Learning Compendium

A thematic review of collated **mental health homicide** investigations.

October 2022

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Introduction

"Lessons will be learned"

As far back as I can remember, following every death in mental health services subject to an independent investigation, the phrase **"lessons will be learned"** comes up at some point. In very many cases they are, not least because the lessons learnt from each tragic case are imprinted on the memories of the clinical and managerial staff involved for the rest of their career. One hopes that these lessons also become part of the *organisational memory*, so that positive changes to mental health practice become embedded in the way mental health care is delivered.

In December 1992, Jonathon Zito was stabbed and killed by Christopher Clunis on Finsbury Park station. This was one of the cases that led to the Department of Health to introduce the Care Programme Approach (CPA). In 1996 the Zito Trust, the charity founded by Jonathon's widow also published "Learning the Lessons" by Dave Sheppard, which summarised the findings from independent investigations published between 1969 and 1996.

Thirty years later CPA has been replaced by the Community Mental Health Framework. Our hope is that the lessons learned from the previous 30 years are not lost, and this compendium of 'learning lessons bulletins' of 41 investigations undertaken by Niche since 2017, will help add to this body of knowledge. Our hope is that services will identify those key elements of practice that can make a difference to service user care, and most importantly reduce the likelihood of such tragedies recurring.

Nick Moor

Partner, mental health investigations

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About this compendium

Niche Health & Social Care Consulting is the leading supplier of independent investigations on the NHS England Independent Investigations Framework, particularly in relation to mental health homicides, suicides and domestic homicide reviews.

When serious incidents occur, mental health care providers, managers and commissioners have a responsibility to embed learning to improve practice and prevent future recurrence. We support organisations in developing the tools to encourage this process. Through our work on investigations and serious case reviews we have amassed a significant body of primary research and here we have collated some of the most relevant and useful reports into a compendium of learning lessons bulletins (LLBs).

In this thematic review, we examine 41 LLBs summarising investigations undertaken by Niche Health & Social Care Consulting into the care and treatment of mental health service users who have committed a homicide, published between July 2017 and August 2021. This thematic review explores the key lessons to be learned from this compendium of bulletins, focusing on the recurring themes highlighted across the key findings and recommendations of each bulletin. Of these reports, four deal with a female service user while the remaining 37 deal with a male service user. Of the service users, six are older persons, five are children or adolescents and 30 are working-age adults

We utilised NVivo software to analyse the underlying themes in each case and found unexpected themes emerging as the most prominent across the compendium. This thematic review therefore aims to provide our clients with a unique insight into the prevalent themes and key areas for learning that arise from our qualitative analysis.

This information is supplied by Niche for *public interest purposes only* and no organisation may place formal reliance upon the contents of this report. The contents of this report must not be used or extracted without our express written permission.

All individual cases have been fully anonymised. That said, we would like to express our most sincere condolences to all of the victim's of mental health homicide and their families. We would also like to say thank you for their contributions to enable learning to take place.

For any further information on our work please contact info@nicheconsult.co.uk

Collated and authored by **Katharine Gwynne**
Investigations, Learning Bulletins and insights **provided by the Niche Team**

1. Key Findings

This analysis identifies similarities across the compendium of learning lessons bulletins (LLBs) and collates them here into our key findings. The existence of these substantial similarities suggests that key learning is not being properly embedded within the system or that there is a lack of sharing of this learning between mental health services on a local and/or national level.

The key findings from the LLBs have been grouped into eight key themes with 35 subgroups. These key themes are highlighted in Figure 1 and 2 below, quantified by the number of references to each theme. A reference can be defined as a phrase or sentence that relates to the specific theme within the 'Key findings' or 'Recommendations' sections of the bulletin.

Figure 1

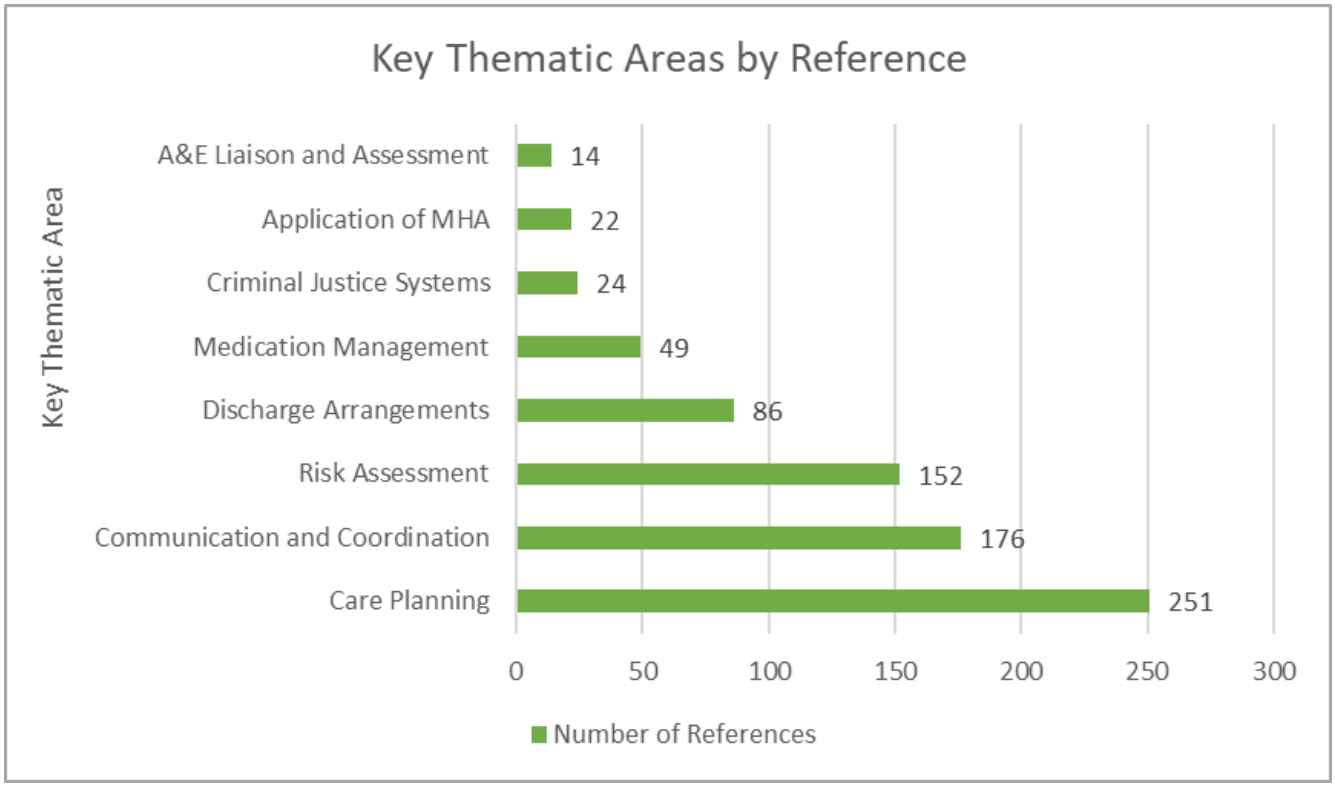


Figure 1 charts the eight main thematic areas against their number of references. As we can see, care planning is the predominant recurring theme by a significant proportion. Recognising other key, but less prevalent themes such as failures in A&E liaison and assessment and failures in application of the Mental Health Act, are also significant to improving system learning.

In fact, issues with care planning occur in almost every case, with a total of 251 references to individual issues or failures with care planning across 40 cases. Issues with communication and coordination, risk assessment, and both patient and service factors also crop up in almost all of the cases (35–38 out of 41).

