An independent investigation into the care and treatment of Patient E

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USE OF ITALICS IN THE TEXT OF THE REPORT

The use of italics in the text of this report reflects direct quotations or reported speech

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1 Executive summary

The death of Patient E's family members

1.1 In December 2021 Patient E telephoned the police to tell them he had stabbed and killed his family members.

1.2 When the police attended, they found that two of Patient E's family members had been fatally stabbed. Patient E was arrested and taken into custody.

1.3 At the time of his arrest Patient E was a patient under Mental Health Trust 1, with his care and treatment provided by his local Community Mental Health team (CMHT). Patient E had a care coordinator (CCO2) and was also seeing a consultant psychiatrist (CP2).

Background and brief mental health history

1.4 Patient E had been involved with mental health services since 2005/2006, when he had reported his first psychotic episode after taking recreational drugs.

1.5 Patient E had intermittent contact with community mental health services from that time, with brief contact from 2009 to 2010 and then again from 2012 until April 2017. He would frequently not attend appointments made with his care coordinator of the time (CCO1), but he would attend some appointments with his consultant psychiatrist of the time (CP1) when he would ask for changes to his antipsychotic medication. It was recorded that he had gambled heavily, and he also drank alcohol to excess.

1.6 In October 2017 Patient E was re-referred to the CMHT by his GP. Because he attended very few appointments CP1 discharged Patient E back to the care of his GP in July 2018. CP1 noted that Patient E blamed many of his personal difficulties on his medication, including his inability to hold down a job.

1.7 Patient E was re-referred in January 2019 after a relapse in his condition but failed to attend his appointment. He was sent a new appointment in May 2019 with a new consultant psychiatrist (CP2) who subsequently took over his care. During the rest of that year Patient E intermittently attended appointments with CP2 (two out of six). However, he also contacted either the first response service (FRS) or Mental Health Hospital 1[1] on 20 occasions, asking to speak with CP2's secretary.

1.8 The first record of Patient E reporting command hallucinations (voices telling him to do things) appeared in the notes in December 2019. In January 2020 it was recorded that Patient E had run out of the house with no shoes on after voices told him to jump in a reservoir.

1.9 Following this incident Patient E received support from the intensive home treatment team (IHTT) in January and February 2020. Patient E was re-referred and accepted on to the IHTT caseload in March 2020. Because the NHS response to the Covid-19 pandemic changed the way services could work, this support became a regular phone call until he was discharged from the IHTT in May 2020.

1.10 In June 2020 Patient E's condition deteriorated and after discussion between the CMHT team leader and CP2 it was agreed that Patient E needed to be cared for under the Care Programme Approach (CPA) and have a care coordinator.[2] He was allocated CCO2 from his local CMHT on 8 June 2020.

[1] Mental Health Hospital 1 is an adult acute mental health hospital provided by the Trust.

[2] The CPA is a package of care for people with mental health problems. NHS (2021) *Care for People with Mental Health Problems (Care Programme Approach)* https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

1.11 Patient E's mental health worsened. Because of an increase in suicidal ideation and because his medication did not appear to be helping him, Patient E was assessed as needing to be admitted to hospital. He was admitted as an informal patient[3] (which means he was not detained under the Mental Health Act 1983 (MHA)) to Ward 1, at the local Mental Health Centre 1 on 8 June 2020, the same day that he was allocated to CCO2's caseload. Following assaults on members of staff on the ward in response to command hallucinations, Patient E was detained under Section 5(2) MHA on 11 June and then assessed under Section 2 MHA. On 7 July 2020 Patient E was detained under Section 3 MHA for treatment because his risks could only be managed in hospital at that time.

1.12 Because his aggressive behaviour could not be managed on the ward, from 14 July 2020 Patient E spent several weeks in a psychiatric intensive care unit (PICU)[4] near London (run by the Huntercombe Group), returning to his previous county on 11 August 2020 when he was transferred to Mental Health Hospital 1, this time to Ward 2. Patient E's mental health condition stabilised on his return. He had several periods of home leave without incident and was discharged to the care of his CMHT on 19 August 2020.

1.13 Following discharge from Mental Health Hospital 1, Patient E's engagement with his care from the CMHT was similar to his previous pattern of frequent non-attendance at appointments with his care coordinator and sporadic attendance with his consultant psychiatrist where he would ask for changes to his prescribed antipsychotic medication.

1.14 Patient E was entitled to Section 117 aftercare arrangements because he had been detained under Section 3 MHA.[5] His first Section 117 review meeting was held on 28 October 2020. As Patient E did not require any social care at that time he was discharged from social care by the council, although they remained the lead agency for coordinating Section 117 aftercare. Future care was to be provided by the Trust and involved monitoring his medication and any side effects through contact with CP2 and CCO2, risk management and multidisciplinary team (MDT) CPA reviews provided by CCO2. Face-to-face visits and telephone contact was intended to oversee his needs, and CPA reviews were to be carried out via Microsoft Teams through the Covid-19 lockdown period.

