Shared learning bulletin

Domestic homicide by a mental health service user Mr G

This document provides an overview of the findings from an independent review into the care and treatment given to Mr G. Mr G was a mental health service user and in 2021 was found responsible for his wife's death following a trial of fact. Inpatient and community adult mental health services might benefit from this bulletin including psychiatric liaison and home treatment teams.

Case background

Mr G had been under the care of mental health services since the 1980s, when he was diagnosed with schizophrenia. Prior to 1995 he had regular hospital admissions under the Mental Health Act (MHA). Between 1995 and 2020 his mental health was stable, and he was compliant with his medication. However, he was never symptom free and continued to experience delusional thoughts which he would discuss with others. Over time he responded well to treatment with clozapine, and his contact with mental health services reduced. In the years prior to 2020 his only contact with services was a monthly appointment for blood tests and medication monitoring with a specialist team.

His wife Mrs G experienced anxiety and depression from her teenage years. As a result, she would hurt herself by cutting or taking an overdose of medication. She would be treated in the Emergency Department for her injuries and had some admissions to hospital for her mental health problems. She also received support from community mental health services. However, for several years prior to 2020 she was managing without this support.

In June 2020, Mr G became physically unwell and was admitted to a general hospital for treatment. During this admission, the medication for his schizophrenia was stopped for a short period of time and he became mentally unwell. He was assessed and detained under the MHA, and transferred to a mental health ward, so that he could be restarted on medication for his mental health in an inpatient setting.

There were two episodes of violence between the couple while Mr G was on leave from the mental health ward in August 2020. On both occasions the police were called, and Mr G was returned to the ward. There was a lack of clarity about who had been the aggressor in these incidents, Mr G or Mrs G.

Following Mr G's detention to hospital, Mrs G's family made repeated attempts to access support for her from the local authority and mental health services. In September 2020, a Later Life community mental health team completed an assessment with her. The outcome was to ask the housing provider to make some repairs to her home and advice about self-referring to support services.

Mr G was discharged from hospital in December 2020. While in hospital he had been referred to a community mental health team (CMHT) and allocated a care coordinator. Following his discharge, he was supported by his care coordinator, other members of the CMHT team, and continued with the monthly clinic appointments for blood tests.

At the end of January 2021 Mr G called the police and asked to be taken to the Emergency Department because he believed Mrs G was trying to kill him. The mental health liaison team and home treatment teams completed assessments with Mr G. Following these assessments Mr G returned home under the care of the CMHT.

Mrs G called the police at the end of March 2021, the day before the incident that resulted in her death. She told the call handler that Mr G would "not wake up" and was "in dreamland." She was concerned that Mr G would cause a fire with his cigarettes. She did not think that Mr G would cause her any harm. The following day Mr G called the police and told them that Mrs G was dead.

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Key findings

History Mr G and Mrs G had a long history of contact with mental health services. However, comprehensive histories were not taken when the couple were assessed by mental health services in 2020.

As a result, historic information about Mr G's presentation and risks when acutely unwell were not identified. This included any potential risk to Mrs G.

Staff believed that they 'knew' Mr G because he had been under the care of mental health services for more than 30 years, but the Trust records were not organised in a way that allowed them to differentiate between his usual delusional thoughts in his chronic presentation and when he became acutely unwell. Had this information been available in January 2021, staff would have been in a better position to make an informed decision about whether Mr G should have been allowed to go home following his attendance at the Emergency Department.

Relationship dynamics: Mental health services did not seek to understand the nature of the couple's relationship and how they navigated life together. There was an over reliance on self-reporting by the husband and wife. No information was sought about Mr G's domestic situation when he was admitted to hospital and no consideration was given to his wife's ability to cope in the community without Mr G.

Support for Mrs G: Mrs G's family encountered barriers to accessing support for her in 2020 and were repeatedly passed between mental health and social care services. This resulted in a three-month delay in mental health services completing an assessment with Mrs G.

When this assessment was completed, it was through the lens of a standard Later Life assessment. It did not consider Mrs G's long history of mental health problems and self-harm. Furthermore, a carers assessment was not completed with Mrs G. The nature of her problems was not explored with her, and the assessment did not identify her reliance on Mr G for day-to-day support with activities of daily living and the problems she was experiencing with finances.

Mrs G's family was not contacted to provide collateral information to support the assessment.

Mrs G was unable to read but the outcome of this assessment was shared with her in writing. Further attempts by mental health services to engage with her in February 2021 were made in writing. Mrs G did not respond to these approaches and the referral was closed.

Safeguarding: Mental health services did not consider the risks inherent in the couple's relationship. They did not attempt to identify who the victim was in the reported incidents while Mr G was on leave from the hospital in August 2020 or put plans in place to keep the couple safe.

