Psychological Approaches

EXECUTIVE SUMMARY OF AN INDEPENDENT INVESTIGATION

INTO THE CARE AND TREATMENT

of

Mr J

2022/13057

January 2024

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INTRODUCTION

This report was commissioned by NHS England under their Serious Incident Framework 2015[1].

The victim and his family

The investigators would like to extend their sincere condolences to the victim's family. We are immensely grateful for their participation in this investigation. We have noted and responded to their questions that fall within the scope of this report, and the details can be found in the section on Family Concerns. It is our sincere wish that this report does not add to their pain and distress but assists in addressing issues and questions raised by the events surrounding this tragic death.

The Person receiving care and support from mental health services

Mr J was 33 years old at the time of the homicide. He was under the care of a mental health Community Recovery Team and in the process of being handed over to the Assertive Outreach Team (AOT). He had been known to mental health services in the area where he lived since 2018 and at the time of the homicide had a recorded diagnosis of unspecified non-organic psychosis as well as a history of substance misuse. Mr J agreed to participate in this investigation and was able to provide consent.

We are grateful to Mr J's family who met with the investigation panel and posed some questions for our investigation as well as providing us with some more background information regarding Mr J's life and his difficulties. These details can be read in the Family Concerns section of this report.

The Incident

The homicide took place near to Mr J's home. The victim, an adult male was not known to Mr J. After his arrest Mr J was remanded in custody. He subsequently pleaded guilty to manslaughter on the grounds of diminished responsibility and was detained in a secure psychiatric hospital under section 37/41 of the Mental Health Act.

BACKGROUND TO MR J'S CARE AND SUPPORT

This investigation has been commissioned to review the delivery of care and support provided to Mr J leading up to the homicide. We have divided the time into three periods of care and provide a summary overview below. The details are taken from Mr J's clinical care records unless otherwise indicated.

[1] NHS England » Serious Incident framework

Hospital admission, discharge and step down

In January 2021 Mr J was admitted to hospital under the Mental Health Act (MHA) after making threats to kill his neighbour, about whom he had developed delusional beliefs. There were also concerns relating to increased substance use and a lack of engagement with his prescribed medication regime. Shortly after this he was transferred to a Psychiatric Intensive Care Unit (PICU) following incidents involving intimidation and violence directed toward fellow patients and staff. This aggression appeared to be driven by delusional beliefs.

After stepping down to a rehabilitation ward in May 2021 from PICU Mr J was discharged to a community step down service for further rehabilitation. On discharge from the community step down service his diagnosis was unspecified non-organic psychosis, and he was prescribed weekly depot[2] antipsychotic medication (flupentixol decanoate 300mg).
He was discharged from the community step down service to his previous home address on the 10th January 2022 following a breakdown in the hostel placement. The discharge was under the Care Programme Approach (CPA)[3] framework.

Return to Living at Home

On return to his flat Mr J had a supported tenancy with workers available on site, a social care support package and input from the Mental Health Recovery Team.

Mr J continued to use illicit drugs whilst in his flat. Over the next few months there were increased concerns regarding his mental state, substance misuse, lack of engagement with support workers and difficulty administering his depot medication. Within a few months he was asking to be admitted to hospital to detox from illicit drugs to improve his mental health.

Crisis Events

During May and June 2022 there were four separate crisis events which resulted in Mr J being assessed in A&E by mental health services. None of them resulted in admission to hospital.

The last contact with mental health services was a few days prior to the homicide by two staff, when Mr J's depot medication was administered successfully. No concerns were raised

[2] A depot injection is a slow-release form of medication. The injection uses a liquid that releases the medication slowly, so it is longer-lasting. It is often used when people are inconsistent in taking medication as it is given by a nurse; the clinicians can be sure that the patient is receiving the prescribed dose.
[3] Care Programme Approach is a package of care that is used by secondary mental health services. Patients will have a care plan and someone to coordinate their care (Care Coordinator) if they are under CPA. All care plans must include a crisis plan.

from this visit. The next planned appointment from the Recovery Team was to administer weekly depot the following week but prior to that the police informed the Recovery Team that Mr J was in custody and charged with murder.

ANALYSIS OF EVENTS

Serious Incident Response

Consider and evaluate the Trust's response following the incident to identify and implement any immediate learning.

The Trust completed the 72-hour report for submission to NHS England. A reasonably full chronology was included in the report. Mr J was in custody at the time. The Trust worked together with other agencies to ensure safe care was delivered to Mr J during this period following arrest. The report confirms that support had been offered by the Trust to the family of both the victim and the alleged perpetrator, but it is unclear who made this contact and for the victim's family, with whom contact was made.

There is no note in the clinical record of a senior member of staff visiting Mr J's family; his family were however spoken to by the Care Coordinator when they visited the Recovery Team requesting an update following the incident.

Learning Point 1: We would expect a senior member of Trust staff to take responsibility for liaison with families, even if it was felt appropriate that they were accompanied by a team member who was known to the family.

Care and treatment /Contact with services

Undertake a critical review and analysis of the mental healthcare and support needs of Mr J; assessing whether these were fully recognised and understood by professionals.

Comment on whether appropriate care, treatment and support services were offered, identifying areas of good practice and areas of learning.

Diagnosis/Formulation

In the clinical records Mr J's diagnosis was variously given as: non-organic psychosis, schizo-affective disorder, schizophrenia, paranoid schizophrenia, and drug induced psychosis. All the clinicians we interviewed recognised that he had a longstanding chronic psychosis which responded to some extent to treatment with antipsychotic medication. Clinicians knew that

he heard voices and sometimes experienced delusions and visual hallucinations but the nature of these were not always well documented. Furthermore, connections between his psychotic thoughts and his behaviours were not always well understood. For example, the links between his paranoid thoughts and his reluctance to leave his home for appointments like his CPA meeting, or with the substance misuse team, were not explored.