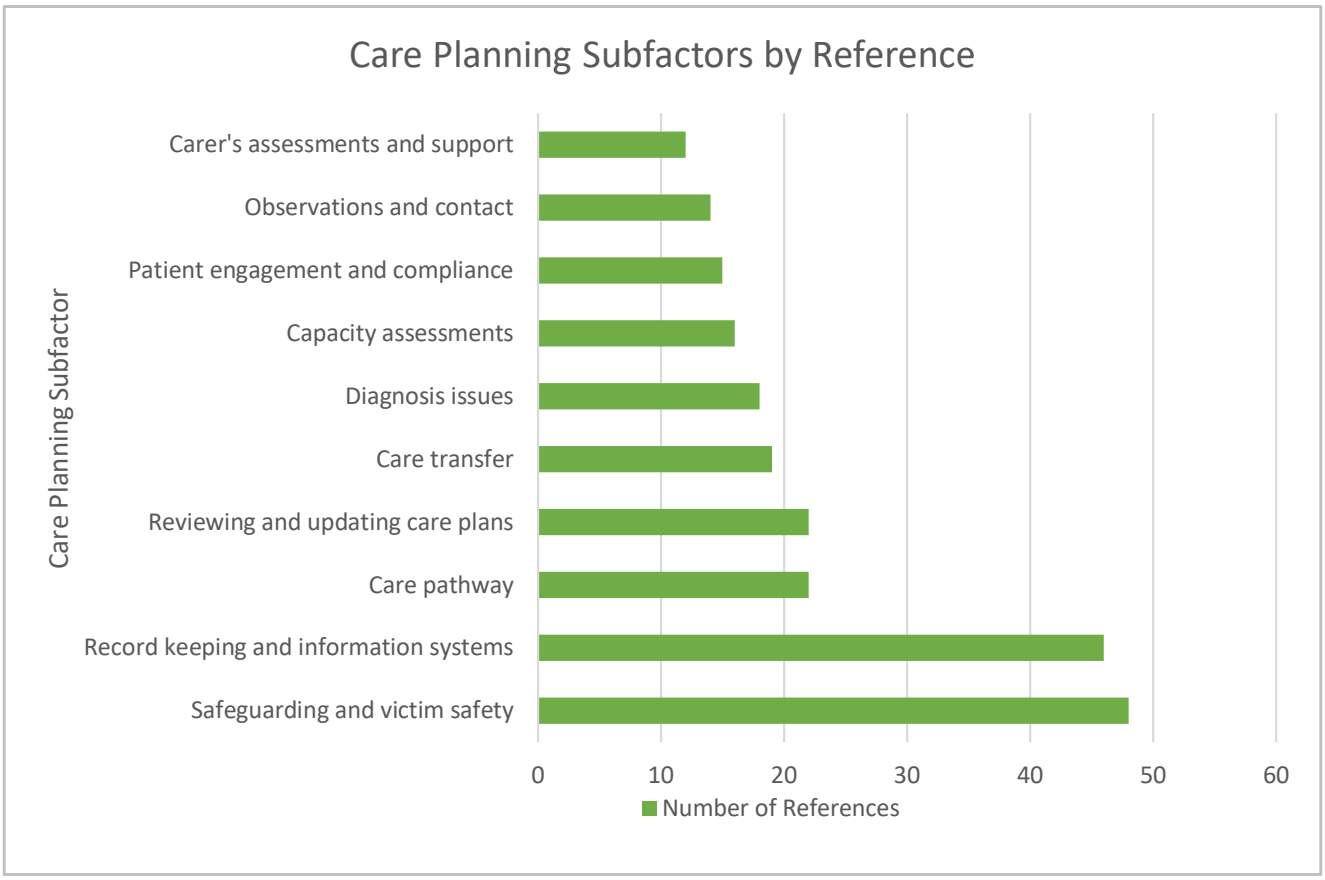
1.1 Care Planning

Of the key themes, by far the most frequently occurring focuses on failures in **care planning**. However, while care planning is arguably the most important factor within the care and treatment of a service user, this theme encompasses a huge range of subfactors. Figure 2 identifies the care planning subfactors by reference.

These subfactors include:

- Safeguarding and victim safety
- Record-keeping and information systems
- Care pathways
- Reviewing and updating care plans
- Care transfer
- Diagnosis issues
- Capacity assessments
- Patient engagement and compliance
- Issues around observations and contact from services
- Failures concerning a carer's assessment and support

Figure 2



Safeguarding and victim safety has been highlighted as the most prominent subfactor within care planning. Adherence to safeguarding standards is fundamental to the prevention of neglect, harm and abuse of vulnerable people, and is therefore vital to research into serious incidents of this nature. However, prior to analysis, we did not expect this thematic area to carry such weight; this is because the theme does not present as a key focus in many of the individual cases, but is a sub focus in most, meaning that the theme is widely dispersed and not as instantly attributable as others.

The most effective safeguarding work depends on high quality communication between agencies and services. This involves multi-agency information sharing and the full inclusion of the potential victim(s) of violence, aggression or domestic abuse in any relevant care planning. Failure to consider different forms of domestic abuse featured frequently in these cases. Services were unaware of unconventional forms such as adult child to elderly parent, or nonviolent forms such as manipulation and verbal abuse; hence their strategies for mitigating domestic abuse risks have not always been effective. There have also been failures in establishing a safe space to communicate with the family or partner about their experiences. This theme has a clear link to communication and coordination themes which will be further discussed.

As highlighted by our analysis, **record-keeping** is also vital to care planning. Good record-keeping can greatly improve the effectiveness and ease of care planning and risk management. It ensures that the involved Trusts and services are fully aware of the patient's symptoms, treatments, inpatient stays, forensic history, medication and discharge arrangements.

There is evidence that **information systems** caused multiple problems with accessing, updating and adjusting patient records and there have been numerous failures to meet the expectations of the clinical record-keeping policy. Issues also regularly arose with prescription sheets and administrative records. The investigation reports show that failure to keep adequate records can have devastating consequences.

1.2 Communication and coordination

Communication is the second most dominant thematic area within this analysis. This theme encompasses a primary sub focus on communication **between different agencies and services** alongside secondary sub focuses on communication **with families** and communication **between patient and staff.**

It is vital that mental health services are fully engaged with multidisciplinary and multi-agency networks where appropriate, to ensure effective and integrated treatment for the service user. Effective communication between services, the service user and others involved in their care creates a collaborative care environment that is better able to reduce risk and the frequency of crises.

If a service user is receiving care and treatment from more than one service, good quality inter-agency communication is key; there should be effective collaboration and joint meetings between these services, with consideration given to a shared care plan. Ineffective communication has often contributed to deterioration in care. Adequate information sharing also ensures that all care planning is collaborative between services and results in good quality patient care.

Closer joint working has been highlighted repeatedly in the 'Recommendations' sections of the bulletins, with particular focus on detail and continuity of care. In multiple cases, the Trust staff failed to properly listen to the service user or to their family or carer(s). **Professional curiosity** and **clinical assertiveness** is vital in this task. Across the cases, staff members consistently failed to take into account the views of the service user's next of kin, even though their informal observations of the service user's condition has the potential to provide a vital perspective for informing their care. Involving the service user's family in their care also gives the service user the everyday support that is often needed to ensure their cooperation with treatment and to keep them fully engaged. Ongoing communication with the service user's family can alert staff to any risks and ensure safeguarding measures are undertaken if necessary; although it is crucial that this communication does not **breach confidentiality**.

1.3 Risk Assessment

Completion of **risk assessments**, as well as regularly **updating and monitoring** them, is crucial to ensuring that services understand any actual and potential risks to the service user or other people involved; the level of ability to control or mitigate those risks; their likelihood of occurrence and their potential impact. The risk assessment process supports decision-making about the service user and an inadequate risk assessment causes inadequate care planning. In several cases, a service user's risk information was largely scattered across different records and systems, and this diluted the usefulness of such information. Risk concerns were also not always conveyed in appropriate detail or adequately incorporated into risk assessments.