Services did not consider Mr G's capacity to make decisions to keep himself safe in 2020.

Care plans: The lack of a comprehensive history for Mr G had a negative impact on discharge planning in December 2020. Discharge planning in December 2020 was limited and did not address the issue of the couple's state benefits or the monitoring of medication compliance.

There was no Care Programme Approach (CPA) assessment or plan in place to inform Mr G's support in the community. This would have been the vehicle for bringing together all of the services supporting Mr G, including services supporting him with his physical health problems.

Medication: Staff identified potential issues with Mr G's medication compliance in August 2020 and March 2021, and medication sharing between the couple in early 2021. However, these concerns were not explored with the couple.

There was an over reliance on self-reported compliance with prescribed medication and monthly blood tests for Mr G. There was no plan in place to monitor compliance with medication following his discharge from hospital in December 2020.

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Key findings (continued)

Risk: Mr G experienced chronic mental health problems and always experienced bizarre thoughts. However, the content of these thoughts would change when he became acutely unwell. The nature of these changes were not described in the risk assessments completed in 2020 and 2021. As a consequence, there was an overreliance on the staff 'belief' that they knew Mr G.

Services did not complete comprehensive risks assessments and risk plans with the couple.

The risk assessment completed for Mrs G by the Later Life services did not consider historic risk, ongoing risk, current risk or risk triggers. As a result, it did not identify that her risks changed when Mr G was in hospital.

Social care: Over time Mr G's support from mental health and social care services reduced. This resulted in services losing sight of his social care needs. The CMHT did not demonstrate an understanding of Mr G's need for support and accepted at face value the couple's assertion that they were self-reliant and could manage their home and finances.

However, the couple experienced challenges managing their state benefits and correspondence. One of them was unable to read and the other's reading skills were limited. Services did not demonstrate an understanding of this and the barrier that this represented to daily activities, e.g. they were not able to read appointment letters.

Record keeping: The communication of decisions by the CMHT was inadequate to support the 'team' approach taken to Mr G's care and treatment. Mr G did not have a care or risk plan, and there was no escalation plan should Mr G's mental health begin to deteriorate or relapse. The minutes of meetings did not contain sufficient detail to allow staff completing additional visits to Mr G to understand the purpose of the visits. CMHT staff did not always review Mr G's clinical record before visiting him, and this resulted in a lack of awareness of his deteriorating mental health in 2021.

Communication: One of the couple was not able to read and write, and the other's ability to manage written communication was limited This was known to some services, but they did not consider the impact this had on their ability to engage with services. In addition, neither was able to reliably use a mobile phone. Information about communications challenges and how these can be addressed need to be clearly recorded in service records. E.g. one of the best approach with this couple was unplanned visits.

Police: The police did not record the contacts they had with the couple as a mental health occurrence. Had they done so, incidents would have been flagged and accessible to all police staff. This information would have been available to the call handler in March 2021 and may have influenced the outcome of the call.

Critical Learning Points

1. Mental health services should not assume that because a patient has been under the care of services for many years, they know the patient and do not need to complete a comprehensive history and assessment of the current situation.
2. Services must recognise that in relationships where both individuals in a couple have mental health needs, the needs of the partner remaining at home when the other is admitted to hospital should be assessed.
3. Risk assessments for patients with acute mental health problems should clearly identify the difference between their acute and chronic presentation.
4. Mental health services should be aware of the communication needs of the patients they support and have clear plans to address them.

Shared learning bulletin

Recommendations

The independent investigation made a total of 22 recommendations. 11 of these recommendations were for the Trust.

Recommendations for the mental health trust

Recommendation 10: One of the couple was not able to read and write, and the other's ability to manage written communication was limited. This was known to services, but they did not consider the impact this had on their ability to engage with services. Neither was able to reliably use a mobile phone.

All agencies should review how information about service users' communication needs are recorded on the clinical record and ensure that any limitations are clearly identified and visible to all who open the clinical record.

Recommendation 11: There is no evidence available to show how compliance with medication was monitored. Also, questions were raised about how the couple managed their medication and potential medication sharing, but this was not explored with them.

The Trust must ensure that plans of care in the community include mechanisms for monitoring compliance with oral medication.

Recommendation 12: Each of the couple had a long history of contact with Trust mental health services. However, a history summarising past service use, was not completed at all in one case, or before the homicide in the other case. If this had been done, professionals would have had an understanding of the tensions and risks in the couple's relationship when they were unwell.

Also, one of the couples' risks when unwell were 'lost' to services because of sustained periods of good mental health.

The Trust must review the expectation to take a history for all patients when they are referred to services or referred to a new service.

The Trust must take steps to ensure that a patient's historic risks remain visible when a patient has a sustained period of stable mental health.