1.15 In May 2021 Patient E was discharged from the care of the CMHT after discussion between CP2 and CCO2 because he was not engaging with mental health care services and frequently did not attend appointments. The council as an organisation were unaware of this decision although there was engagement through a social worker alongside the CMHT.

1.16 On 11 August 2021 Patient E contacted FRS again as he felt he needed to be back under the care of the CMHT because his mental health had deteriorated. He was signposted to his GP, and his GP then contacted FRS on 12 August 2021 with an urgent referral for assessment by the CMHT.

1.17 This referral was received and triaged by the First Response Service (FRS). The FRS then passed the referral to the CMHT. The CMHT started the initial screening on 19 August 2021. After speaking with a colleague in the GP practice on 19 August 2021, the GP made a further telephone appointment to speak with Patient E. The GP had a telephone consultation with Patient E on 24 August 2021 and found that his mental health had further deteriorated, Patient E reported that he had *"murdered someone at age 14 and if he does not murder someone again he is going to hell*". The GP then contacted the FRS again on 24 August 2021 as they felt that Patient E needed urgent support from the CMHT, and they had not been informed of the outcome of their referral of 12 August 2021. Patient E was assessed in person by the FRS on 25 August 2021. The outcome of this assessment was a referral to the Intensive Home Treatment Team (IHTT). Patient E was accepted by the IHTT but would not engage with them, and he was accepted back onto the CMHT

[3] Section 131 of the Mental Health Act (1983) relates to the admission of informal patients who are deemed to have capacity to consent to be admitted for treatment of a mental disorder. https://www.legislation.gov.uk/ukpga/1983/20/section/131

[4] The Huntercombe Hospital – Roehampton. https://huntercombe.com/wp-content/uploads/2018/12/Roehampton-7.pdf

[5] "*Section 117 of the Act requires clinical commissioning groups and local authorities, in co-operation with voluntary agencies, to provide or arrange for the provision of after-care to particular patients detained in hospital for treatment who then cease to be detained.*"
Department of Health (2015) *Mental Health Act 1983: Code of Practice*
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

caseload in September 2021 where his care continued in a similar pattern as before. He continued to intermittently engage with CP2 but would not engage with CCO2.

1.18 After several missed appointments with CCO2, Patient E was referred for assessment by the intensive outreach team (IOT) in October 2021. This was because he was not engaging, however, they determined that because he was occasionally engaging with CP2 he did not meet their referral criteria. He remained under the care of the CMHT.

1.19 Patient E contacted the FRS on 7 December 2021 saying he felt his mental health had deteriorated. An appointment was made for him to see CP2 on 9 December, but again he did not attend. CP2 telephoned Patient E's home and although he was not able to speak with Patient E, he did manage to speak with a family member who reported that Patient E was "*probably asleep as he stayed up late at night on his computer*".

1.20 CCO2 attempted to contact Patient E by telephone on 13 December 2021. They were unable to leave a voice message. They then sent a letter to Patient E offering a face-to-face appointment on 10 January 2022 at his home address.

1.21 On Thursday 16 December 2021 CP2 managed to speak with Patient E on the telephone after Patient E had telephoned CP2's secretary requesting a call-back. Patient E reported that when he had increased his medication (quetiapine[6] 400mg) "*it had got worse*". An appointment was made for Patient E to see CP2 on Monday 20 December 2021.

1.22 Patient E attended this appointment and reported that he was having vivid hallucinations, with voices telling him he was a rapist and a paedophile. He was also experiencing command hallucinations telling him to kill himself or others and saying that his family "*would be in hell for eternity*". Although these symptoms were similar in nature to those reported before his last admission, CP2 noted that previously he had been fearful and distressed and this time those emotions were absent. It was recorded that Patient E was calm, able to think logically and give informed consent. Depot antipsychotic medication (which is an injection with slow-release medication) of zuclopenthixol[7] was discussed. Patient E was willing to consider taking the depot medication and an appointment was made for him to receive a test dose in a weeks' time and a review appointment was made for 30 December 2021. In the meantime, he was started on 10mg of zuclopenthixol to be taken orally twice a day and given a prescription for two weeks supply. Patient E was also prescribed zopiclone[8] 7.5mg at night to help him sleep and advised to reduce his quetiapine to 200mg. CP2 also referred Patient E to the IHTT, informing them of the deterioration in Patient E's mental health and that he was hearing voices telling him he was a paedophile and to kill others to protect his family.

1.23 The following day, 21 December, the team leader for the CMHT received a telephone call from the police station telling them that Patient E was in police custody following the killing of his family members.