1.4 Discharge Planning

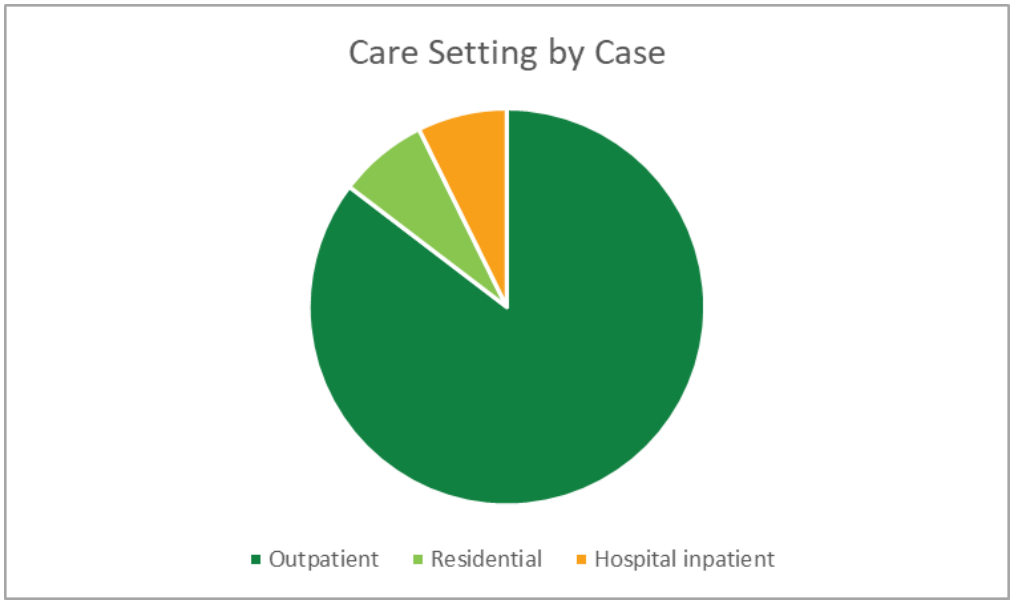
Discharge planning and Care Programme Approach (CPA) arrangements often did not fully comply with Trust policy. Discharges of service users were found to be unplanned and unstructured and there was frequently a lack of assurance that the service user had the appropriate enhanced package of care in place or adequate Section 117 aftercare. Arrangements were not always made to appropriately grade service users with complex needs or forensic histories, which was necessary to ensure they were adequately supported with assertive and proactive care. Regular delays and failures were found in Community Mental Health team (CMHT) Care Coordinator allocation for service users in need. Also, service users in receipt of the CPA did not always have the appropriate comprehensive assessment and care plan.

Any plans for discharge from an inpatient unit should be appropriately planned with the patient, their GP and all relevant community services. This should include a clearly documented plan detailing the specific roles, responsibilities and timescales involved in discharge. Adequate emphasis should be placed on the service user's longitudinal risk profile and management plan, with consideration given to community treatment orders (CTOs). Ultimately, there is multifaceted learning to be taken from the failures in discharge arrangements across this compendium of reports, with improvements needed in almost every aspect of discharge planning.

2. Care Setting

Another important component to consider is the care setting in which the service user lived at the time of the homicide, whether this was in an outpatient setting, in a residential setting (including supported housing and care homes), or in a hospital inpatient setting. The environment of the care setting provided for the service user, and the level or type of care, depends on multiple factors: the nature and severity of the person's mental condition, their physical health and the type of treatment prescribed or indicated. Inappropriate care settings are closely linked to ineffective **discharge arrangements** and **misuses of the Mental Health Act** (MHA) and can be exacerbated by inefficient interagency working between NHS mental health services and local authority structures. There have been several cases in which the level of observation of the service user in their primary care setting was inadequate and ineffective.

Figure 3



In 35 out of the 41 cases in this compendium, the mental health related homicide took place while the service user was living in an outpatient setting in the community, as shown in Figure 3. Appropriate observation and contact with the service user is key to ensuring consistent engagement with their care and treatment, and it can be harder to maintain engagement with the service user in an outpatient setting.

Many cases involve a failure to properly apply the MHA to a service user living in the community or to refer the service user for a MHA assessment at times when these would be beneficial to the service user's care. Staff may fail to consider the benefits of informal admission when the service user is not compliant with their treatment plan. Many cases also highlight issues with risk management and escalation plans in these cases. Conditional discharges granted to the service user did not always adequately include a threshold for recall to hospital or any plans to review the service user's care in the event of a crisis or deterioration.

Similarly, problems with residential care provided for the service user has contributed to failures in care planning and support. Supported accommodation arrangements are not always adequately risk assessed. Despite providing a service to individuals with complex needs, supported accommodation is not always regulated by the Care Quality Commission (CQC) and staff in the accommodation are not usually required to be professionally qualified. Staff are not appropriately prepared or supported to deal with such complex needs.

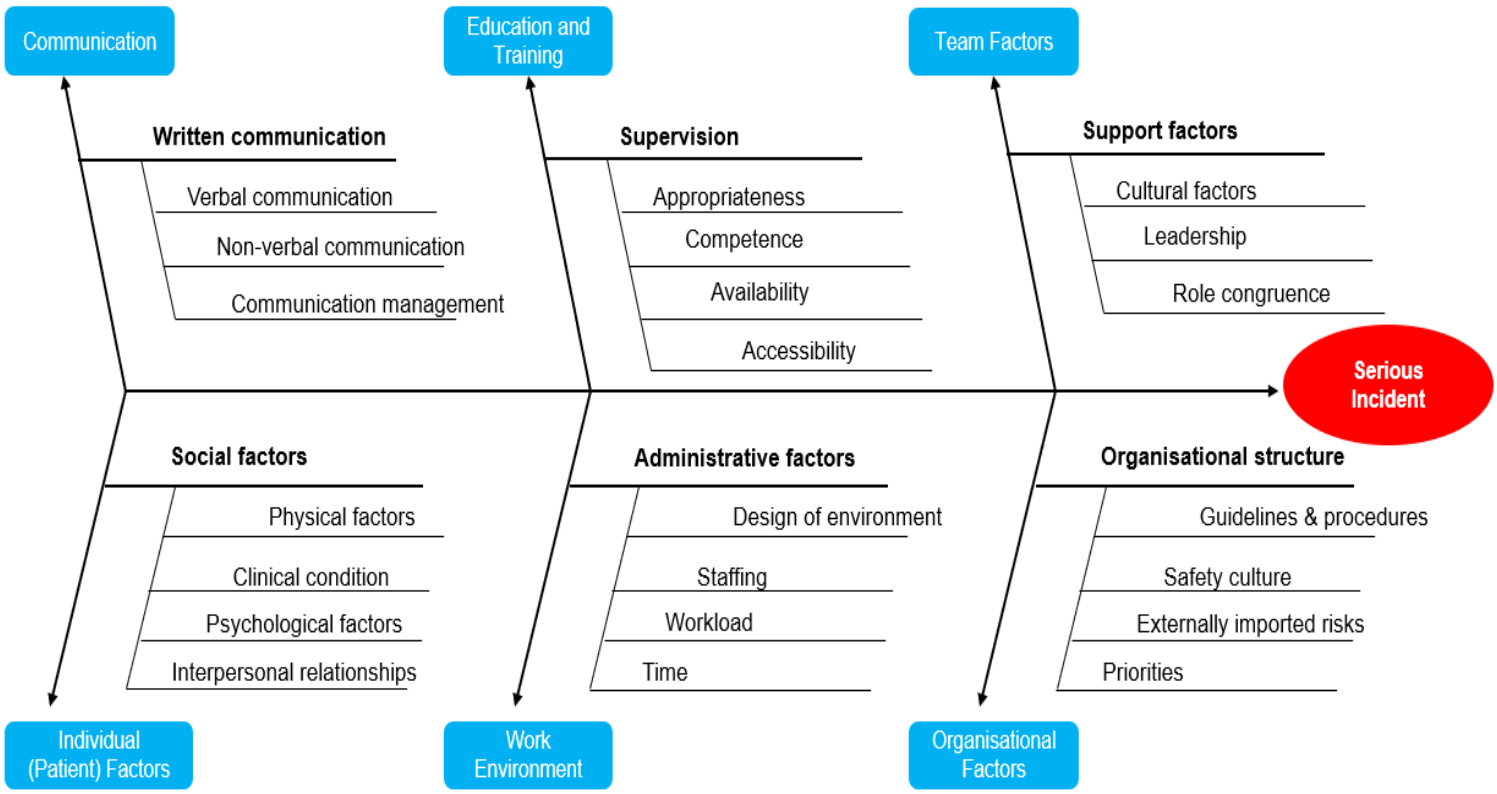
3. Contributory Factors

The **contributory factors** can be identified through the development of an Ishikawa diagram (fishbone analysis). This is one of the analytical tools advised within the NHS England Serious Incident framework. According to the National Patient Safety Agency (NPSA), contributory factors are the factors that affect the performance of individuals whose actions may have a direct effect on the delivery of safe and effective care to patients, increasing the likelihood of a **care delivery problem** (CDP) or **service delivery problem** (SDP). CDPs and SDPs are points in the timeline at which something happened that should not have happened, or when something that should have happened did not happen.

A **root cause** is also a fundamental contributory factor. In patient safety terms, a root cause is the earliest point at which action could have been taken to improve the support system or anticipate the event. The focus of many internal investigations centres on the service user at the centre of the homicide study, but the root causes should always be seen as the system failures which contributed to the incident occurring.

The key contributory factors within the 41 investigations analysed in this report are highlighted in Figure 4. Relevant factors have been identified using the NPSA Contributory Factors Classification Framework.