Everyone who worked closely with Mr J recognised that using illicit drugs, in particular crack cocaine and heroin, made the symptoms of his mental illness worse, in particular his hallucinations and delusions. However, on occasion, those clinicians undertaking 'one off' assessments in a crisis, appeared more inclined to see his acute symptoms as transient and as a direct consequence of drug taking, leading to them giving less weighting to his underlying psychotic illness. This was not always the case; in May 2022 A&E liaison staff clearly identified his history of psychosis and previous links to violence (command hallucinations) to others, increased Illicit drug use, withdrawal from services and worsening low mood as the presenting problems.

Learning point 2: It would have been helpful for there to be a more consistent formulation[4]across services which translated into a clear care plan regarding the nature of Mr J's difficulties considered from a longer-term viewpoint. This could have included the link between delusional beliefs and aggression towards others, and the drivers to increasing risk.

Care and support provided

When Mr J was admitted to hospital under the Mental Health Act in January 2021 it was because he was violent as a result of delusional beliefs, taking illicit drugs and not engaging with treatment including his medication. Initially he continued to be aggressive and required containment in a psychiatric Intensive Care Unit (PICU). With treatment, his mental health improved. However, his discharge from the step-down service in January 2022 was not because he had progressed sufficiently with his rehabilitation but because he constantly broke the conditions of residence by bringing in illicit drugs and staying out all night. Mr J stated that he did not want to leave but understood why he could not stay. The records note that the team at the community step down service expressed concerns about Mr J's vulnerability on moving back to his flat but were reassured that he would have ten hours of social care support per week and twice weekly visits from his Care Coordinator. In addition, his Care Coordinator would organize support from the Substance Misuse team, though it was clear at the time that Mr J was at best ambivalent about addressing his substance misuse.

[4] We use the term *formulation* throughout this report to describe an understanding of an individual's difficulties, that integrates diagnostic considerations with a broader developmental perspective and a range of psychological and social factors.

Mr J moving back to his own flat with support from the Recovery Team and social care was the only pathway available in the circumstances. There were no other supported accommodation providers that would accept him. The plan put in place was somewhat reduced from the initial plan in that Mr J's care would be led by his care coordinator, who would see him only once or twice a month. His care would be supervised by Dr 1. Additional support would be available from social care support workers who would visit him twice a week (total 5 hours) and from the onsite housing officer in his supported tenancy. Staff from the Recovery Team would also visit once per week to administer his depot antipsychotic medication. At our interviews, the team considered that this was a very good package of care. We agree that this care package was appropriate in the context that Mr J's mental state was relatively stable at the time and that there was no alternative supported accommodation that would take him. It was intended that the package would be further enhanced by input from the substance misuse services. This will be addressed in the next section of this report.

A referral to Occupational Therapy (OT) was made to support Mr J in engaging in therapeutic activities in the community. This is good practice and a very positive element of a care plan for someone with a chronic mental illness. However, we understand that Mr J did not engage with this additional support.

When Mr J's engagement with services began to deteriorate over subsequent months his care coordinator and other members of the team made determined efforts to see him regularly and to ensure he received his medication. In April, although he did not attend his CPA meeting, the time was used to review his care which is an example of good practice. It was appropriately recognised that Mr J could be better supported by the Assertive Outreach Team[5] and that he may benefit from increasing his dose of antipsychotic medication. The implementation of these changes was slow and in practical terms no change was made to his care until the Assertive Outreach Team began to see him alongside the Recovery Team in June 2022.

Dr 1 wrote a letter to Mr J's GP advising that he would try to visit Mr J and discuss his antipsychotic medication with him with a view to supplementing his depot injection with oral tablets to take twice a day. Dr 1 suggested to the GP that should Mr J see the GP before Dr 1 saw him; the GP may wish to prescribe this medication. However, no appointment was made and the medication was not reviewed by Dr 1. Mr J did not visit his GP and the medication therefore remained unchanged. Reviewing Mr J's medication should have been a priority in a patient with deteriorating mental health and erratic engagement. There are no set guidelines covering timescales for review of medication but it is our

[5] At this time the AOT team was a newly formed team and did not come into operation until May 2022.

professional opinion that against a background of increased symptoms and disengagement with services this is something that should have been done within a few days.

From early May 2022 there were a series of crisis events. We will cover the response to these events individually, but it should be noted that they had common features.

- Recent use of heroin or crack cocaine
- Increased psychotic symptoms both in strength and frequency
- Delusions and hallucinations
- Command hallucinations telling Mr J to harm himself and others
- Ambivalence/reluctance to engage with services
- Increased anxiety
- An apparent rapid reduction of acute psychotic symptoms after presenting to A&E and spending 12-24 hours in the hospital.

On the 5th May 2022 when Mr J attended A&E there was a very clear formulation made of his presenting problems in that he had a history of psychosis with previous links to violence (command hallucinations to harm others), increased Illicit drug use, withdrawal from services and worsening low mood. Nurse 1 noted recent discussions in the Recovery Team about Mr J requiring additional antipsychotic medication and recommended that he should be taken to the Decisions Unit pending a joint assessment with the Home Treatment Team and the Recovery Team. Unfortunately, due to the Recovery Team workload it was not possible to arrange the joint review. Given that Mr J was much more settled the following day, he was discharged home with the expectation that the Recovery Team would review his care plan and medication. In a follow up visit on the same day Mr J told his care coordinator that he was feeling much better and that the voices had been increased by his drug use and he hadn't used drugs since going to hospital. There was no review of his care plan to prevent future crisis and his medication was not reviewed.

On the 13th May Mr J was accepted by the Assertive Outreach Team and they began to work with him alongside the Recovery Team from the 1st June. However, they would not formally take over his care until there was a CPA handover meeting with both consultant psychiatrists and both care coordinators from the teams present in person. This was planned for the CPA meeting in July.