[6] Quetiapine is an antipsychotic medicine that works by affecting chemicals in the brain such as dopamine and serotonin. It does not cure the condition, but it can help with the symptoms https://www.nhs.uk/medicines/quetiapine/
[7] Zuclopenthixol is an antipsychotic that works by affecting dopamine levels in the brain. It does not cure the condition, but it can help with the symptoms https://bnf.nice.org.uk/drugs/zuclopenthixol/
[8] Zopiclone is a medication that belongs to a group of medicines called hypnotics. It is used for the short-term treatment of insomnia in adults https://www.nhs.uk/medicines/zopiclone/

Key findings

1.24 The key findings are summarised below.

Engagement with Patient E and his family by mental health services

1.25 One of Patient E's family members attended the discharge meeting from Mental Health Hospital 1 in August 2020, which was in line with good practice. We also noted that attempts were regularly made by CP2 in particular, and by all services in general, to return Patient E's phone calls and reply to messages.

1.26 However, engagement with Patient E during the period August 2020 to May 2021 and in particular, August 2021 to December 2021, was affected by a number of factors which impacted on the way in which staff were able to engage with him. We have examined the system issues and other factors that impacted on staff members ability to engage with Patient E. These provide insight into the challenges staff faced. They include:

- The commissioned service working pattern being Monday to Friday 9–5. Patient E generally slept heavily during the day and was awake during the night, which significantly impacted the ability to engage with Patient E. Also, key staff were employed on a part-time basis which complicated engagement further.
- Staff members not following the Trust's Failure to Attend Policy. This meant there was no escalation when Patient E did not engage with the CMHT, CCO2, the IHTT or any professional or service. It also led to a lack of understanding of Patient E's changing presentation, including the increasing risk of his impulsive responses to his command hallucinations. There were multiple missed opportunities to develop a comprehensive care plan for Patient E to help him engage.
- After re-referral to the CMHT in August 2021 Patient E actively avoided interaction with CCO2 (as told to the investigation by CCO2). However, given that Patient E was experiencing command hallucinations to kill someone, was entitled to Section 117 aftercare arrangements and did not consistently engage with CP2, different approaches to improve engagement could have been tried, including changing his care coordinator. While engaging with Patient E was typically by telephone, when this failed, other methods of contact, for example, home visits, were not adequately pursued.
- Delays in the IHTT engaging with Patient E due to problems with responses by the IHTT to GP referrals and communications issues between Trust teams. This meant key information was not shared to develop a strategy for engaging with Patient E.
- Caseload management (CLM) between CCO2 and the local Community Mental Health Team (CMHT) team leader was not in line with Trust policy. Also, topics such as family engagement were not routinely discussed in CLM regarding this case with CCO2 and this contributed to the absence of a robust action plan to meet Patient E's needs and manage his risks.
- The CMHT not typically involving Patient E's family members in MDT meetings or engaging with them during the formulation of care plans. While we recognise that at least one of his family members often attended outpatient appointments with Patient E, because of the impact of the Covid-19 restrictions there was markedly less face-to-face contact with his family members from September 2020. This investigation has not seen any evidence that there were discussions with Patient E's family members about how services and the family could work together to improve engagement.
- Patient E or his family were not provided with any support or education about the nature of his illness or the signs of relapse, which is seen as good practice in National Institute for Health and Care Excellence (NICE) guidance. This meant his family did not get the support they needed to be able to identify a relapse and to seek help.

- There being no evidence of Patient E's family members having been signposted by the CMHT to the local authority (Council 2a) for a carers' assessment as required by the CPA policy and supported by the Care Act 2014.

Frequency of risk assessments to inform the team of further actions.

1.27 Patient E's risk assessment while in Mental Health Hospital 1 in 2020 was regularly updated in line with Trust policy and good practice. It recognised Patient E's increased risk of harm to himself and others as a consequence of his response to command hallucinations.

1.28 There was a lack of a structured approach to the identification, assessment, formulation and management of Patient E's clinical risk once he was in the community after being discharged from Mental Health Hospital 1. We would have anticipated that his risk assessments were updated on at least 12 occasions but only three were completed and they were not updated after the most significant events.

1.29 Risk assessment processes were not standardised in the Trust. Our analysis of some of the reasons why risk assessments were not recorded on SystmOne[9] showed significant differences between policy expectations and the on the ground practice of nursing staff and medical staff. These two groups completed risk assessments in very different ways. This impacted on the way information was recorded and then used and shared between team members.

1.30 The threshold for the referral criteria to the IOT was too high. Patient E's infrequent engagement with CP2 was considered sufficient to not warrant acceptance by the IOT, even though he had been referred because he was not engaging with CCO2 or the IHTT. This meant an opportunity was missed to develop a plan to support CP2 and CCO2.

