Version 6

London Borough of Brent

Executive - 28th May 2003

Report from the Director of Social Services

REPORT OF THE INQUIRY INTO THE CARE AND TREATMENT OF AB

For Action **Name of Wards Affected**
None

1.0 SUMMARY

This report summarises the Mental Health independent Inquiry Report, into a homicide by a mental health patient known to Brent Mental Health Trust and Brent Social Services, in 1998. It identifies issues raised by the Inquiry Team as a result of their investigations, and the Team's recommendations.

Appended to this report is the action plan that has been prepared, following these recommendations, and submitted to the Strategic Health Authority by the Primary Care Trust in consultation with Social Services.

1.1 The Action Plan will now be implemented across health and social services, housing, probation and the prison service. However, since the time of the incident many positive changes and developments have taken place in relation to services for people with mental health problems in Brent and many of the actions already implemented.

1.2 The report also sets out how the agencies involved and Brent Primary Care Trust will seek to use the lessons learned from this Inquiry, as with others, to improve the standard of service delivery in the future.

It is also important to note that in the words of the Inquiry Team "The homicide did not appear to have resulted from a premeditated intention. The view of the Inquiry Team is that it could not have reasonably been foreseen by any agency."

2.0 RECOMMENDATIONS

2.1 Members are asked to note the report and agree the action plan at appendix 1.

3.0 FINANCIAL IMPLICATIONS

3.1 The action plan is being implemented within existing financial resources.

4.0 STAFFING IMPLICATIONS

4.1 The action plan is being implemented within existing staffing resources.

5.0 DETAIL

Incident

AB was convicted in October 1998 of the manslaughter, stabbing to death, of her boyfriend. She was aged 28 at the time. AB was sentenced to 3 years imprisonment and was subsequently released on licence in September 1999.

Because AB had in the past suffered from mental ill health, and because she had been convicted of manslaughter, the Department of Health 'untoward incident' procedure was followed. This requires the Health Authority to set up an Inquiry chaired by an Independent Chair into the Care and Treatment AB had received from the various services she had come into contact with, to report the findings of this Inquiry, and make recommendations accordingly.

5.1 The Inquiry into the homicide was set up, by the then Brent and Harrow Health Authority (BHHA), in 1999, and reported back in November 2002. The NW Sector Strategic Health Authority (StHA) took over responsibility for receiving the Inquiry Report and ensuring its subsequent publication. The Primary Care Trust, which replaced BHHA has provided an administrative function to the StHA and has also undertaken responsibility for completing an action plan, in conjunction with Central and North West London Mental Health Trust (CNWL), Brent Council Housing Services, Probation and the Prison Medical Service, to ensure the recommendations are implemented.

5.2 Department of Health (DH) Inquiry procedure.

The DH required HA's and now StHA's to have 'serious untoward incident' procedures. Part of this is for the setting up of an Independent Inquiry, separate from the service area, to make recommendations. As the mental health service in this case, included Social Services and other agencies involvement, the Inquiry remit covered these. The reports findings are recommendations, they do not have a statutory force, but all agencies have agreed to accept the recommendations.

Action Plan

5.3 The Joint Commissioning Manager for the PCT and Social Services has the responsibility to ensure the action plan implementing the recommendations is completed, to submit this to the StHA for scrutiny, to provide reports and advice to the PCT Board and Director of Social Services in relation to the recommendations and action plan. He will also monitor the implementation of the action plan by the mental health services in Brent and report back as and when required.

The Inquiry

5.4 The AB Inquiry Chair was a solicitor, and the other panel members were a former Director of Social Services and a Consultant Psychiatrist from another area of the country.

Inquiries of this nature do usually take some time to complete their findings and report back. On this occasion, however, matters were complicated by the changes that had taken place to services during the period of the Inquiry, the large amount of evidence that had been submitted and the death of the Inquiry Chair during the proceedings.

The Inquiry took evidence from the five main service areas involved with AB over the years, as well as from General Practice. Those were: the Probation and the Prison Service because of her criminal offences; Social Services because of their involvement in relation to assessing her mental state, her admissions to hospital, liaison with housing over her accommodation needs and helping her manage her life in general; the Mental Health Trust who treated her in acute hospital settings; and the Brent Housing Services who were helping her with her accommodation needs.