Figure 4



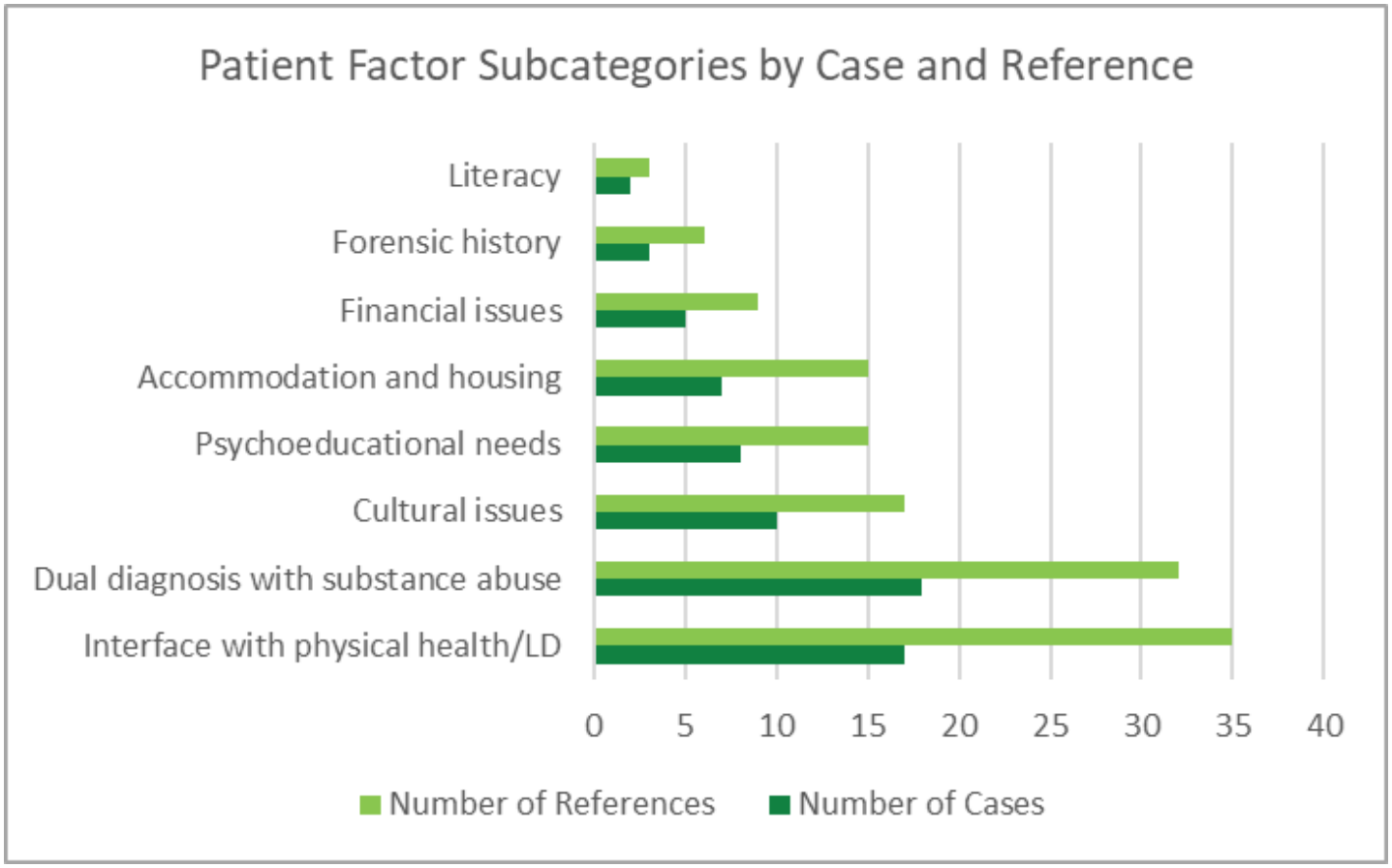
4. Individual (Patient) Factors

Individual (patient) factors act as a cross-cutting component for this compendium, affecting 90% of all cases. This category encompasses issues centred on the individual patient's characteristics. Figure 5 demonstrates how prominent each factor is across the compendium, measured by the number of references to this factor across all the cases and the number of individual cases they relate to.

This component includes:

- The interface between mental health and physical health or learning disability (LD)
- Dual diagnosis with substance abuse (including alcohol abuse)
- Issues with cultural factors such as race and ethnicity, gender and religious issues
- Psychoeducational needs
- Accommodation and housing
- Financial issues
- Forensic history
- Literacy

Figure 5



Multiple diagnoses are a significant focal point in this analysis of failures in mental health care provision. The major subfactor within patient factors centres on **the interface between mental health and physical health or learning disability**. Within healthcare provision, there is an initial focus on physical health which often does not give adequate consideration to a patient's underlying mental health issues, which may surface as the more serious issue affecting their health in the long term. The co-occurrence of serious mental illnesses, such as psychoses, with other mental health related conditions, such as dementia, autism and Asperger's Syndrome, present new challenges for health systems and increase the possibility of a serious mental illness being misdiagnosed or ignored. Similarly, in several cases, symptoms of a serious mental illness were missed because they were instead attributed to the service user's learning disability, and a learning disability may have been ignored as the symptoms were instead attributed to the patient's mental illness, with detrimental effects to the service user's care and treatment.

The subfactor of **dual diagnosis** of mental health and substance abuse, including alcohol abuse, also emerged repeatedly in this compendium of bulletins. Abuse of alcohol and/or illicit substances was a recurring theme in the reports and it often correlated to time spent in a prison setting or on probation; instances of aggression or violent behaviour; and instances of domestic abuse. Chronic use of some illicit substances can exacerbate underlying mental health problems, which can lead to increased paranoia, hallucinations, depression and anxiety; this is clear in the recurrence of this theme within serious incident investigations. However, the interagency coordination between mental health services and specialist drug and alcohol services can be disjointed and ineffective.

In some cases, Trusts have been unable to provide an assertive care pathway for service users dealing with substance misuse and complex mental health conditions. The care pathway has failed to include escalation routes into appropriate inpatient beds and access to clinical and forensic support and advice when needed.

Cultural issues has been highlighted as another prominent subfactor within this category. Cultural factors encompass **race and ethnicity**, **gender, religious and spiritual issues**, and **language** and **cultural norms**. Trusts and services routinely fail to appropriately address cultural factors in care planning and CPA needs assessments. Appropriate cultural awareness is vital when communicating with a service user's family or carer. Good communications and working relationships should also be maintained between Trusts and local **faith organisations** to ensure that service users are offered other forms of informal support within the community. Equally, if the service user prefers a holistic approach to their treatment, this must be offered where possible. Spiritual and cultural issues should always be considered, assessed and incorporated into care plans.

Serious mental illness occasionally coincides with **radicalisation**, which can manifest itself as concerning spiritual delusions or religious extremism. Across the compendium, there is a strong correlation with time spent in a prison setting, suggesting that extremist ideas are heavily propagated in these environments. Our analysis shows that the service user is most likely to be male and an adolescent or young working-age adult. Gang culture also features heavily in several of the reports, particularly in reference to drug gangs and the recent emergence of the phenomena of child criminal exploitation (CCE) known as 'county lines' and 'cuckooing'.

Formal safeguarding procedures have not always been adequately completed for the service user in these instances and there has been a lack of guidance provided about the management of safeguarding issues and safety concerns. In one case of CCE, there was a lack of professional curiosity about the 'red flags' in the young person's experiences, despite system-wide programmes in place to identify and intervene in radicalisation and grooming by drug gangs. The development of staff education in working with young people about drug and gang culture remains a strong focus within the recommendations across the compendium, with a particular focus on the mental health implications of drug and gang culture, the safeguarding implications and risk assessment concerns. Services should ensure that all staff members demonstrate adequate awareness of the manifestations of adult and child criminal and sexual exploitation and are aware of the multi-agency services available to service users and their families. Appropriate links between Trusts and the police should also be maintained to ensure an awareness of local established networks.

Psychoeducational needs have too often been overlooked in care planning. Psychoeducation is a form of education, the goal of which is to help people better understand and come to terms with their mental health conditions; it can have a positive impact on a patient's compliance with treatment and medication and their communication with services. Poor insight into the illness and the causes of relapse can lead to intermittent engagement with care teams and inconsistent compliance with medication. In several cases within this compendium, the service user's care plan did not include adequate focus on the underlying aspects of their mental health condition and their risk assessment failed to identify psychoeducation as a possible risk-mitigating intervention. In these cases, the service user should have been offered psychoeducational interventions to address their poor insight into their condition and to promote engagement with services.