1.31 The monitoring of risk assessments was not sufficiently detailed. Trust business intelligence systems (BIS), that provided routine assurance that risk assessments had been completed, did not provide sufficient detail for cases like Patient E. Trust policy stated that as Patient E was on the CPA, he should have had a risk assessment completed, at a minimum, every six months or when his risks or presentation changed, but the Trust BIS reported only on those who had not had a risk assessment in the last year. This meant the risk assessments did not highlight the deterioration and signs of relapse appropriately.

Multidisciplinary teamworking and communication

1.32 We did not find any concerns about cultural issues within and between the various teams involved in Patient E's care. There was professional respect and there was an underlying kindness, understanding and willingness to listen to others and learn from this case. We also noted during our investigation how reflective staff were, in an effort to try and see things from different perspectives.

1.33 The CMHT's lack of coordinated multidisciplinary teamworking led to a loss of situational awareness which reduced the team's ability to monitor, anticipate and respond to Patient E's dynamic risk.

1.34 The investigation found that there was inadequate clinical leadership to drive Patient E's care forward.

1.35 We established that roles were not clearly defined and therefore processes were not implemented. Individuals did not take control of the processes needed to address Patient E's care in a coordinated fashion. This was complicated by team members working different hours on different days and by the use of locum staff, which limited the opportunities for information sharing, communication and general case discussion amongst members of the CMHT with regard to Patient E. They also did not make full use of established Trust or departmental platforms and processes for information sharing.

[9] SystmOne is the electronic clinical record keeping system used by the Trust.

1.36 There was no evidence in Patient E's care plan of documentation that reflected a wider team agreement of how different elements of Patient E's care would be managed. Therefore, it is unclear if there was a shared understanding from the outset between the care coordinator and consultant psychiatrist as to how they would work together to deliver safe, effective care for Patient E. This led to a lack of coordination in bringing Patient E's case to the attention of relevant MDT meetings for discussion.

1.37 A lack of coordination, misunderstanding about when and who should call complex case meetings and failure to follow procedures meant that Patient E's psychiatrist was often working on their own. As a locum, they were also only at work in the CMHT on two days a week without the insights, perspectives and expertise of the wider MDT. Although the investigation learned from interviews that there was often communication and discussion about Patient E within the team, this was not translated into a shared care plan or risk assessment.

Case Load Management, CPA and Section 117 processes

1.38 We hold the view that in services where proactive multi-agency reviews of the care of people in receipt of Section 117 aftercare do not take place there is a greater likelihood of care being below standard. The structures of multi-agency care and MDTs for people on CPA alongside Section 117 aftercare, are intended to stop patients "*falling through the net*".

1.39 Case Load Management (CLM) was not completed consistently. Patient E's engagement with community mental health services was almost non-existent from August to October and we would have expected some discussion of this at CLM in November and December 2021. CLM to support the care coordinator to deliver CPA and Section 117 aftercare arrangements under the MHA 1983 should have identified the requirement for Section 117 review before Patient E's discharge from the CMHT in May 2021. CLM should also have identified the requirement for a further Section 117 review in October 2021, as planned in October 2020. We could not evidence that CLM was delivered in line with Trust policy regarding directing staff to maintain Trust care standards and adherence to Trust policies.

1.40 Patient E's reviews under Section 117 were to be held annually, with the next one scheduled for October 2021. This is not in line with the Trust Section 117 policy which states that reviews should be completed every six months.

1.41 Although Council 2a staff working with the CMHT attended daily 'huddles'[10], we have not seen any evidence of discussion between the CMHT and Council 2a took place about Patient E's discharge from the CMHT in May 2021. There is no mention in the Council 2a records of Patient E's re-referral in August, or the intended annual review of Section 117 aftercare which should have occurred in October 2021.

1.42 We would have expected a planned and proactive approach to Patient E's care following his re-referral to the CMHT in August 2021 that noted Patient E's deterioration which had led to his admission in June 2020. Before 2019 Patient E had frequently disengaged from services and not attended appointments, only contacting his consultant psychiatrist when he wanted to discuss his medication. We would have expected a planned and proactive approach that noted Patient E's changed presentation after the deterioration which had led to his admission in June 2020. We believe that following this admission, there should have been a recognition that his risks had increased and with that there was a need for more robust structures to help prevent his further deterioration and increase his engagement with mental health services.

1.43 Because these reviews of Patient E's care did not happen, this led to Patient E's care being provided in a way which was not sufficiently robust and assertive to meet his needs.

[10] The huddle is a daily meeting within each CMHT where the MDT discusses any issues, concerns and risks arising for any service user.

Medication management

1.44 Patient E was exclusively focused on his medication at the expense of other aspects of therapy or recovery. Also, he was at times forcefully keen on changes to his medication, actively seeking them during consultations.

