Independent investigation into the care and treatment of Ms D

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 D was subsequently arrested and convicted as the perpetrator of this offence.

Ms D 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 D 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 following is a summary of the internal investigation team report undertaken by the Barnet Enfield and Haringey NHS Mental health Trust in July 2004

The Independent Investigation concluded the internal investigation was robust and addressed the main service delivery concerns in its recommendations.

There was no reference to liaison with the victim's family or liaison with the perpetrators involved which would now be considered to be standard practice.

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 management, organization 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 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

A known service user, Ms D, and an accomplice, killed the accomplice's partner on the 3rd November 2003 in the accomplice's home. At the time of the incident Ms D was 43 years old. She has six children, four of whom have since been adopted. Her two youngest children live with her estranged husband.

Ms D had a history of violence and criminal assault prior to her contact with the Trust. In 1997 Ms D served two and a half years of a four year sentence for manslaughter. She was released on parole on the condition that she sought treatment for her alcohol problems. In February 2002 Ms D was charged with an offence of unlawful wounding. In this case Ms D had been drinking with two men. A row ensued which deteriorated into violence and Ms D used a broken bottle slashing the man's face and right ear. Most incidents of violence involving Ms D were triggered by or involved alcohol consumption.

Ms D first presented to the Trust services on the 24th January 2002 at the Emergency Reception Centre (ERC) intoxicated with alcohol and having taken an overdose. In the next two years she was to present in a similar way a number of times. She was admitted 4 times in this period all following crisis attendances with both health and social problems. A number of diagnoses were made including unipolar depression with symptoms of anxiety and post traumatic stress, personality disorder with poor impulse control and alcohol abuse.

The period leading up to the homicide was characterised by admissions followed by periods of disengagement and a failure to attend out-patient appointments followed by self- presentation at the ERC service.

Ms D's longest period of admission began on the 5th March 2003 when she was admitted to Lordship ward. During this admission the multidisciplinary team

attempted to get Ms D a hostel placement with community care support. Ms D was turned down for at least one hostel placement and not assigned a place by the Community Mental Health Team (CMHT) as they did not feel she met their eligibility criteria.

Ms D was compliant with treatment initially during this admission but in the last few weeks of her stay she began to consume alcohol and return to the ward intoxicated. She was often aggressive and on some occasions violent. Ms D was discharged on the 13th May 2003 without a completed Care Programme Approach (CPA) plan but with an ongoing prescription of the antidepressant Venlafaxine.

During her contact with the Trust Ms D had been sign- posted to the Haringey Advisory Group on Alcohol (HAGA) on a number of occasions. This is a voluntary sector agency for motivated clients. Self-referral is expected. Ms D had some contact with HAGA but did not engage.

Ms D had a further two shorter admissions to hospital on the 8th June and on the 22nd June 2003, both following a crisis. Ms D was homeless at this time and was staying at a friend's flat. Ms D was again referred to the CMHT at Canning Crescent on the 18th June 2003 and refused on the grounds of eligibility criteria for CMHT care. During both admissions Ms D left the ward failing to return and was reported as absent without leave (AWOL). On both occasions she was discharged in her absence. Ms D made one further contact with the Trust's services when, on the 23rd July 2003, she requested an outpatient appointment and was given one for that afternoon, but she did not attend.

Ms D was charged with the murder of the victim on the 3rd November 2003. The victim was the partner of Ms B, another service user. Ms B was also charged. Ms D was convicted of the murder of the victim in August 2004 and sentenced to life imprisonment.

6. Findings

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

6.1 Failure to adhere to the Trust CPA process

The delivery of enhanced CPA in the care and treatment of Ms D at that time fell below acceptable standards. The Team believe that this showed a failure of staff to familiarise themselves with some key policies and procedures and to use these to help manage the complex care needs of Ms D, and that CPA was not effectively used during the period of Ms D's care and treatment.

There was poor understanding and practice of the principles of CPA in those services involved with Ms D. This also meant that liaison between community services, voluntary sector and inpatient services were poor. In Ms D's case where plans were initially organised there was no care coordinator allocated to follow this through.

6.2 Inadequate clinical risk assessment of Ms D

Ms D was a challenging patient. Those providing her care tended to emphasise her alcohol abuse problems over others meaning that comprehensive assessment of her behaviour and the risks she presented to herself, her children and others did not take place. Some opportunities to engage Ms D more effectively were missed. More use could have perhaps been made of the dual diagnosis service and a forensic assessment may have helped community and inpatient services develop a plan to address Ms D's cycle of crisis and disengagement. A more comprehensive review of her offending history may have given a more accurate picture of the risks she presented.

6.3 Lack of a seamless care between inpatient and community services including voluntary sector

The configuration of services in the Trust at that time did not support staff to provide assertive care for patients with the spectrum of complex problems presented by Ms D. CPA was poorly understood and implemented at the time of the homicide, but to operate properly, CPA needs to be supported by clear care pathways and good multi-disciplinary working

7. Notable practice

At the time of the incident in 2003 the Trust had begun to undergo a review of its services, and it was recognised that certain areas needed reshaping. There were pockets of notable practice identified not only from this report but in interview with the Associate Director at the time.

There was some evidence of good clinical risk assessment and dual diagnosis services were attempting to provide more responsive support to inpatient ward staff regarding the care and management of patients admitted with concurrent drug and alcohol problems.

The risk assessment completed by the doctor on Ms D on presentation at the emergency reception centre on the 5th March 2003 was very clear and comprehensive

The initial work by the dual diagnosis worker with Ms D showed good records of therapeutic engagement that could have been developed further.

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 progress of the Trust investigation action plan has shown effective working between the Trust and its partner agencies in addressing the internal investigation team recommendations of 2005.The Investigation Team were impressed by the whole systems approach taken by the organisation in addressing these recommendations and commend the Trust for its work since 2005/06 onwards.

Over the last 5 years there have been a number of changes within the organisation. It has been noted as stated earlier that the Trust has made significant improvements in the areas of concern outlined in the report. This was clearly evident in the July 2008 report of the Joint Services Improvement Group action plan

9. Recommendations

Whilst the care and treatment of Ms D fell below acceptable standards, (this was measured against National guidance under the Care Programme Approach issued by the Department of Health April 1991.and also against the Trust's CPA Policy 2001 and 2003) the Independent Investigation Team did not feel that this directly contributed towards the incident.

Whilst the Trust undertake regular audit of CPA performance of Trust services, the Investigation Team recommends a follow up audit of CPA performance indicators as stated in the Joint Services Improvement Group action plan to ensure the Care Programme Approach is effectively embedded in service delivery from a service user's perspective. This should be done within 6 months of the publication of this report.

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.