Other patient factors that crop up regularly include unsuitable **accommodation and housing** and **financial issues**, including gambling debts, thefts and receipt of welfare benefits. Service users have consistently not been offered the appropriate support to deal with issues in these areas, which may have had a severe impact on their mental health. There has not always been consideration or discussion of the risks of unsuitable housing or problematic finances; these should always be factored into risk assessments where relevant as they can have a substantial impact on a service user's mental wellbeing. In several cases from the compendium, the service user's **literacy** has negatively impacted their treatment. Communication from the mental health services should always reflect the patient's individual needs and be delivered in a way that is easily accessible and personalised.

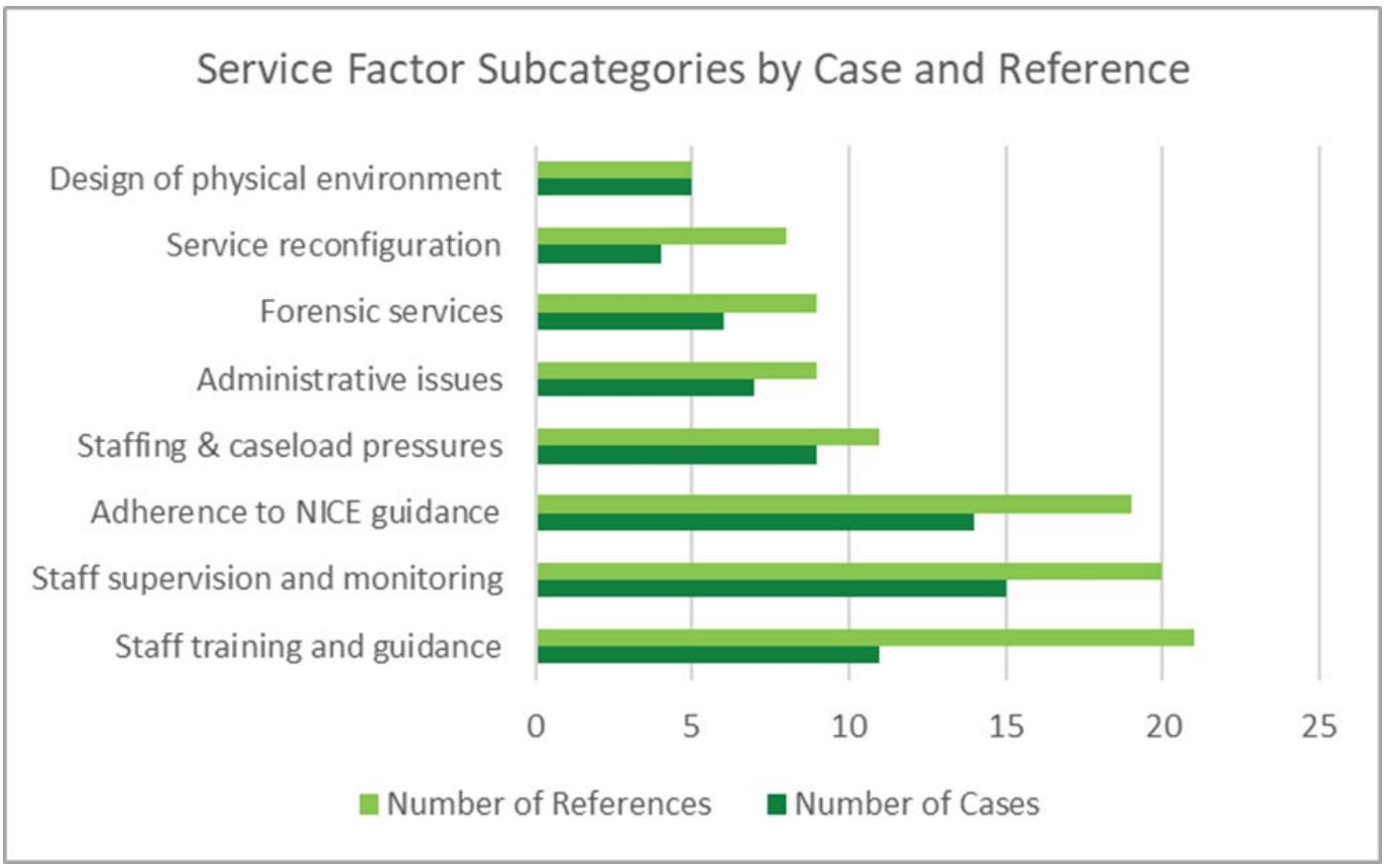
5. Service Factors

Service factors were also implicated in many of the homicides, affecting 35 out of the total 41 cases within the compendium. This category encompasses issues that centre on service provision and the results of our analysis can be seen in Figure 6.

This component includes:

- Staff training and guidance
- Staff supervision and management
- Adherence to NICE guidelines
- Staffing and caseload pressures
- Administrative issues
- Forensic services
- Service reconfiguration
- Design of physical environment

Figure 6



The overriding issue within this subfactor concerns **staff training and guidance**. Staff should be receiving appropriate training in all areas of their work; effective staff training increases engagement from staff members and patients, addresses internal weaknesses, and ensures that staff members are adequately supported and equipped to carry out their challenging role. A programme of training on risk assessment was recommended multiple times across the compendium. In one case, failures in adequately assessing patients were further exacerbated by the attitude of the care team that tolerated incomplete or out-of-date risk assessment and care plans.

In several cases, staff members were not clear on training requirements and/or demonstrated low compliance with risk training, which had negative results on the quality of their work. This can be attributed to a failure in **staff supervision and management**, which is another prominent service factor. These are integral to ensuring the service runs smoothly and effectively. Appropriate management offers staff the opportunity to improve and learn from others.

NICE guidelines are evidence-based recommendations for health and care in England, issued by the National Institute for Health and Care Excellence (NICE). One of the functions of the guidelines is to encourage healthcare professionals to improve the quality of care and services. Unfortunately, failure to adhere to NICE guidelines is an issue that surfaced repeatedly across these reports. There have been periodic failures to implement NICE guidelines and to regularly review local policies and procedures in line with appropriate NICE guidance. All relevant policies and procedures should also be updated whenever new guidance from NICE is issued.

Another issue seen repeatedly is staffing and caseload pressures. Rising caseloads and increasing numbers of service users with complex mental health problems risks overstretching medical staff and undermining progress. **Staffing pressures** result in care not being adequately delivered, culminating in poorer patient outcomes; several cases highlight inadequate staffing levels and inappropriate **skills mix** within teams as key contributing factors to poor care delivery. In some cases, inadequate staffing levels meant that the senior clinicians did not have time to attend to the more complex cases and provide adequate supervision. In addition to this, high turnover of staff coupled with locum consultant leadership had adverse effects on the cohesiveness of the workforce that is needed to deliver high-quality care.

Conclusion

When there is a serious incident in healthcare, the system failures are usually acknowledged and learning is taken into account; however, unless this learning becomes fully embedded within the system, the lessons taken from this serious incident will not endure and the aspects of the mental health care system that failed in the first case will not improve. **Lessons need to be learned and properly embedded into the system to ensure real progress.**