1.45 CP2 was responsive to Patient E's reported symptoms and side effects, and, on balance, the prescribing was collaborative. Changes to medication were communicated to Patient E and comprehensively to the GP via letters, which included the rationale for change and the proposed future treatments with clear action plans.

1.46 Patient E reported a number of side effects caused by the psychotropic medications. He said that the medication made him gain weight, would make him drowsy and on some occasions admitted that he had become clinically worse on certain medications (i.e. quetiapine). At times he could not tolerate the side effects, nor the distress caused by his symptoms, leading him to change his medication himself by reducing the dose, increasing the dose and at times by abruptly stopping taking it. This had a detrimental effect on his psychosis, and he often suffered relapses. It became difficult to manage his medication because of his self-made changes which were not medically advised.

1.47 In addition, Patient E was not routinely monitored by any other member of the CMHT for extra-pyramidal side effects (EPSE), and also when an inpatient he did not have Lunsers[11] completed, despite Patient E complaining of side effects. There should have been regular monitoring of treatment response and side effects as per NICE guidance.[12] Although he was obviously resourceful and may well have searched the internet for information about his medication, Patient E and his family members should also have been given information leaflets about his medication, the possible side effects and how to minimise them.

1.48 There is limited evidence in the records to demonstrate family or patient involvement in psychosocial interventions[13], which may have improved Patient E's insight into his illness and the need to engage with mental health services, abstain from illicit substances and engage better in his recovery.

1.49 There was also scope to address poor medication compliance using a psychosocial approach. This could have involved discussions with Patient E (using a motivational interview approach) about the pros and cons of medication, the effects of reducing, abruptly stopping or overmedicating against advice, and the impact of substance misuse on illness and prescribed medication. It is unclear from medical records whether such an approach was considered.

1.50 Patient E had not previously tolerated quetiapine when prescribed it as an inpatient in 2020. It had not previously been effective in relation to his symptoms. Although we have the benefit of hindsight, the prescribing of quetiapine at Mental Health Hospital 1 did coincide with Patient E's condition worsening and his assaults on staff.

1.51 Patient E was re-prescribed quetiapine in late 2021 after a telephone consultation. We accept that it was not possible at that time to be able to regularly conduct face-to-face assessments of Patient E due to his underlying nature. However, when quetiapine was re-prescribed in 2021 there was a lack of adequate monitoring. We have not seen any evidence that Patient E and his family members

[11] LUNSERS - The Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) is self-rating scale for measuring the side-effect of antipsychotic medications. https://innovation.ox.ac.uk/outcome-measures/liverpool-university-neuroleptic-side-effect-rating-scale-lunsers/
[12] NICE Clinical Guideline [CG178] (12 February 2014) Psychosis and Schizophrenia in Adults: Prevention and Management https://www.nice.org.uk/guidance/cg178
[13] Psychosocial treatments for schizophrenia include social skills training, cognitive behavioural therapy (CBT), cognitive remediation, and social cognition training among other Psychosocial treatments have been shown to be significantly associated with a lower number of relapses an admission to hospital and a positive impact on service user function and clinical outcomes. See Ventriglio et al; "Psychosocial interventions in schizophrenia: Focus on guidelines" International Journal of Social Psychiatry; Vol 22, issue 8 and "Psychosocial Treatments to Promote Functional Recovery in Schizophrenia" Robert S. Kern et al Schizophrenia Bulletin, Volume 35, Issue 2, March 2009, Pages 347–361, https://doi.org/10.1093/schbul/sbn177

were warned of the need to monitor for any clinical worsening, suicidal behaviour or thoughts and unusual changes in behaviour.

Recommendations

1.52 This investigation has made recommendations to inform learning from this event.

Recommendations for Mental Health Trust 1

Recommendations to improve patient and family engagement

Recommendation 1: Failure to Attend Policy **There were weaknesses in the application of the Failure to Attend Policy.** The Trust must strengthen their response to patient non-engagement by: • identifying patients at risk of non-engagement who are on CPA, and entitled to Section 117 aftercare; • monitoring and prioritising those patients; • ensuring that these patients are discussed in CLM and in MDTs and that contingency plans are formulated; and • ensuring that the current Trust policies on Failure to attend' and 'Non-compliance with Treatment' are robustly followed for service users in receipt of CPA and Section 117 aftercare.
Recommendation 2: Information sharing for patients who are not engaging. **There were weaknesses in the way the IHTT and the CMHT communicate to each other about persistently non-engaging patients.** The Trust must provide guidelines to IHTT so that they know when and why to feedback to CMHTs about referred patients who are persistently not engaging.
Recommendation 3: Psychoeducation for service users and primary relatives of severely ill patients with psychosis. **As Patient E's condition deteriorated, there was an increasing lack of engagement with him and his family members, and no evidence of any attempts to provide education about the nature and course of his illness and its treatment. Patient E and his family were not provided with an opportunity to improve their knowledge and understanding of medication options and their side effects. Improving the education and compliance of service users and carers of people with psychosis is best practice guidance[14]**

[14] NICE Clinical Guidance [CG178] (12 February 2014) *Psychosis and Schizophrenia in Adults: Prevention and Management – How to Deliver Psychological Interventions* https://www.nice.org.uk/guidance/cg178/chapter/recommendations#how-to-deliver-psychological-interventions

The Trust must ensure that CMHTs have effective processes in place, so service users and families are offered timely information and educational opportunities about the course and nature of psychosis including medications and their side effects in line with best practice guidance.