On the 21st May, Mr J was taken to A&E by his family. On this occasion records show his presentation was more bizarre and more disturbed than earlier in the month. He was attempting to assault members of the public in response to delusional beliefs and to leave the unit. In these circumstances it was entirely appropriate for Mr J to be assessed under the Mental Health Act for admission to hospital. We have been unable to interview any of the clinicians involved in this MHA assessment and so the information given is only from the clinical record.

The process for admission to hospital under the Mental Health Act is prescribed in law. For admission under Section 2 of the Act, three professionals, an Approved Mental Health Professional (AMHP) and two doctors, one of whom should be section 12 approved[6], are required. These professionals must each make independent decisions on whether a person meets the legal criteria for admission. The criteria are:

- The person is suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment (or for assessment followed by treatment) for at least a limited period, **and**

- The person ought to be so detained in the interests of their own health or safety or with a view to the protection of others.

Professionals are also required to explore less restrictive alternatives to detention under the act such as treatment in the community or in hospital informally with the patient's consent[7].

The assessment was delayed until the next day giving an opportunity for any effects of acute drug intoxication to resolve. This is normal practice.

When undertaking the MHA assessment, the following day, Dr 3 and the AMHP both noted that Mr J's presentation was much more settled. He did not appear to be responding to auditory hallucinations and did not express any delusional beliefs. Dr 3 did specifically ask Mr J about his delusional belief that his close family member had been assaulted, and although he responded that she had told him this the previous evening, (she had not) he could be challenged on this belief, meaning it was not considered to be delusional in nature at that time. It was also noted that he had recently accepted his depot medication as prescribed and was under the care of the AOT. The outcome of the MHA assessment was that Mr J did not require detention in hospital and he could be discharged home with the expectation that the Recovery Team would review his care plan.

During a follow up meeting, at his home, the next day his Care Coordinator reported that Mr J felt better because he had not used drugs for three days and arrangements were put in place for his social support workers to take him to meet with the substance misuse team on the 25th May. This was a positive piece of work capitalising on a possible 'window of motivational opportunity'. However, Mr J did not go and neither his care plan nor his medication was reviewed following this crisis.

[6] Section 12-approved doctor A medically qualified doctor who has been recognised under section 12(2) of the UK's Mental Health Act 1983 (amended in 1995, 2007), who has specific expertise in mental disorders and has received training in application of the Act.

[7] Mental Health Act 1983 (publishing.service.gov.uk)

On the 3rd June Mr J again presented at A&E. He stated he felt suicidal with low mood. He went on to say he was meant to be 'sectioned' last week but had managed to talk 'them' (sic) out of it. He now felt he needed to be sectioned because he was a risk to the public because he was attacking "skin heads" who he believed to have assaulted his family member (He reported having punched a stranger in the street). It was felt by the assessors that Mr J did not require a Mental Health Act assessment because he engaged well in the interview, stating that he did not have any current thoughts, plans or intent of self-harm or suicide. The assessors felt that, compared to previous assessments, there was an improvement in his mental health presentation, and engagement with his community mental health teams was the best way forward. They checked with the police regarding whether they wanted to take any action in relation to the alleged assault. It is unclear from records whether or not the victim had reported the assault but there is a note in the clinical record saying the police were happy for Mr J not to be detained. Mr J was given crisis and helpline numbers, encouraged to engage with his mental health teams and to discuss reducing substance use with them. He declined referral to the substance misuse team. There is no record of the Recovery or Assertive Outreach Teams reviewing Mr J following this crisis presentation.

A few days later, Mr J made several attempts to use the crisis contact numbers he had been given. He telephoned the Crisis and Home Treatment Team and left voice mails. When they returned the calls, he did not answer. He again attended A&E. His presentation was very similar to that on the 3rd June. He reported a lot of delusional material regarding the person who he thought had assaulted his family member. He said he thought he had seen them standing outside his window. He also reported a greater intensity of thoughts about harming himself. He told staff that his depot injection was overdue. It should have been given on the 3rd June but there is no record as to why it was not given. The 2nd and 3rd June were public holidays followed by a weekend which may have meant the date of administration needed to be adjusted or it may have been that an unsuccessful attempt to locate Mr J and administer medication had not been recorded.

The assessing nurse requested admission to the Decisions Unit pending a joint plan between the Recovery Team and the Substance Misuse Team. In particular, she was worried about the link between his delusions and violence to others as had happened earlier in June. The Decisions Unit declined to admit him on the basis that this joint planning between the two teams could be safely undertaken with Mr J at home.

Arrangements were made for Mr J to be taken by taxi to the Recovery Team base where his depot was administered by the duty team. It was noted that during this process he was pleasant and sociable in his interactions, and he accepted the depot medication without issue. There was no discussion noted about the A&E

attendances, review of his care plan or plans to work together with substance misuse. A joint review did not take place.

Three days later Mr J was seen by the AOT team. Although there was evidence, he was using illicit drugs, there was no indication of paranoia or persecutory delusions. He was described as well kempt and appropriately dressed and showed good rapport during the appointment. Substance misuse and recent hospital attendances were explored in the conversation as likely being linked. However, it was noted at this visit that there were no concerns requiring further action and a follow up visit was arranged in one week.

The last contact from mental health services was with the Recovery Team the following week, by two staff, when Mr J's depot was administered successfully. No concerns were noted from this visit, and the next planned appointment from the Recovery Team was to administer weekly depot the following week however prior to this the police informed the Recovery Team that Mr J was in custody on a murder charge.

Learning point 3: It would have been helpful to ensure that the plan of referral for OT support was followed, which should have included ensuring that the outcome of any assessment was noted.

Learning point 4: A review of Mr J's antipsychotic medication should have been undertaken promptly following his non-attendance at his CPA meeting in April and his subsequent presentations in crisis.

Learning point 5: Where significant events occur (such as a crisis assessment) then local and national guidance[89] indicates that there should have been a review of Mr J's care plan, including his medication, in order to try to prevent further occurrences.