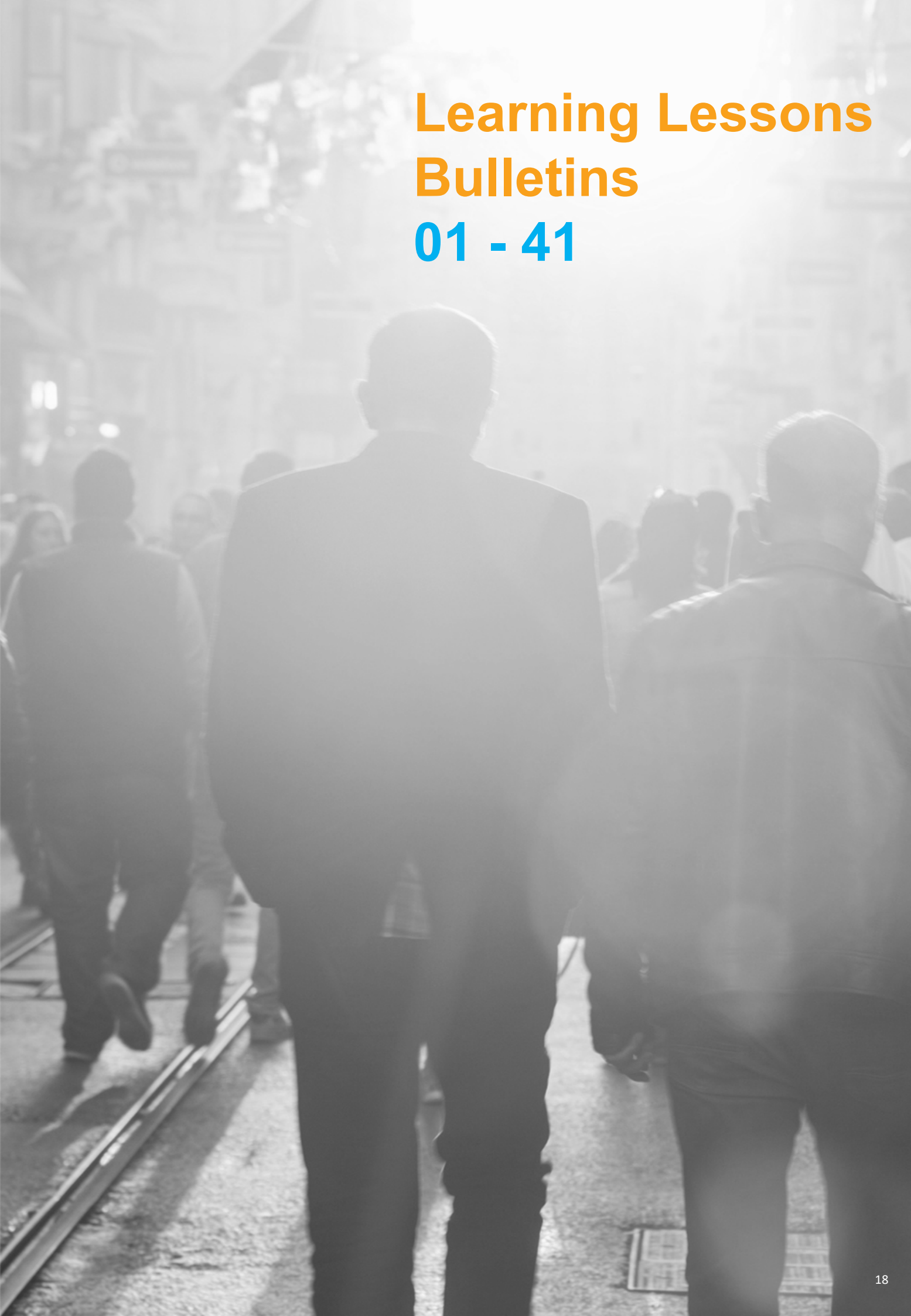
This compendium has highlighted the key factors and subfactors that contribute to failures in mental health care provision. While not the theme with the highest proportion of references across the compendium, failures in **communication** stand out as the most important underlying factor. Evidence shows that poor communication between different services within a Trust can lead to information not being adequately shared, with direct effects on care planning, safeguarding, completion of risk assessments and discharge arrangements. Equally, we can clearly see the consequences of failing to properly communicate with and listen to the patient's family/carer, and of failing to keep them adequately involved in the patient's care and updated on their treatment, care plans and discharge arrangements.

While it is useful to consider the compendium as a whole, it is crucial that we recognise the complexity of each individual case. Even if Trusts and services implement the proposed adjustments to their systems, there will always be an element of human error and unpredictability. In many of the cases studied here, some of the mistakes made are examples of poor practice on the part of the individual practitioner, such as a patient's name misspelled or out-of-date contact details given. According to the NHS Commissioning Board, there may be occasions when nothing could have prevented the incident and no root cause(s) can be determined and key safer practice issues may be identified which did not materially contribute to the incident. However, the trends specifically identified in this report are not related to human error and recurrent failures must be dealt with.

The phasing out of the **Care Programme Approach** (CPA) in 2021/22 by NHS England and NHS Improvement marks a significant transition in care planning and delivery. The NHS Community Mental Health Framework suggests a move towards a minimum universal standard of high-quality care for everyone in need of community mental health care, which should involve a flexible, responsive and personalised approach. Therefore robust and high-quality risk assessments, care planning and coordination remain key to delivering safe mental health care for high-risk service users.

Next steps

As we look ahead to new mental health service structures and the escalating challenges of limited resources and increased demand, particularly heightened by the global Covid-19 pandemic, it is vital that we incorporate the lessons we need to learn into our system adjustments and staff training. When a serious incident takes place it is imperative that the mental health care system learns from this and takes noticeable steps to improve services for future service users, so the likelihood of such an event occurring again is reduced.



Learning Lessons Bulletins 01 - 41

Learning Lessons Bulletin - 01

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user S, who killed his parents.

Key themes: risk assessment, care planning, medication management, discharge arrangements, application of Mental Health Act (MHA)

Agencies and teams who might benefit from this bulletin:

- **Early Intervention in Psychosis Teams**
- **Community forensic services**
- **Substance misuse services**

Case background

S was first diagnosed with paranoid schizophrenia after being transferred from prison to the inpatient secure forensic mental health service, following his stabbing of his girlfriend's father and brother. His behaviour was noted to be increasingly bizarre. He spent four months as an inpatient and was treated with antipsychotic medication before returning to prison.

S had seven admissions to the forensic service clinic over the following decade, and he was discharged to the care of the Forensic Integrated Resource Team (FIRT). His admissions resulted from assaults on his parents and other bizarre behaviour. He was treated with depot medication.

S had periods of being settled in the community and further inpatient admissions to the clinic. He requested that he stop his depot medication and was admitted after this. There were doubts about his compliance with oral medication, and he had been using cannabis and alcohol more regularly.

From his final admission, S lived in the community with mental health and housing support under the care of the FIRT, later called the Forensic Outreach Service (FOS). His diagnosis of paranoid schizophrenia did not change from this time, and he had a complex delusional belief system in which he believed his parents had harmed him as a child. He experienced auditory hallucinations and believed there was a prophecy which would lead to him killing his parents. This was known to services and his parents, and was regularly discussed with him by professionals in his care team.

Key findings

Care delivery

There was inadequate risk assessment and risk documentation throughout the care delivery process. Care Programme Approach (CPA) guidelines were not appropriately followed.

There should have been a review of treatment processes. S's mental illness was not robustly treated and his compliance with medication was not addressed as it should have been. The full powers of the Mental Health Act (MHA) were not used to detain S in hospital.

The difficulty for both of S's parents to act as caring parents but also to recognise and manage the risks to them from their son was not addressed in a consistent manner. There was no consideration of how these ambivalent feelings towards their son could be properly managed through his father's role as nearest relative under the MHA.

Service delivery

The medical management and clinical provision of the clinic were not adequate. The isolation of the clinic and FIRT during the Trust's management changes caused issues that should have been dealt with. The FIRT operated in isolation, without senior oversight of management and clinical practice.

Key learning points

1. The formulation of HCR–20 risk assessments in the secure services should be aligned to best practice principles and there should be a quality assurance structure to audit the quality of risk formulations and management plans.
2. The planning of victim safety in partnership with individuals concerned must form part of the core risk assessment and treatment planning, especially where this involves a family member or partner.
3. Ongoing contact with family members or partners must form part of the core risk assessment and care planning by the Care Coordinator. Equally, where there is a question of responsibility for the welfare of a child, specific focused risk assessments must be conducted with respect to risk towards the child, in conjunction with other statutory agencies.
4. There should be a robust risk assessment for lone workers in the community, and risk management plans must be applied.
5. There should be a programme of training for Section 12 doctors and Approved Mental Health Professionals (AMHPs) on risk assessment for forensic patients, focusing on both the nature and degree of mental disorder.
6. There should be a Trust-wide policy on prescribing high dose antipsychotic medication which includes standards for auditing. An audit of the usage of depot medication in the Secure Division should be carried out and anomalies addressed.
7. There should be a joint agency approach to physical health checks and information sharing between GPs and mental health services regarding results of health checks.

Learning quadrant – individuals and all agencies

Individual practice reflections

- How will compliance with medication be monitored?
- Are your risk assessments and plans detailed and up-to-date? Do they demonstrate your professional curiosity about all aspects of the patient's life?
- Do you have ongoing contact with the patient's family and are you listening to their concerns? Is there victim safety planning?
- Have the appropriate risk management interventions been discussed with the family?
- How do you manage alcohol and substance abuse?