Client Background

5.5 AB was born in Lambeth to Irish parents and soon afterwards moved with her family to live in Willesden. Her parents divorced in 1988. Following the divorce AB lived from time to time with each parent. She has a younger brother. Her early school life seemed to go well, but by the age of 14 her behaviour had become such that she was expelled from school

Between March 1991 and the date of her conviction, 1998, AB was in touch on numerous occasions with mental health and social services in Brent. During this period of time she became the responsibility of a number of staff from all the service areas including having an allocated social worker, and from time to time contact with her was closed when it was felt she would not benefit from services or when the diagnosis of her mental health had changed.

The contact and the issues that she presented to the various agencies as well as the response of those agencies is summarised below in the Inquiry findings.

Inquiry Findings

5.6 A summary of the Inquiry Report identifies the following issues in relation to AB prior to the homicide in 1998:

- As a teenager she began taking drugs and dropped out of school, she frequently used Primary Care Services but also frequently failed to attend appointments.

- She was a young woman who exhibited numerous problems including mental disorder, drug and alcohol abuse, prostitution, imprisonment, unemployment and unstable and unsuitable accommodation.

- She had a long forensic history.

- All agencies in contact found it difficult to maintain contact with her.

- AB had 3 voluntary admissions to hospital but frequently failed to comply with medical treatment or to attend for out patient appointments.
- Diagnoses varied throughout her contact with the agencies and there was confusion over the correct treatment. She was diagnosed as being schizophrenic, then as having a personality disorder and at other times no evidence of psychosis could be found.

- She was not on the Care Programme Approach (CPA). This is a means of determining the level of service a person needs. There are two levels of CPA, Enhanced and Standard. Enhanced means the person has a high level of mental health and social care needs and has to maintain frequent contact with services including for treatment. Standard requires a less intensive involvement.

- Insufficient focus was given by the agencies involved to her drug and alcohol problems.

- Social Services did not keep consistent engagement with her because of her inability to engage.

- There was a lack of inter agency co-operation, primarily between Health, Social Services and Probation.

- Reports produced by these agencies lacked accuracy and clarity.

- The Probation Service failed to comply with its own National Standards.

- The Prison Service did not liaise with other agencies.

- The Brent Housing Service did provide an appropriate level of service.

- The quality of risk assessments completed by the agencies involved were not up to the expected standard.

Recommendations

5.7 The Inquiry Team made 69 recommendations, these covered Probation, the Mental Health Trust, Social Services, Housing and the Prison Medical Service.

These recommendations covered all the areas in the body of the report identified as shortcomings in practice, failure to keep to standards and where services could be improved, including:

- The need for agencies to work more closely together and protocols to enable this to happen.

- Communications and the sharing of information.

- Complying with policies and national standards.

- Appropriate implementation of the CPA.
- Risk assessments and the recording of information.

- Discharge procedures and notifications.

- Assertive engagement with difficult to engage service users.

- The need for integrated health and social care service provision, easier access to services and the pooling of budgets.

- Monitoring of, and following up on, failure to attend for appointments.

- Ensuring reports are accurate and enable appropriate services to be provided and action taken.

- Ensuring appropriate eligibility criteria are in place.

5.8 Action Taken

An action plan covering all the 69 recommendations has been produced by the agencies involved.

Since the homicide took place there have been numerous changes to the structure of mental health services and to the way agencies work together and share information. These have taken place as part of good practice but also through the implementation of the Government's modernisation agenda.

5.9 The full action plan is attached but below is a summary of some of the key changes that have already taken place:

- There has been an integrated mental health and social care service in Brent since April 2001, with a single point of entry, single assessment, single care planning and care co-ordination. This service is called Brent Mental Health Service (BMHS).

- There have been significant changes to the implementation of CPA and the eligibility criteria has been revised in line with national standards.

- There have been significant improvements in collaborative working between agencies including the vulnerability reporting procedures to Housing.