Substance misuse

The NICE guideline on 'Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings CG120' [10] sets out how secondary mental health services should assess and record the use of illicit substances and their effects on people with enduring psychosis. Substance misuse was recognised by all professionals as a significant factor in driving both Mr J's presentation to services and the instability of his mental state. However, there was a lack of detail and depth to the assessment of his substance misuse problems which was evident from the minimal detail in the clinical records and in our interviews. For example, although documented occasionally, it did not

[8] Adult Community Mental Health Services SOP
[9] Overview | Psychosis and schizophrenia in adults: prevention and management | Guidance | NICE
[10] Recommendations | Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings | Guidance | NICE

appear to always be recognised that part of Mr J's motivation to use drugs was to 'self-medicate' to reduce or detract from his psychotic symptoms. We also found that at times, teams accepted Mr J's assurances that he was ready to stop using substances, but they did not fully recognise the degree of support he would need to initiate this process (because of his underlying mental illness). This was given weight during assessments at A&E and the Decisions Unit when Mr J's previous behaviours and clinical presentations indicated that his ability to maintain any commitment to stopping using illicit drugs was virtually non-existent without intensive support.

There appeared to be 'windows of opportunity' following periods of forced abstinence from drugs, whilst in hospital, when Mr J felt most motivated to address his substance misuse but the service response to these opportunities was not always sufficiently agile. On the 31st January there was a note that the Care Coordinator would contact the substance misuse Team to refer Mr J, but there was no record that this happened. On the 4th February it was noted that Mr J said he telephoned the substance misuse team, but they told him that his case was closed, and he needed to be re-referred. This advice from the care coordinator does not align with the practice position of the substance misuse team which is that they accept self-referrals and Mr J could have been offered an appointment over the telephone or attended to service that day via drop in.

On the 3rd May there was a further note stating his Care Coordinator would re-refer him to substance misuse services and rearrange the support workers' hours so that they could take him there, but it is not documented whether or not this happened. After the second crisis presentation at A&E on the 25th May arrangements were made for the support workers to take Mr J to the substance misuse team. However, he did not attend, and no follow up plans/actions were noted.

During the period of time under consideration, the Trust was responsible for delivering the substance misuse services pathways for adults living in the area as commissioned by the Local Authority. This was a comprehensive service, with three clinical pathways: opiates, non-opiates, and alcohol pathways. This service has now been recommissioned and the tender awarded to a third sector provider as from August 2023.

We received slightly different perspectives on the relationship between the community Recovery Team and the substance misuse service. The latter were clear that they welcomed liaison between the services and were keen to promote discussion and joint working. The recovery team were of the view that the substance misuse team required service users be motivated to attend the service; they thought that all they could do was to try and use persuasion or encouragement to access the service. We note that the Dual Diagnosis policy addresses the question of liaison between teams within the Trust, or the offer of

consultancy or training however staff were not always clear as to what might be available to support mental health teams.

The substance misuse service manager acknowledged that there had been some historical tension between services within the Trust because there were a number of people using the substance misuse service who had mental health needs; they had found it difficult to persuade the mental health teams to take on such people as teams said the substance misuse pathway had sufficient mental health expertise. At interview we were told that there was some improvement in this and that a substance misuse clinic had been established within the recovery team, to support joint working and advice.

Learning point 6: We recognise the difficulty that mental health teams face in persuading individuals to engage with substance misuse services when they may be resistant or at least ambivalent about desisting from substance misuse. Enhancing the training, support offer, and co-working opportunities to mainstream mental health teams in this area is likely to improve the teams' confidence and skills in assessing and motivating service users to contemplate engagement with the specialist provision.

Consider and outline whether there were any organisational or operational barriers to the effective support, assessment, and risk management for Mr J, and how NHS services should respond effectively if similar circumstances were to occur in future.

Administration of medication

We heard from clinicians and saw in clinical records that the administration of Mr J's weekly depot injection was allocated as a task to 'duty' staff. In practice this meant that each week it was a different person who administered the injection. On the whole, the notes written on these occasions were minimal. They stated that staff had checked whether he felt he was a risk to himself or others but there was often little else noted. We believe that this evidenced a mechanistic task-based approach to delivering medication which failed to capitalize on the potential opportunity for the injection to be consistently given by one (or a small group of) nurse/s. By this means, those administering the medication could have developed their rapport with Mr J and increased their understanding of the care plan and presenting risks. This would have enhanced the continuity of care and support for Mr J.

Team resources and caseload

We fully acknowledge that there is a national difficulty in recruiting and retaining mental health staff. Importantly, the Recovery Team staff told us that there was a constant turnover of staff with high vacancy levels for both nurses and doctors. Senior staff and Recovery Team staff also told us that they felt overwhelmed by the way resources were structured at the time, with consultants covering an entire catchment area of some 1000 patients, and care coordinators having caseloads that were too high. We were pleased to hear at interview that care coordinator caseloads have been reduced to 25 and there were

now in place plans to improve the structures, with four smaller teams caring for a smaller (250) pool of patients. Lack of resources contributed to the failure in joint working between the crisis Home Treatment Teams and Recovery Team and to the failure to review Mr J's medication.

Transition between Teams

Points of transition are often a significant risk for mental health patients. It is therefore understandable that the Trust wanted to ensure a full clinical handover from one team to another. We recognize that in this case the AOT team was newly formed, and it was positive that they began working alongside the Recovery Team as soon as they were able to. Nevertheless, given that the need for more assertive care was recognised in early April 2022 it was too long, in our view, for Mr J to wait eight weeks before any additional resource was added to enhance his support. Although we agree that the handover protocol adhered to best practice, the long delay resulted in a risky situation. We consider that a pragmatic adjustment to the protocol should have been made to expedite the handover.

Communication within the Trust

We have already commented on the communication between the Trust's community recovery service and the substance misuse service in an earlier paragraph.