Governance focused learning

- How is family intervention managed for families of patients with psychosis or schizophrenia, and is it in accordance with NICE guidelines?
- How do you ensure that tools such as HCR–20 are used to best practice standards?
- What assurances do you have that discharges are planned, safe and in keeping with guidance?
- How do staff shortages influence safe practice?

Board assurance questions

- What assurances do you have that risk assessments are completed to the required standards?
- What assurances do you have that sufficient safeguarding measures are implemented to protect the family from harm?
- What assurances do you have that CPA policies are followed appropriately?
- What assurances do you have that all staff are fully aware of the MHA and the process of assessment?

System learning

- Are you providing adequate training in understanding and awareness of when to incorporate the MHA?
- What steps are you taking to retain competent and capable staff to provide the community forensic service?

Learning Lessons Bulletin - 02

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr L, who killed his father, Mr T, in the family home.

Key themes: risk assessment, care planning, record keeping, discharge planning

Agencies and teams who might benefit from this bulletin:

- **Early Intervention in Psychosis Teams**
- **Mental health commissioners**

Case background

Mr L first became unwell while at university. He had inpatient admissions later that year before returning home to live with his family. Mr L was allocated a Care Coordinator who met with him regularly.

Mr L was reviewed by a Specialist Trainee Doctor who noted that he was suffering from depressive symptoms. The Doctor prescribed an antidepressant. A month later a second review reported that Mr L was experiencing negative symptoms of schizophrenia. As a result, Mr L was prescribed depot medication as well as a different oral medication and received therapy with a trainee psychologist.

Mr L continued to report psychotic symptoms in the form of receiving messages from an unknown person. Mr L was started on a different medication to reduce his experience of restlessness. He later informed his Doctor that he had stopped taking his antidepressant medication as he had found that attending church and exorcisms provided helpful alternatives. He said that his symptoms of psychosis and depression had improved but he continued to experience leg shaking when he was receiving messages. He was keen to come off his medication completely.

Mr L attended his Care Programme Approach meeting accompanied by his father. Mr L reported that he was working regularly at his father's restaurant and taking various courses. Mr L said that he had stopped taking his antidepressants four months previously and found psychology sessions and attending church helpful. He continued to reduce his medication further.

The following year, Mr L and his father, Mr T, attended a review with the multidisciplinary team. Mr L was now seeing an occupational therapist and was attending an occupational therapy group weekly. Mr L was still experiencing some delusions but he was resistant to medication. Mr L agreed to continue with the occupational therapy input and some interventions from his Care Coordinator that focused on structured activity planning. The incident took place a few weeks later.

Key findings

Care delivery

- Mr L felt that he should have been observed more. He was seen every one to two weeks by his Care Coordinator or occupational therapist. Mr L reports that he presented very differently in the period leading up to the incident.
- Risk assessments were not adequately reviewed following a change in presentation.
- Mr L's paranoid schizophrenia was not fully in remission and interventions to treat his symptoms were not sufficiently robust or inclusive, particularly when considering the involvement of his family. Mr L's dose of antipsychotic medication was reduced and this dose may not have been sufficient for a full remission.
- Although some psychological therapies were in place, family interventions could have been more structured.
- Mr L felt his psychosis and overall presentation were directly related to spiritual issues. However, there is no evidence that this was communicated to staff at the time. There is also no evidence to indicate that the spiritual care team were present at any discussions about Mr L's care and treatment.

- There was no consideration or discussion of the risks of supporting Mr L to directly receive council funding. A more detailed assessment of the risks of Mr L receiving direct funding and exploration of alternatives should have been undertaken prior to the application for direct payments being supported.

Service delivery

- A large number of Mr L's clinical records were incomplete or lost.

Key learning points

1. Carer's assessments and support must be offered and documented in line with the Trust strategy. There must be a system for Care Coordinators to initiate monthly contact with carers of clients who are on CPA.
2. Appropriate support must be given to clients wishing to apply for self directed support funding, who are known to have gambling habits.
3. Risk assessments and risk management plans should be reviewed when new information comes to light. An ongoing audit programme should be implemented to provide assurance about organisational compliance with this requirement.
4. Staff should take responsibility for issuing formal invitations to all those they believe should be present at a CPA meeting, or document discussions where this intention is changed.

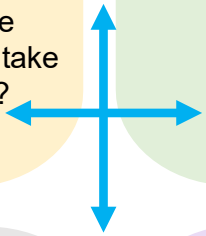
Learning Quadrant – individuals and all agencies

Individual practice reflections

- Are your risk assessments and plans detailed and up-to-date? Do they demonstrate your professional curiosity about all aspects of the patient's life?
- Are the patient's treatment and medication management in keeping with NICE guidelines? Does this include structured family interventions where needed?
- How do you provide extra support for service users who struggle with addictions? Do you take this into account when assessing their risks?

Governance focused learning

- Although you are familiar with this individual with complex needs, do you regularly stop and have a fresh look at their risks and risk management?
- Are your risk escalation thresholds and triggers reliable when service user circumstances change?



Board assurance questions

- What assurances do you have that risk assessments are completed to the required standards? Are there clear procedures in place to address risk to family members?
- What assurances do you have that CPA policies are followed appropriately?

System learning

- What assurances do you have that staff training includes adequate focus on the preservation, storage and retrieval of clinical records?

Learning Lessons Bulletin - 03

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr W, who killed Mr L after a minor collision of their cars.

Key themes: diagnosis issues, risk assessment, inter-agency communication

Agencies and teams who might benefit from this bulletin:

- **Learning disabilities services**
- **Early Intervention teams**

Case background

Mr W was under the care of the Trust for over seven years before the incident. He was first referred to an Early Intervention service by his GP because he had become increasingly reclusive and abusive and had a poor appetite. The psychiatrist noted his likely diagnosis as schizophrenia and he was prescribed medication and allocated a Care Coordinator.

Mr W demonstrated poor insight into his illness and treatment, frequently asking to cease contact with the service and stop taking his medication. He also demonstrated obsessive behaviour and was often aggressive with his family. The Early Intervention Service had further contact with Mr W's family and made a referral to the autistic spectrum disorder service for an assessment.

Mr W reported hearing voices but rejected any psychotic diagnosis. He was having financial difficulties and was supported by his Care Coordinator. Mr W's mother continued to report bizarre and aggressive behaviour by Mr W and it was found that he had lost his job. He was disengaging with services and had stopped taking his medication.

Mr W later established a relationship with an older woman which appeared to have a positive impact on Mr W. He continued to display obsessional behaviour (now towards his girlfriend too), while showing signs of anxiety and hearing voices. Mr W's autism was discussed in multidisciplinary team (MDT) meetings but he had never been formally diagnosed, nor had this been discussed with Mr W's family. His diagnoses were noted as Asperger's Syndrome and psychosis. He was reported to be doing irresponsible things and hearing voices.

Over the following year, there were increasing concerns about Mr W's mental state, medication compliance and lack of psychological therapy. He disengaged with the housing support provider and stopped taking his medication again. He became increasingly verbally abusive towards his girlfriend and there were several incidents of Mr W assaulting members of the public.

Mr W reported that he had been feeling anxious and paranoid and had not been attending appointments. His finances were problematic. The final report stated that he had fallen out with his girlfriend because he had been physically abusive towards her. The incident took place two days later.

Care and service delivery

- Mr W's diagnosis was unclear and insufficient. Trust staff did make efforts to engage Mr W; however, because the Trust had failed to undertake robust assessments in relation to psychosis and autism, this led to a flawed set of assumptions about how to manage Mr W. The staff also considered his violent behaviours as matters for the criminal justice system, and not directly related to Mr W's mental illness. This denied Mr W the opportunity to receive appropriate treatment and consequently resulted in Mr W's behaviours gradually escalating over time.
- Mr W's risk assessment was incomplete and not updated regularly as his mental state developed. The Trust should have ensured that there was a robust assessment in accordance with best practice and NICE guidelines on which mental health care and treatment was based. There was also no longitudinal clinical review of Mr W's presentation and management.

- There was an inappropriate response to concerns raised 48 hours prior to the incident. This may be related to the lack of appropriate family engagement throughout Mr W's care.

Interagency communication

- There was inconsistent interagency communication and incident reporting throughout Mr W's care. Care Programme Approach (CPA) documentation was sent to the receiving team when Mr W transferred between Trusts, but no up-to-date care plans or risk assessments were completed.