Recommendations to improve risk assessment.

Recommendation 4: Documentation of risk assessments

There was variation in work systems which meant that doctors and other staff had different ways of completing risk assessments documentation.

Safeguarding forms do not require the assessor to consider either risks to vulnerable adults by patients or the risk of exploitation of patients.

- The Trust must ensure that all staff (including locum staff) are trained on and are using standardised methods to document risk assessments on SystmOne. This should be audited within six months.
- The Trust should revise safeguarding forms to include guidance on safeguarding risks to vulnerable adults/others.

Recommendation 5: Monitoring of risk assessments

There were inadequate systems in place to monitor the frequency and quality of risk assessments. Trust-level data was not sensitive enough to provide adequate intelligence about whether individual patients were being risk assessed at the appropriate frequency.

The Trust must introduce more sensitive and effective controls that monitor and maintain appropriate frequency and quality of risk assessments for complex patients. This should be led by the individual patient's needs (as distinct from a standard annual target). We understand the Trust is considering implementation of the Management and Supervision Tool[15] to support this.

Recommendation 6: Prioritisation of deteriorating patients

At the time of the incident the CMHT did not have a risk stratification system to indicate which patients were at higher risk of deterioration or were at risk of harm to themselves or others. A system which could have supported the team to convey essential information about dynamic risk would have enhanced awareness in the wider team, and would have helped prioritise the service response. We understand the Trust is considering developing this.

The Trust must ensure it has an approach for a risk stratification or an early warning system for patients in CMHTs to enhance team awareness of situations where patients may be deteriorating and to help identify and prioritise those patients at higher risk of deterioration.

[15] https://nhsaccelerator.com/innovation/management-and-supervision-tool-mast/

Recommendations to improve multidisciplinary teamworking and communication.

Recommendation 7: Response to urgent primary care referrals

There were delays in referring Patient E to IHTT because of barriers to effective communication between the GP and FRS. The first urgent referral from the GP was not responded to appropriately.

- The Trust should develop a standard operating procedure (SOP) for urgent referrals from primary care. This should include clear response times, what to do if the situation escalates further and clear points of contact, and feedback to the referrer.
- This should be discussed with primary care services through the integrated care board (ICB) and communicated to all practices.
- The Trust should monitor all urgent referrals made to IHTT and report to the Quality Board on any delays experienced.

Recommendation 8: CMHT operational working

a: CMHT care planning for erratic and sporadic patient engagement

When Patient E was not engaging in the autumn of 2021 there was no contingency/care plan to guide the service response as required by Trust policy.

The Trust must provide assurance to the appropriate sub-committee of the Board that CMHTs are responding appropriately to service users who do not engage in line with Trust policy.

b: CMHT member team roles at complex case meetings

There was a misunderstanding between team members of their respective roles regarding who should and could discuss cases at the complex case meeting.

The Trust must provide assurance to the appropriate sub-committee of the Board that all CMHT staff are aware of who can take cases to the complex case meeting, and that staff fully understand the reasons for doing this.

c: Part-time working – impact on providing equitable access to care

Appointments were delayed due to key CMHT staff being part-time, with no suitable alternative arrangements in the event of non-urgent matters requiring attention within normal working hours.

- The CMHT SOP must articulate what needs to be done by when and whom, so that patients can be seen quickly by being offered an appointment with another member of the team when their own clinical team are not working, thereby providing equitable access to care.
- The Trust must provide assurance to the appropriate sub-committee of the Board that the SOP has been implemented and evaluated in respect of the continuity of cover and part time working.

d. IOT threshold for acceptance.

Patient E was referred to but not accepted by IOT as he had limited engagement with CP2. However, he was not engaging with his care coordinator or the IHTT and would have benefited from a more assertive approach.

IOT referral and acceptance criteria should be revisited and tested in the light of this case.

e. CMHT operating hours

Patient E would have benefited from contact from the CMHT in the evening, but this could not happen because the service is commissioned to deliver a Monday to Friday '9 to 5' service.

The Trust should work with commissioners to understand the demand for, and benefits of, CMHT extended hours working beyond Monday to Friday 9 to 5, so as to scope the nature of such a service and build this into strategic development plans.