We heard at interview that complex cases were discussed at the weekly multi-disciplinary team meeting, and we were told that Mr J was discussed in that forum and that there were other update discussions between the Care Coordinator and Dr 1. We note that the clinical record does not contain any reference to complex case discussions and the outcome of update discussions was often not recorded. Whilst we acknowledge that separate records were made in the form of meeting minutes, such discussions are an important part of the clinical record, highlighting shared reflections and decisions. As such they should be recorded in the clinical records. We understand that this practice has since changed and MDT outcomes are now recorded in the clinical records contemporaneously.

We heard at interview with Service Leads that there are plans in place to implement a new system of work to ensure appropriate monitoring and review of the care of patients on the caseload.

Where teams are working with high numbers of patients it is important that systems of work clearly facilitate routine review of all patients at agreed intervals alongside the ability to review and organise work in response to changing patient risk. This means that time is made to give thought to all patients irrespective of their level of need alongside time to work responsively with those most in need.

Learning point 7: Reviewing the skill mix in teams could ensure that the administration of medicine becomes part of a holistic package of care and supports continuity.

Learning point 8: It would be beneficial to have a clearer system for prioritizing service users for discussion in the community team, with an agile and dynamic system for RAG-rating risk and care concerns that is reviewed more than once a week.

Learning point 9: The timing of planned transitions of care should be led by patient need, with the organisation of effective handovers to support this.

To avoid hindsight bias, seek to understand practice from the viewpoint of the individuals and organisations involved at the time, making use of relevant research and case evidence to inform the findings.

It is difficult to avoid hindsight bias. The panel were assisted in this case by the clear evidence provided by the interviewees and clinical records, which enabled us to consider the care provided from the point of view of each team concerned, at each point in time. Furthermore, the panel have professional experience of delivering acute and community care and understand the pressures and constraints that such services face when demand is high and resources are constrained.

Risk Assessment, Care Planning and Safeguarding

Consider the appropriateness and effectiveness of decision-making processes, including policies, assessments and tools used to inform decisions, with specific reference to care and treatment pathways.

The decision to discharge Mr J from the stepdown accommodation was made by the service because of his continually disruptive behaviour. We concluded that this process was well managed in the circumstances. It was a decision taken over time; Mr J was given a lot of warning about the consequences of his continued behaviours. At the point of discharge the ongoing pathway was agreed at a multi- disciplinary meeting involving the accommodation staff and the Recovery Team.

The decision to refer Mr J to the AOT was timely and agreed following a multi-disciplinary team discussion. In the light of Mr J's failure to engage fully with the Recovery Team, and in view of the local operational policies, this was an appropriate referral. Our concerns about the delay in the enacting of this transfer are discussed in the previous section of this report.

At the crisis assessment in early May 2022 the initial decision by nurse 1 to request a joint assessment with the Recovery and Home Treatment Teams was an example of good practice and would have enabled the Recovery Team to highlight how difficult it was to engage Mr J. This could have enabled the Home Treatment Team to adopt a more realistic assessment of Mr J's ability to engage with substance misuse services and cooperate with a review of his medication. We fully understand that given the pressure of other demands on the teams it was not possible to arrange the joint review and given that Mr J was much more settled it was a reasonable clinical judgement to discharge him home with the expectation that the recovery team would review his care plan and medication. That this review did not subsequently happen is a significant oversight.

In the second crisis assessment in late May 2022, we believe that there were gaps in the decision-making process of the MHA assessment. The AMHP and Drs 3 and 4 did not speak to Mr J's family as part of the assessment. Had they done so, Mr J's family are likely to have emphasised that Mr J denying his illness and not wanting to engage with services (as he presented when they took him to A&E) was a typical pattern they had found to be commonly associated with a relapse in his mental health, and which had previously precipitated admission to hospital under the MHA. There was no record to indicate Mr J's views on whether he wanted his family involved in the assessment or not. It is not a requirement to consult family as part of a MHA assessment but it is considered to be good practice[11]. The clinicians involved may have believed that the information from the family given to the nurse undertaking the triage assessment the previous day was sufficient to inform their decision.

We also found that assessment did not take sufficient account of the documentation indicating the persistent nature of Mr J's delusional beliefs and their links to violence. Had they done so they may have taken a more longitudinal view of his psychotic illness and its impact on his current presentation. However, we must emphasise that the assessors may still have reasonably considered he could have been managed in the community and that that was, in line with the MHA guidance to use the least restrictive option necessary.

It is difficult to view this crisis intervention without hindsight bias. On balance we agree it was a reasonable clinical judgement not to detain Mr J under the Mental Health Act. However, we also consider that there were missed opportunities to consolidate and add to the complex clinical formulation, to recognise an apparent escalation in disturbance levels over time, and to facilitate joint working between teams on a more effective package of community care.

[11] 1 Guidance | Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services | Guidance | NICE

We agree that the crisis assessment on the 3rd June did not warrant an admission to hospital or a MHA assessment. On this occasion Mr J was not as aroused, as he had been on previous assessments and, was more engaged and cooperative with the assessment process. Staff also ensured that the police were consulted about the alleged assault on a stranger prior to discharging Mr J, which was good practice. We do, however, believe that Mr J should have been promptly reviewed by his community team. Given that this was his third presentation at A&E in a month there was a need for an urgent review of his care plan in order to prevent a further crisis. We understand that the Trust's newly implemented record system will prompt staff to review care plans in such circumstances going forward.

By the fourth presentation to A&E on the 7th June it should have been very clear to the teams involved that without a significant enhancement in his care provision, further crisis was inevitable, involving the risk of physical assault to others in the context of delusional beliefs and substance misuse. We believe that the longer-term view -rather than treating this as another 'one-off' assessment - demonstrated that care in the community was no longer meeting his needs and Mr J should have been admitted to hospital, under a section of the Mental Health Act if necessary.

Leaning Point 10: Safe care would be promoted by holding in mind the longitudinal view of the illness, rather than a single assessment, and by promptly reviewing the care plan after a crisis episode.

Examine the effectiveness of care planning, including whether Mr J, and his family were sufficiently and appropriately involved.

