the recommendations appear to have been implemented except for one concerning managing consultants' workloads. The BEHMHT has provided robust evidence and on going management of the implementation and monitoring of the recommendations. The Investigation Team commends the Trust on their commitment and openness to scrutiny and the learning and change that has taken place.

9. Recommendations

The Investigation Team did not feel that the lack of CPA directly contributed towards the incident

The Investigation Team endorse the Board Level Inquiry Panel's recommendations and add the following:

1. The Trust needs to ensure that Trust policies related to CPA, Risk, and Child Protection are implemented. This should include regular audit of practice and development of action plan to address weak areas.

2. The Trust need to ensure that integrated working occurs within Trust and external services to facilitate communication and clarity regarding roles and responsibilities.

3. The Trust needs to continue its partnership work with the PCT. The remit should be extended to include care pathways between and through services.

4. The Trust should implement clear prescribing guidelines and monitoring guidelines especially those medications which have the potential to cause dependence.

5. The Dual Diagnosis Network was set to ensure the delivery of seamless care for patients with a dual diagnosis. The Trust should ensure that funding for the service is continued and that the service is regularly audited.

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.