Recommendation 9: Support for locum consultant psychiatrists

CP2 received ad hoc supervision and did not attend routine team and governance meetings due to being part time.

The Trust must revisit the arrangements in place for locum/part-time consultants and examine what support is needed to ensure they receive regular supervision are able to attend relevant departmental meetings.

Recommendations to improve CLM, discharge planning and Section 117 processes

Recommendation 10: CMHT discharge planning and Section 117

There was an inadequate discharge plan and no Section 117 meeting in advance of discharging Patient E from the CMHT in May 2021.

- The Trust must ensure discharge planning processes are revisited to ensure that Section 117 reviews are being held in line with Trust Policy.
- The relevant Trust policy[16] should be reviewed to include any learning from this case and to ensure the expectations for what staff will do are clear. The policy should be reissued within six months.

Recommendation 11: Clinical and caseload supervision

There was infrequent CLM supervision in this case that was not in line with Trust policy. The challenges of managing a patient who did not engage were not adequately explored and resolved.

The Trust must assure itself that anyone providing supervision routinely do so in line with the Trust's good practice standards.

[16] Currently this is the CPA policy, but it is likely the Trust will move towards implementing the community mental health framework.

Recommendations to improve medication management.

Recommendation 12: Medication, side effects and involving carers.

The monitoring of Patient E's medication, efficacy, side effects and his compliance was not adequate.

- The Trust must ensure that services users on anti-psychotic medication are monitored at appropriate intervals for side effects using the appropriate methods (e.g. LUNSERS or monitoring blood results) and the services user's condition is monitored for clinical worsening and efficacy in line with NICE guidance.[17]
- Existing medication audit processes within Mental Health Trust 1 should be revised in light of this recommendation.

Recommendation to improve organisational resilience.

Recommendation 13: Embedding learning from this case

There were missed opportunities in the clinical management of Patient E's care, including critical tasks not being completed by frontline staff and compliance controls used by management to prioritise a deteriorating patient and assess risk.

Mental Health Trust 1, Council 2b and ICB 2 must provide assurance that learning from this case in relation to complex (non-engaging and subject to Section 117) patients, such as Patient E, is shared and joint systems put in place to address the above recommendations (1–13). This will also support the assurance review to be undertaken by Niche 6 to 12 months after the publication of this report.

Recommendation for Mental Health Trust 1, Council 2b and ICB 2

Recommendation 14: Section 117 aftercare

Patient E received Section 117 aftercare. It is the duty of the local authority and the ICB to ensure this is provided and reviewed. Patient E was discharged from the CMHT with no involvement of the local authority in May 2021, and they were not informed, and a planned review did not happen in October 2021.

The Trust must develop effective processes for the monitoring of compliance with Section 117 aftercare policies.

Council 2b, ICB 2 and Mental Health Trust 1 do not have a jointly agreed Section 117 policy in place (although there is an agreed policy between the Trust and Council 1).

Council 2b, ICB 2 and Mental Health Trust 1 must develop, agree and implement a robust Section 117 after care policy which includes effective monitoring and oversight arrangements.

[17] NICE Clinical Guidance [CG178] (12 February 2014) Psychosis and Schizophrenia in Adults: Prevention and Management – How to Deliver Psychological Interventions https://www.nice.org.uk/guidance/cg178/chapter/recommendations#how-to-deliver-psychological-interventions

Appendix A – Terms of reference

Terms of reference for independent investigations in accordance with Appendix 1 of NHS England's Serious Incident Framework 2015

The following terms of reference for independent investigation 2021/25969 have been drafted by NHS England in consultation with Health and Care Partnership 1 and Community Safety Partnership 1.

The terms of reference were developed in collaboration with the investigative supplier and the affected family.

Purpose of the investigation/commission

To establish the facts that led to the incident in December 2021, and whether there are any lessons to be learned from the case in relation to the provision of mental health care and treatment of Patient E.

To identify any areas of best practice, opportunities for sustainable system learning and areas where improvements are required, with a focus on the period from 2018 to 2021.

Involvement of the affected family members, professionals and Patient E

- Ensure that affected family members and relevant staff are fully informed of the investigation and the investigative process and they understand how they can contribute to the process.
- Involve the family as fully as is considered appropriate, in liaison with victim support, police and other support or advocacy organisations.
- Ensure that staff contributing to the investigation process understand how their information will be used and processed and are aware of available organisational support.
- In collaboration with Patient E's clinical team, offer a minimum of two meetings to Patient E so that he may contribute to the investigation process by providing an account of his experiences of his care and treatment and so he can receive the findings of the investigation (as appropriate).

Serious incident response

- Consider and assess the Trust's response following the incident, to identify and implement any immediate learning.
- Review the Trust's application of the duty of candour to the affected family.