Mr J had a longstanding psychotic illness characterized by hearing voices which distressed him and at times, paranoid thoughts, command hallucinations and a delusional belief that someone had assaulted a close family member. He used illicit substances which aggravated his symptoms and when acutely unwell assaulted others in the context of his delusional beliefs. As a result of his illness and substance misuse, he had social care needs, including difficulty in engaging in day-to-day tasks; he needed a lot of support to do simple tasks like keeping his flat tidy. He lacked a structure to his day with few positive activities during the daytime.

We found that the care plan provided a good level of support for Mr J's social care needs and was mostly effective in ensuring he took his antipsychotic medication. There were missed opportunities to understand Mr J's thoughts and emotional states, in particular, how his paranoid and delusional beliefs affected his behaviour.

The care plan in relation to substance misuse was unrealistic and did not take into account the threefold challenge of poor motivation, poor engagement, and poor social skills alongside a chronic mental illness. A more assertive approach with more use of motivational techniques was needed.

The care plan in relation to his crisis presentations with acute psychotic episodes did not meet his needs and the staff were insufficiently mindful of the distress Mr J was experiencing. The fact he seemed better when in the Decision Unit overnight showed that he could respond to an intervention, not that the care plan was working. Attributing this sudden profusion of crisis presentations to 'substances' was to neglect the gains from stabilisation of his mental state, review of his medication and a re-assessment of his care needs including liaison with substance misuse services.

Mr J was difficult to engage in his care plan and uncertain about whether treatment and medication helped but we found that the Recovery and AOT teams made significant efforts to involve him in his care plan. However, as discussed, we believe that the team expected too much from Mr J in terms of spontaneous engagement and underestimated the degree of support required for him to do so.

Offering people with chronic mental illness support to take part in positive activity during the day can have a beneficial effect on their symptoms and daily routines. We fully acknowledge that Mr J was difficult to engage and did not respond to offers of occupational therapy.

Mr J's family told us they felt excluded from his care. They said they were not contacted by services, their calls were not returned, and they were not invited to CPA meetings.

For an adult who has capacity to make the decision (as Mr J did) permission is required to disclose any confidential information to families. In January 2022 the clinical record described Mr J as estranged from his family; later entries indicate that this may have been a fluctuating view from Mr J. When we spoke to him, he said that sometimes his psychotic symptoms had meant that he felt he could not trust his family. We also heard from Mr J's family that on occasion he told them not to see him because he had voices telling him to harm them. There were indications in the clinical records that Mr J's family were actively involved in his care, such as when they brought him food and when they sought help for him when he was in crisis, but there were other records where he explicitly said he did not want family involved such as during the crisis assessment on the 3rd June. It is our opinion that given this changing situation Mr J's views on involving his family should have been more regularly reviewed.

Whilst we recognize that negotiating confidentiality boundaries can be difficult and time-consuming there is now a wealth of evidence that involving families in the care of someone with psychosis can be beneficial[12]. We acknowledge that CPA invitations did say Mr J could bring his family, but the onus was on him to do so. The family had information which would have added to the clinical picture.

On the 20th May a member of Mr J's family attended the Recovery Team reception wanting to inform staff of concerns about him. He had turned up at another relative's house appearing agitated and his relatives were frightened by his behaviour. He was invading personal space and shouting. Eventually he left. Mr J's family wanted him to be assessed in hospital. They were advised that the relatives should lock their door and call the police if Mr J returned so that the police could use their 136 MHA powers to take Mr J to hospital[13]. There is no record that the family were informed of any actions which would be taken by the Recovery Team which left them feeling the Recovery Team were doing nothing. Staff in fact did go to Mr J's flat to try and review and support him but got no answer. Following the crisis assessment, the next day the care coordinator wrote that Mr J was happy for his family to be involved with his care and for information to be shared with them. The care coordinator telephoned Mr J's relative updating them on his care.

Learning Point 11: A more proactive approach to seeking consent and involving families could better support and inform the care of those with acute mental health needs.

Review the adequacy of the assessment and management of risk for Mr J, including during periods of behavioural change, the risk he posed to others, specifically in relation to risk of violence, non-compliance with medication, whether risk-related information was communicated, escalated, and acted upon appropriately and effectively across services and with external agencies (such as police).

The Trust policy on 'Clinical Risk Assessment and Management of Harm' requires that; *'the risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the people who use our service in response to crisis'.* Mr J's risk assessment document did not meet these criteria. Whilst it did refer to Mr J's risk to others and to himself this was not written in a clear formulation. Neither was it updated at relevant points in his care. For example, we found no update at the point he was discharged from the step-down facility back to his address. There was no update at the point he was referred to AOT and only one of the four crisis assessments (03/05/22) resulted in an update.

[12] Effective family interventions for people with schizophrenia - The Lancet Psychiatry
[13] Community mental health teams do not have any legal powers to take people to hospital.

This failure to adequately review risk meant that when the predictable crisis events occurred there was no service plan of how to respond to them. Poor risk assessment may also have contributed to the apparent lack of urgency in reviewing Mr J's medication and the lack of clarity in the clinical record on the link between his delusions and his violent behaviour.

We have already identified the lack of a protocol for an agile RAG-rating system in the community team. This meant that the team failed to respond with urgency to Mr J's apparently unstable and escalating behaviour in the weeks prior to the homicide.

Learning point 12: Dynamic risk assessments supported by clear clinical formulations would support teams in agile and pre-emptive decision making.

Consider and comment on any issues relating to safeguarding, including any concerns raised with professionals by Mr J's family, and determine if these were adequately assessed/escalated appropriately.

Though not strictly relating to safeguarding procedures there were two occasions when Mr J's personal health and wellbeing may have been at risk and where this was not given appropriate consideration.

On 27th April 2022 two female staff attend to administer medication. The notes say they found Mr J's flat door open. They called his name but received no answer. The clinical record states that they arranged for two male staff to attend the next day. There is no record of what they thought had happened to Mr J or any actions taken to ensure his safety, for example, alerting the housing officer on site or requesting that the police undertake a safe and well check. We were unable to interview the staff concerned.

