Independent investigation into the care and treatment of Mr R

Case 18

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 7th March 2006 that resulted in the death of a member of public on the 9th March 2006. Mr R was subsequently arrested and convicted as the perpetrator of this offence.

Mr R was receiving care from the drug and alcohol services at the North East London NHS Foundation Trust, (the Trust) formerly the North East London Mental Health NHS Trust in the period leading up to this incident. It is the care that Mr R 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 following the incident. The internal investigation was chaired by a Non-Executive Director and also included the Trust's Medical Director, Associate Director of Nursing, SUI inquiry Manager and an external member.

The Terms of Reference, identified care and service delivery problems, conclusions and recommendations are provided in this report.

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 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 drugs and alcohol issues at the 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 (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's 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 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 quality assurance provided by the Health and Social Care Advisory Service as required.

4.5 Independent Investigation start date

The Independent Investigation started its work in October 2007.

5. Summary of the incident

Mr R was an unemployed 42 year old Irish male, of no fixed abode (NFA). He had a long history of drug and alcohol misuse. His first contact with drug and alcohol services was in 1991, when he was admitted for alcohol detoxification. Mr R made sporadic attempts to rehabilitate and reduce his alcohol and drug misuse over the years.

On 7th March 2006, Mr R and a friend together with a third man, were drinking together at a Hostel in Walthamstow. After having some food they all left at the same time to cash Mr R's giro and to buy more alcohol and cigarettes. They congregated outside the Walthamstow Magistrates Court to continue drinking when it began to rain. All three moved to a disused mini cab office in Marlow Road, E17, a known place used by street homeless people.

According to the third man there was an unprovoked attack on Mr X by Mr R who began shouting "I'm a boxer" as he continuously punched Mr X, who was reported to be bleeding. Mr R and the third man then left the scene to go to a fish and chip shop to buy more alcohol. It was reported that Mr X staggered on to a bench in Wood Street, E17 where a passerby saw him and called an ambulance.

Mr X was taken to hospital and died on 9th March 2006.

At the time of the incident Mr R was a current service user of the Trust's Community Drug and Alcohol Team. Mr R was known to have been a previous service user although there is no evidence to suggest that they knew each other through contact with Trust services. Mr R was 44 years old at the time of the incident.

Mr R pleaded guilty to manslaughter on 11th June 2007 at the Old Bailey Court and was sentenced to a prison term of four years.

6. Findings

The Independent Investigation team did not identify any care and service delivery problems that are relevant to the incident.

7. Notable Practice

The internal investigation report concluded that the care provided to Mr R leading up to the incident appeared to be appropriate. This Investigation would draw the same conclusion. The level of care provided by the Community Drug Alcohol Team was of a high standard.

The Team scheduled appointments with Mr R in a speedy manner and their assessments were thorough, and they utilised risk assessment tools. In particular, the assessment carried out by the locum staff- grade doctor on 13 February was very comprehensive. The case was also discussed in a multi-disciplinary setting on 14 February and the decision made was quickly communicated to the Alcohol Team and to Mr R's General Practitioner.

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

The role of this Independent Investigation was to review the Trust's internal investigation and assess its findings and recommendations and the progress made in their implementation. This included an evaluation of the internal investigation Action Plan.

The Independent Investigation Team identified the following issues in relation to the Trust's internal investigation:

- The report is poorly written in parts, and omits certain key information (i.e. the report does not identify the staff that were interviewed).
- The investigation reviewed the care provided to both Mr R and Mr X. This made it somewhat difficult to ascertain which findings relate specifically to Mr R.
- In addition to this, the report did not evidence in sufficient detail how the panel came to its findings and conclusions.
- The Trust's incident reporting templates at the time did not support Root Cause Analysis, and there is no reference to Root Cause Analysis in the internal investigation report.
- The internal investigation report did not identify any support provided to staff and to families (the 72 hour report for Mr X records that the Community Drug and Alcohol Team Manager contacted his family to offer condolences).
- The internal investigation report took 17 months to complete.
- The report was not submitted to the Trust Board (the Trust's procedure is to submit reports to a Board committee).
- The Trust's investigation file cannot be located, and remains missing.

Due to the issues identified above, the Trust's current SUI policy was reviewed, and an interview held with the Medical Director, who was a member of the internal investigation team. This was done in order to try to gain a better understanding of how the internal investigation was conducted, and also to assess what improvements the Trust had made in the SUI investigation process.

The Trust's current SUI Policy is comprehensive and written in accordance with best practice. It addresses in detail the Trust's expectations regarding the support provided to staff, service users and families following an incident, and throughout an investigation. It also adopts Root Cause Analysis and the current templates support this process.

The Medical Director was able to confirm that the internal investigation panel did interview relevant staff. The Medical Director was also able to provide some insight into how the panel came to its findings and conclusions. He also gave evidence regarding improvements in the management of the SUI process, including the standard and timeliness of reports, and also detailed how the Trust was making further improvements in this area.

Despite the issues identified above, the review of Mr R's clinical records and the interview with the Medical Director provides evidence to support the findings of the internal investigation, and the Investigation Team are of the opinion that the internal investigation's findings and recommendations are reasonable.

9. Recommendations

Conclusions

1. Mr R received a very good standard of care from the Trust in the period leading up to the incident.

2. Care and service delivery issues identified by the internal investigation are not relevant to the incident in question. They are, however, reasonable, and the Trust has made commendable progress against the action plan.

3. The Trust has made major improvements in its handling of SUIs and embedding learning, and continues to do so.

4. The Trust's overall performance and governance arrangements have improved markedly since the time of the incident, as recognised by the recent Healthcare Commission ratings, and the Trust's authorisation as a NHS Foundation Trust.

Recommendations

1. A consistent approach to clinical risk assessment should be developed across London (NB the London Mental Health Trust CEO Group is preparing a two year improvement programme in this area).

2. Exemplar practice regarding the procedures, management and governance arrangements of SUIs should be disseminated across the sector, as should wider learning from SUIs.

3. Trust Boards should take the lead in ensuring that procedures, management and governance arrangements are clear, effective and well resourced.

4. The Trust needs to ensure that all internal investigations are completed within 60 days utilising a root cause analyses methodology.

5. Senior clinical input must be considered as part of the Multi Agency Public Protection Agency process. This input should take the form of a Consultant Psychiatrist.

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.