- Extensive training is now given in risk assessment and the forms and procedures used by health and social care agencies clearly identify the risks individuals present or face.

- There is close follow up of people at risk following discharge from the acute services and those who fail to keep appointments.

- An Assertive Outreach Team has been in place since 1999, this is now being revamped in line with national guidance.

- Housing Services have or are implementing all the recommendations required of them in the action plan.

There is still much work to do in refining protocols and continuing to ensure smooth and where possible seamless working arrangements. The action plan indicates where this is happening.

There has also been much work undertaken in improving the prison environment and discharge arrangements for mentally ill prisoners, the ongoing work is detailed in the action plan.

5.10 Specific developments in Social Services

There were a total of 32 recommendations that related specifically to Social Services.

- Of these many have been resolved by the implementation of the Integrated Mental Health Service (BMHS) in April 2001, the aim being to ensure there is integrated management within the Trust. All managers for the mental health teams have both health and social service responsibilities and are employed by the Mental Health Trust. There is a 'pooled' fund arrangement in place to cover the management costs. These arrangements were approved by the Social Services Deciding Committee on 14th February 2001.

- Those that relate specifically to CPA have again been resolved both by the introduction of the integrated service and by the joint implementation of CPA across the service.

- The need for Assertive Outreach and Intervention has been resolved although this has now been reviewed with the aim of introducing a more robust service during 2003.

- There are good working relationships with Housing Services and improved communications across all agencies.

- Information is now shared across the service.

5.11 Outstanding actions

The outstanding actions that relate to, or include, the role of Social Services and Housing are:

- Assessment of supported housing needs across the Borough and plans in place to improve the stock of accommodation. This is being taken forward by the mental health Local Implementation Team with the involvement of all agencies and will be reported into the planning process during 2003.

- There is going to be a Pilot Vulnerability Panel, which is going to look at all hospital discharge cases on mental health grounds. The Panel is due to commence in May 2003, and will consist of senior officers from the Housing Resource Centre (HRC), Community Mental Health Trust (CMHT) and the Mental Health Housing Team (MHHT). Depending on how this pilot works will determine whether the role of the Panel is to be expanded further to look at other cases where mental health clients are involved.

- Quarterly liaison meetings are taking place between senior officers in the CMHT and Housing Department, which has instigated working on joint training (first session to take place in June 2003) and the operation of protocols such as information sharing.

- Changes to the Dual Diagnosis services in Brent to provide a more robust and effective service, this will be planned during 2003/4.

- Discussions on further pooled fund arrangements between Health and Social Services to improve the provision of flexible, effective and seamless services to this vulnerable group, and remove any remaining organisational barriers to change and modernisation.

5.12 Next Steps

The Joint Commissioning Manager is responsible for ensuring that BMHS implements the actions agreed across the service. The lead for this will be the BMHS Head of Service. The Joint Commissioning Manager will ask the other agencies involved to ensure that they implement the agreed recommendations. The Joint Commissioning Manager will report to the Assistant Director Community Care on the progress of implementation.

The PCT receives copies of all Independent Inquiries as part of its Clinical and Corporate Governance function. The Director of Nursing leads this process and there will clearly be a role for the Clinical and Corporate Governance Committee.

There are still some outstanding actions detailed in 5.10 for Social Services and Housing and the Joint Commissioning Manager has been asked to report back to the StHA in six months time on progress to date. He will also report on actions still needed in the probation and prison service. Updated reports will also be provided to the PCT Board and Social Services.

Conclusion

5.13 The recommendations reflect good practice and many had been implemented prior to the Inquiry report. As detailed above the outstanding actions have been approved by the agencies and therefore members are recommended to accept and agree the action plan.

6.0 BACKGROUND

6.1 The detail and reasons for the integration of the mental health and Social Services functions into one partnership body is outlined in the Social Services Deciding Committee report on 14th February 2001.

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A full copy of the Inquiry Report is available from Christabel Shawcross, Assistant Director - Community Care, Mahatma Gandhi House, 34 Wembley Hill Road, Wembley HA9 8AD Tel: 020 8937 4230.