Recommendation 13: One of the couple had been under the care of Trust services for more than 40 years and there was a pervasive belief among staff and teams that they 'knew' them. Even when mentally stable, the service user experienced delusional beliefs. This investigation identified that staff were not able to differentiate between their delusional beliefs when they were mentally stable and those when he was unwell.

The Trust must ensure that for patients who have delusional beliefs associated with chronic mental health problems, that any delusional beliefs they have when they are mentally stable are clearly identified in their risk assessment, along with any delusional beliefs that indicate their mental health is deteriorating.

Recommendation 14: This investigation noted that there was 'cutting and pasting' in some of the Wellbeing Team clinical records, this could lead to confusion about a patient's presentation.

The Trust must provide evidence that there is a quality assurance process in place to monitor the quality of all clinical record keeping, to ensure they are correct.

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Recommendations (continued)

Recommendation 15: There was no medical review or oversight following a discharge from ward 18, either of the Trust community teams.

The Trust must ensure that there is a medical review for all patients prescribed clozapine within four weeks of their discharge from the ward.

Recommendation 16: The ward did not complete a discharge Care Programme Approach (CPA) review in December 2020 and there is limited evidence about communication and discussions between inpatient and community services.

The Trust must ensure that there is a CPA review for all patients who are discharged to the care of community teams.

Recommendation 17: Risk assessment is not included in the Trust mandatory training. Good risk assessment and planning should be at the centre of all mental health services.

The Trust must complete a learning needs analysis for all staff groups and services about risk assessment and management and develop mandatory training that meets these identified needs.

Recommendation 18: The couple lacked the ability to manage their benefits or access the support needed when there were issues. Their Universal Credit was stopped after a period when one was in hospital for 28 days This left them with no discernible income for a short period, until one of them began to receive a pension when they reached 65. This resulted in distress and to the couple accruing rent arrears.

The Trust must have a process in place for when a patient has been admitted to inpatient services for 28 days or more. The process must ensure they, and their dependents, are in receipt of the correct benefits and their housing is secure.

Recommendation 19: The minutes for the Trust daily Flexible Assertive Community Treatment (FACT) meetings did not contain sufficient information about the presenting issue or the plans to address it.

The Trust must ensure that all concerns and plans for care are sufficiently recorded when discussed by multidisciplinary teams, e.g., consider the use of the SBAR (situation, background, assessment, recommendation) format.

Recommendation 20: The care coordinator (CC) was employed by the Trust to work one day a week; this is insufficient to provide support to service users with complex mental health needs. The CC did not complete a CPA review with one of the couple between December 2020 and March 2021.

The Trust must ensure that CCs have sufficient availability to meet the needs of the service users on their caseload.

The Trust must ensure that all service users under the care of the Trust adult community team have an up-to-date CPA care plan.

Learning Quadrant

Individual practice

- Am I clear about my responsibility to review a patient's contact with mental health services and complete a history? Do I consider potential issues patients might have regarding daily living skills, and do I challenge self-reporting?
- Do I have risk assessments in place that differentiate between a patient's chronic and acute presentation?
- Do I have clear plans in place to monitor compliance with medication for patients who require it?
- Do I recognise how the needs and vulnerabilities of carers may change when a partner is admitted to hospital and take this into account in relation to care planning, risk assessment and safeguarding?
- Do I feel confident to identify domestic abuse and do I understand how to safeguard a patient and keep them safe?

Governance focused learning

- How are we assured our mental health services are meeting the needs of patients who require clozapine as they age?
- How are we meeting the needs of couples who both have a long history of mental health problems?
- How are we assured risk assessments and care plans are relevant and appropriate?
- How are we assured appropriate action is taken in response to relatives asking for help? Do we monitor the reasons that people are turned down for this support i.e. where no immediate action is taken?
- How are we assured our staff can identify and respond appropriately to incidents of domestic abuse?
- How are we assured that we are responding to the social care needs of our patients?

Board assurance

- As a Board member how do I know that concerns raised by families about struggling to access support are listened to and acted upon?
- As a Board member am I assured that the Trust is working effectively to support long term users of mental health services as they age and their needs change?
- As a Board member how do I know that elderly carers of vulnerable patients are being adequately supported by our services?
- As a Board member how do I know that patients assessed as high risk have a current risk management plan available on discharge?

System learning points

- Do we have clear channels of communication, including regular contact and clear protocols between the mental health services and social care?
- Is record sharing between the police and the Trust effective in ensuring that vulnerable service users are identified and there are plans to keep them safe?
- Does the local domestic abuse strategy include appropriate focus on the impact of mental ill health, and the risks faced by elderly, particularly female, carers?
- Have we recognised and responded to the need for system wide collaboration and learning in relation to serious incidents?