In late May 2022 when Mr J was discharged from the Decisions Unit. His family reported he was sent home in a taxi, wearing only a dressing gown and no shoes; he had no money and no keys to his flat. His family (who had brought him to hospital) told us they were not informed of his discharge or given the opportunity to provide his clothing/keys. This resulted in Mr J returning to a relatives' home looking for help. The family told us the relatives were distressed and concerned by this, having been frightened by his acutely psychotic presentation at their home the previous night. This falls short of the duty of care required on discharging someone from hospital. Staff were unable to recall the specific circumstances of his discharge. The care coordinator spoke to Mr J's relative the following day and advised that they should call the police if Mr J turned up again. They did not consider that the relatives had care and support needs as they did not normally have regular contact with Mr J.

Determine whether there were any missed opportunities for the Trust to engage with other services and/or agencies to support Mr J, including consideration to Mr J's reluctance to engage with Substance Misuse Services.

We consider that there were greater opportunities for liaison between those undertaking crisis assessments and the teams delivering ongoing care.

Review and assess compliance with local policies, national guidance, and relevant statutory obligations.

We have made reference to policies and guidance in the above sections, as appropriate.

FAMILY CONCERNS

The victim's family

We met with the victim's brother to understand the key issues his family wanted addressed by this report. Their viewpoint was invaluable to us. In particular, they were keen to emphasise that they did not want this report to be a paper exercise and wanted to understand why it was perceived safe for Mr J to be among the general public when he was clearly unwell and when the condition was made worse by substance misuse. *"Surely someone's mental condition does not change in less than four weeks after more than ten years and with repeated use of illicit drugs, a situation known by all the professionals overseeing the patient?"*

We broke these concerns down into several individual questions which we have addressed in the body of the report:

- Services knew that Mr J was taking illicit drugs which interfered with his medication, negatively affected his mental health, and increased his risk to others. Why was this allowed to happen?
- Were all the known risks of violence towards others, (including any previous offending, information from the family, police, and community mental health team) considered when deciding it was appropriate for Mr J to be cared for in the community?
- If Mr J was mentally ill, as the psychiatrists for the court say he is, then why, just a few weeks before he killed my brother, was he not detained after being assessed in hospital?
- Are there any changes that can be made to services to ensure something like this does not happen to another family?

Mr J's family

We met with Mr J's family. They helped us understand Mr J's history and illness and particularly their struggle as a family to support him and obtain the help they believed he needed. We broke their concerns down into a number of individual questions which we have addressed in the body of the report:

- Was the decision not to detain Mr J in Hospital on the 22nd of May reasonable?
- In determining that Mr J was not suitable to be detained at that time. Was all available information on his mental health presentation considered, including information from his family, the police and the CMHT?
- Were all the possible alternatives to discharge from Hospital considered?
- Why was Mr J sent home from that assessment in a taxi with no shoes, no proper clothes, no money, and no door keys?
- Given that they wished to support him, and Mr J consented to this, were Mr J's family sufficiently involved in the planning and delivery of his mental health care?
- Were the CMHT/Crisis team sufficiently responsive to concerns raised by Mr J's family in relation to his deteriorating mental health and increased risk to others?
- Why were the family always told that Mr J's use of illicit drugs meant there was little that could be done to improve his mental health?
- Could more have been done to help Mr J stop using Illicit drugs?

SUMMARY

Mr J had schizophrenia; an enduring psychotic illness characterized by hearing voices which distressed him. He used illicit substances which often made his symptoms worse. He experienced difficulty in engaging with community services. This was widely recognised by those who worked with him. There were varying opinions amongst professionals as to the nature of his psychosis with some believing it was mostly transient as a result of illicit drug use despite clear documentation indicating that it was a chronic illness.

We found that services underestimated the degree of support that someone with Mr J's level of need required if he were to have any possibility of engaging with services. Staff were not well trained in substance misuse and the actions taken to attempt to engage Mr J to reduce his substance misuse were not sufficiently assertive. Though the referral to the AOT was reflective of the need for additional resources the transition was too slow.

Gaps in care planning, review, and risk assessment meant that changes to Mr J's care were implemented too slowly or not at all. In the four weeks prior to the homicide, there was no enhanced care plan in place that addressed Mr J's increasingly frequent crisis presentations to A&E; on the occasion of his fourth presentation in crisis, he was sent home with the advice that his needs could be met in the community. We believe that they were not being

met in the community, and he should have been admitted to hospital in view of his enduring psychotic experiences and his risk to himself and others.

We have responded to the agreed Terms of Reference and family questions in identifying some learning points during the course of this investigation. In our view, Mr J presented services with several significant challenges. We also recognize the great resource pressures the community services were working under.

Throughout the report we have highlighted 12 key learning points. We have consolidated these learning points into **four broad systemic recommendations** that we consider important in developing improvements in care and support in the future.

Recommendations

a. *We have referred to potential improvements in the formulation of an individual's difficulties, care planning and risk assessment to clarify the understanding of complex cases.* ***The Trust develop a care panning process which provides greater emphasis on a longitudinal perspective, more curiosity regarding the full range of factors influencing behaviour, and risk summaries that are updated and lend themselves more easily to safety planning approaches.***

b. *This investigation highlights some of the problems associated with teams working independently from each other, with the potential for individuals with complex difficulties to fall outside of service criteria, or to be excluded from some service provision****. The Trust should ensure a pathway of care that promotes joint working between teams and a shared understanding of patients which will help to reduce this area of risk.***

c. The Trust should ensure a greater degree of proactive planning, informed by dynamic risk assessment and care planning, to manage complex cases in the community.

d. The Trust should ensure a more proactive approach to family involvement in the care of patients with psychosis which could improve care planning and enhance support to patients and their families.