Care and treatment/contact with services

- Compile a detailed chronology of contacts and service access for Patient E.
- Carry out a critical review and analysis of the healthcare and support needs of Patient E; assessing whether these were fully recognised and understood by professionals; commenting on whether appropriate care, treatment and support services were offered; and identifying both areas of good practice and areas of learning.
- Consider and outline any organisational or operational barriers to the effective support of Patient E and how services should respond effectively if similar circumstances occur.

- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time, including a focus on interconnecting and influencing factors, making use of relevant research and case evidence to inform the findings.

Inter-agency working and communication

- Consider and comment on any issues in relation to safeguarding, including any concerns raised with professionals by Patient E or his family, and determine if these were adequately assessed and acted on.
- Consider Trust policy in relation to carers' assessments and determine whether appropriate action was taken in this case to provide assessment and support to the individuals providing care to Patient E.
- Determine whether there were any missed opportunities to engage other services and/or agencies to support Patient E and/or his family.
- Establish what lessons are to be learned about the way in which professionals and organisations work individually and together to safeguard individuals.
- Identify whether information sharing within and between agencies was appropriate, timely and effective.

Risk assessment and care planning

- Review the adequacy of risk assessments and risk management for Patient E, including risk assessment during periods of behavioural change or during changes in his personal circumstances and the risk he posed to others, specifically in relation to the risk of violence and how this information was escalated and acted on.
- Explore the response to Patient E's non-engagement with his care coordinator and whether this was sufficiently risk evaluated and appropriately managed.
- Consider whether non-concordance with the medication regime was sufficiently understood, managed and risk assessed and determine whether changes in medication were appropriate and in line with national guidance.
- Examine the effectiveness of care planning, including whether Patient E and his family were sufficiently and appropriately involved.
- Determine whether appropriate strategies were in place to support Patient E with the impact of gambling and alcohol on his mental health and risk.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.

Deliverables

- To ensure continuous learning, promptly communicate opportunities for early learning identified during the investigation through regular touchpoint meetings.
- Provide NHS England with a monthly update on progress (template to be provided by NHS England) detailing actions taken, actions planned, family contact and any barriers/risks to the investigation's progress.
- Based on investigative findings, make system, organisational or service specific, outcome-focused recommendations, with a focus on sustainable system improvement and with a priority rating.

- Provide a final written report and a separate, anonymised and publishable executive summary to NHS England (that is easy to read and meets NHS England accessible information standards) within six months of receipt of all clinical records.
- Provide a concise, anonymised, case study which clearly outlines the learning points and opportunities for improvement, to enable wider sharing of learning across the NHS.
- Share the findings of the report, in an agreed format, with the affected families and Patient E. Ask for their comments and ensure appropriate support is in place for receiving the findings, ahead of publication by NHS England.

Where recommendations are made:

- Contribute to a stakeholder meeting hosted by NHS England before publication, to provide an opportunity for organisations to explore and fully understand the intention behind all recommendations to assist effective action planning and make any appropriate revisions to the recommendations based on discussion.
- Conduct an evidence-based assurance review with key stakeholders, in conjunction with the relevant commissioner, 6 to 12 months after publication of the report, to assess the implementation and monitoring of the associated action plans.
- Provide a short written report, for NHS England, outlining the findings of the assurance review, that will be shared with families and stakeholders and which will be made public.

Appendix B – Professionals involved

Pseudonym	Role	Team
CCO1	Care coordinator	CMHT
CCO2	Care coordinator	CMHT
CP1	Consultant psychiatrist	CMHT
CP2	Consultant psychiatrist	CMHT
CP3	Consultant psychiatrist	the Trust
SW1	Social Worker	Council 2a (now Council 2b)
CMHT Team Leader	Team Leader	CMHT

Appendix C – Glossary

AMHP	approved mental health professional
BD	twice a day (prescription)
Mental Health Trust 1	Mental Health Trust 1
BIS	business intelligence systems
Council 1	Council 1
CCG	clinical commissioning group
CMHT	Community Mental Health team
CLM	caseload management
CMHT	community mental health team
CPA	Care Programme Approach
CQC	Care Quality Commission
FRAM	functional resonance accident model
FRS	first response service
ICB	integrated care board
IHTT	intensive home treatment team
IOT	intensive outreach team
KPI	key performance indicator
LA	local authority
LSSA	local social services authorities
LUNSER	Liverpool University Neuroleptic Side Effect Rating Scale
MHA	Mental Health Act
NICE	National Institute for Health and Care Excellence
Council 2a	Council 2a
OD	once daily (prescription)
PICU	psychiatric intensive care unit
RAG	Red, Amber Green (assessment rating)
RC	responsible clinician
SEIPS	System Engineering Initiative for Patient Safety
SOP	standard operating procedure
SSRI	selective serotonin reuptake inhibitor

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