We held a recommendations meeting with the Trust on 1st December 2023, which was attended by a number of relevant service leads. We note that the areas recommended for consideration by the investigation team were in line with the Trust's existing thinking and some proposed actions to improve service design and patient safety are already planned or underway.

Below are some of the current Trust activities of relevance: It is our expectation that these Trust actions will be combined with our recommendations and the Trust will develop and overarching SMART action plan.

Risk summaries/formulation

- The Trust is changing its electronic patient record, which will allow it to develop a system for recording easily accessible risk summaries and improved safety planning.
- The Trust is already planning a Trust-wide training programme in 2024 in relation to risk formulation and safety planning.
- The Trust plans to introduce daily huddles in the community teams, with a clear escalation and stepped care model that can respond to the dynamic nature of risk in the caseloads.

Teams working independently from each other

- The Community Transformation Framework action plan addresses some of the concerns in this area. The Trust is moving towards smaller team groupings within the community services, and this will foster closer multi-disciplinary team working across one or two Primary Care Networks with a stronger pathway of care. A model of 'warm' handovers between primary care and the community teams will improve the communication and management of risk.
- There is an aspiration to build stronger links between the community pathways of care and the three acute inpatient settings in the Trust. Currently PIA (Purposeful Inpatient Admission) aims to make inpatient admissions purposeful and the model includes expectations of greater collaboration with the community teams, both pre and post discharge.

Improving confidence and skills in working with substance misuse

- The Trust is implementing motivational interviewing training trust wide in 2024.
- With the change in substance misuse provider (from the Trust to a voluntary sector provider), the Local Authority has commissioned a dual diagnosis team from the new provider.
- The Trust recognises that there remains a need to provide support and expertise to mental health professionals where a service user with dual diagnosis declines the offer of a specialist substance misuse service. This is likely to be a particular need for professionals working with individuals with non-opiate based substance misuse.

Working with carers when patients do not consent to share information

- The Trust recognises that there is a need to provide clear guidance and support to mental health professionals where a patient does not consent to information sharing with family/carers but where those individuals would like to share information or have support needs.

Multi-agency forum for managing complex individuals with behaviour that is challenging but does not meet the threshold for statutory multi-agency arrangements.

- The Trust's community transformation plan (see above) will assist their staff in developing a greater knowledge of and connection with the range of services in their area.
- The Round Table learning event identified relevant work in this area which needs to be developed to ensure practitioners have clear guidance as to what is available and to whom and where they should focus their networking with other agencies.
- The Trust will need support from the Integrated Care Board, in order to work collaboratively with the local Safeguarding Executive Board to develop this multi-agency work.

The Trust will need to develop an action plan that is written in SMART[14] format, drawing on all the above points, and including the following:

- Relevant actions that are already completed since the serious incident, with evidence of the necessary impact.
- Relevant actions that are already underway, with timelines for completion.
- Relevant actions that are planned but not yet implemented, with timelines.
- Additional actions arising from our recommendations, not covered by any of the above

[14] Actions that are specific, measurable, achievable, realistic and timely defined.

APPENDIX I: PSYCHOLOGICAL APPROACHES CIC

Psychological Approaches is a community interest company delivering a range of consultancy in collaboration with mental health and criminal justice agencies; our focus is on the public and voluntary sector, enabling services to develop a workforce that is confident and competent in supporting individuals with complex mental health and behaviour (often offending) that challenges services. We have a stable team of six serious incident investigators, and offer a whole team approach to each investigation, regardless of the specific individual or panel chosen to lead on the investigation. Our ethos is one of collaborative solution-seeking, with a focus on achieving recommendations that are demonstrably lean – that is, achieving the maximum impact by means of the efficient deployment of limited resources.

Lead investigator

RNLD/RMN, MSc in Forensic Mental Health

A Learning disability and mental health inpatient, prison, and community specialist
Lisa Dakin is a Mental Health & Learning Disability Nurse Consultant and specialist in secure inpatient and prison healthcare, with over 30 years' experience working as a nurse leader in forensic & prison mental health and learning disability services. She was formerly Head of Nursing and Associate Clinical Director for Forensic & Prison services in a large NHS Trust. Lisa has considerable experience of independent incident investigations across complex mental health care pathways including acute, forensic, prison and community services. Lisa has undertaken a number of Mental Health Homicide Reviews (MHHR) on behalf of NHS England including those conducted in parallel with Domestic Homicide Reviews (DHR). Lisa has an MSc in forensic mental health and undertook post graduate training in leading & managing partnership working. She has recently completed Healthcare Safety Investigation Branch (HSIB), Safety Investigation Training at level 2.

Co-investigator

Consultant Clinical & Forensic Psychologist, and Director of Psychological Approaches
Dr Craissati has 30 years' experience in working in forensic and prisons directorates and was previously Clinical Director of such a service (Oxleas NHS FT). Until 2023, she was national consultant advisor to the offender personality disorder pathway across England and Wales and specialises in the community management of individuals with serious offending histories and personality difficulties. She has published widely in this area. She currently chairs the boards of a mental health trust and an acute trust and was previously chair of the quality committee; she therefore has a detailed knowledge of matters pertaining to patient safety.

Psychiatric advisor to the panel

Consultant Forensic Psychiatrist

Dr Brook has 40 years in the NHS. She currently works with sick doctors. She qualified at Guy's, and trained in general practice in Nottingham, becoming interested in the problems of alcoholics. She trained in psychiatry in London, undertaking research at the Institute of Psychiatry before joining Oxleas NHSFT in 1996 as a consultant forensic psychiatrist. She retired from this post in 2016 but continues as the Appraisal Lead for Oxleas. She has extensive experience in ensuring quality in postgraduate medical education and appraisal and has had a regulatory role for over ten years with the General Medical Council's fitness to practice procedures – first as medical examiner and supervisor, then as panelist for the Medical Practitioners' Tribunal Service; panel chair since 2012. Dr Brook has published research in both addictions and forensic psychiatry.