Key learning points

1. Effectiveness of training in dual diagnosis of psychosis and autism should be assessed and monitored by Trusts.
2. The liaison between stand-alone specialist consultants and teams responsible for the care coordination of clients should sufficiently mitigate the risk of the more remote way of working.
3. Appropriate evidence should be present to support the diagnosis of autism when given to a client.
4. Processes should be in place for effective multidisciplinary review of clients who present with recurring or escalating risks.
5. Benefits of informal admission must be properly considered and documented. If a client is not compliant with their treatment plan, consideration should be given and documented for assessment under the Mental Health Act (MHA).
6. When there has been no face-to-face contact with a client for over six months, a documented multidisciplinary discussion must take place.
7. Risks must be properly considered and documented, and appropriate action must be taken where children and young people are having contact with a vulnerable adult.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- How will compliance with medication be monitored, and how will you manage non-compliance?
- Are your risk assessments and plans detailed and up-to-date? Do they demonstrate your professional curiosity about all aspects of the patient's life?
- Do you have ongoing contact with the patient's family?
- Have the appropriate risk management interventions been discussed with the family?
- What would trigger you to undertake a fresh look at risk if it started to change?
- Have you considered the benefits of informal admission?

Governance focused learning

- How is family intervention managed for families of patients with psychosis, and is it in accordance with NICE guidelines?
- Are your risk escalation thresholds and triggers reliable when service user circumstances change?

Board assurance questions

- What assurances do you have that risk assessments are completed to the required standards?
- Are there adequate information sharing agreements and joint working practices with other key agencies?

System learning

- Are you providing adequate training in assessing and monitoring a patient with a dual diagnosis, such as psychosis and autism?
- How are you supporting improved information sharing between agencies and services?
- How might you recognise and take steps to address a rising risk profile across your system?

Learning Lessons Bulletin - 04

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user F. F injured M while in hospital, resulting in her death.

Key themes: risk assessment, care planning, observations

Agencies and teams who might benefit from this bulletin:

- **Mental Health Services for Older People**

Case background

F and M were both patients on a mental health ward for older people. Arrangements were being made to plan for M's discharge home.

F first came into contact with Mental Health Services for Older People (MHSOP) following cognitive impairment and was diagnosed with Alzheimer's disease. He was first admitted to the ward a year prior to the incident following a deterioration in his mental state, when he had become increasingly confused, agitated and aggressive. He was subsequently discharged home with a full package of care and a Care Coordinator.

Later that year F was admitted to a different ward under Section 2 of the Mental Health Act (MHA) following his assault on four members of A&E staff when F and his wife had attended hospital. They were both admitted to a care home, as they could no longer manage to live independently.

The following spring F became increasingly agitated and aggressive again. The Community Psychiatric Nurse (CPN) was asked to urgently assess F as the care home felt they could no longer manage his unpredictable aggressive behaviour and some care home staff were afraid of him. Based on this assessment, an MHA assessment was completed and it was agreed that F needed detention under Section 2 of the MHA. He was then admitted to the mental health ward where the incident later took place.

Key findings

Risk assessment

- F had received a comprehensive suite of multidisciplinary assessments; however, not all were signed or completed correctly. There were inconsistencies in the completion of some assessments, with some having not followed the guidelines correctly.
- The assessment of his risk of aggression was based on a robust formulation and thorough consideration of the factors that may increase the risk of aggression. However, not all the incidents involving F were reported correctly, which potentially downplayed the consideration of his actual risk of aggression.
- When F was on enhanced observations, these were not recorded in accordance with the policy.
- There were inconsistencies in the various assessments made of F's risk of falling. The assessment of the risk of falls had not been consistently and comprehensively applied to all the known risk factors, and aspects (such as a 10 year probability of major osteoporosis) appear to have been poorly understood.
- Much of the care planned in the intervention plan was not linked to findings from assessments.
- Care interventions for M, such as trying to reduce her frailty through monitoring food and fluid intake, had also not been care planned.

Key Learning Points

1. The findings and observations of patients when admitted to MHSOP wards must lead to accurate care planning and appropriate interventions.
2. MHSOP wards should fully comply with the policy on recording observations.
3. All relevant policies and procedures should be updated whenever new guidance from NICE is issued.
4. MHSOP wards should follow the Trust's own best practice guidelines with regards to behaviours that challenge in dementia.
5. Assessments of risk in elderly patients must be completed thoroughly and accurately, incorporating all aspects of relevant medical history, which then should lead to appropriate interventions to mitigate these risks.
6. The NICE clinical guideline on *Osteoporosis: assessing the risk of fragility fracture* should be fully implemented for all patients with a history of long-term steroid use, correctly identifying all patients at risk of fragile fracture on respective caseloads.

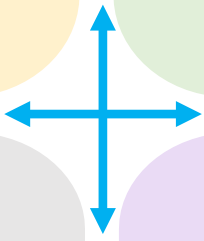
Learning Quadrant – individuals and all agencies

Individual practice reflections

- Are your risk assessments and plans detailed and up-to-date? Do they demonstrate your professional curiosity about all aspects of the patient's life, incorporating all aspects of relevant medical history?
- Does the risk assessment sufficiently consider risk of violence to others and include robust safeguarding interventions?
- Are your staff appropriately supported to deal with this individual?

Governance focused learning

- Do all MHSOP wards fully adhere to the appropriate policy on recording observations?
- Are care plans based on accurate assessments and formulations?
- Are incidents of violence in MHSOP wards given appropriate consideration and reported accurately?



Board assurance questions

- What assurances do you have that risk assessments for high-risk service users are completed to the required standards?
- What assurances do you have that NICE guidance is adequately adhered to across all relevant policies and procedures?
- How do you know that risk management plans are collaboratively developed, understood and shared with all those involved in a high-risk individual's care?

System learning

- Do you offer appropriate and up-to-date training to all staff working on MHSOP wards on developing adequate care plans and appropriate risk interventions for all patients?
- Are staff given adequate training in the nature and unpredictability of aggression in MHSOP wards?

Learning Lessons Bulletin - 05

Independent investigation

Introduction

This document provides an overview of findings from an independent review into the care and treatment of service user M, who committed the homicide of his mother.

Key themes: care planning, medication management, communication, risk assessment, diagnosis issues

Agencies and teams who might benefit from this bulletin:

- **Child and Adolescent Mental Health Services**
- **Learning disabilities services**
- **Mental Health Liaison**

Case background

M was 16 years old at the time of the homicide, under the care of the Children's and Young People's Service (CYPS) and living at home.

M was first referred to the CYPS at five years old by his GP, following a query from his family about whether he might be suffering from attention deficit hyperactivity disorder (ADHD). He was referred for an assessment for autism spectrum disorder (ASD) by his paediatrician and he was later assessed by a Community Mental Health Nurse, Social Worker, Psychiatrist and Physiotherapist. During this period a multi-agency meeting was made aware of concerns regarding a delay in the production of the requested reports.

M began a trial of medication (methylphenidate) and was given a formal ASD diagnosis. His ADHD medication was to remain the same and behavioural interventions were to be the preferred option for treatment of his ASD. From the following year he remained in CYPS ADHD service for medication review only.

There are reports of M being increasingly aggressive at home and at school, self-harming and becoming obsessed with online horror material. M became more violent with his family, including hurting his mother by grabbing her by the throat, and an assault on his grandfather. The explanation given for this behaviour in clinical records was noted as "*undertreated ADHD*". There was no communication with safeguarding or other agencies.

Key findings

Treatment plans

- There is evidence to suggest that there were deficits by CYPS in the provision of care and treatment to M and that appropriate actions by the clinical team could have prevented the incident.
- M was not receiving appropriate interventions for his psychosis. He was not in receipt of specialist Early Intervention in Psychosis Services (EIPS), which would have provided a holistic assessment of his needs and risks and appropriate management plans, including inpatient care if it was needed.
- M was prescribed a low dose of antipsychotic medication that had not been titrated against symptoms. He was not being monitored in accordance with NICE guidelines.
- M was also taking methylphenidate, a drug with psychosis as a known side effect at doses beyond the manufacturer's recommendations, which may have worsened his psychotic symptoms.

Information sharing

- M's family were not adequately involved in care planning and risk management.
- Communication with social services was not adequate. There was also no communication with safeguarding about M's family.

Service factors

- There were frequent delays in assessment and diagnosis.
- M's care was not coordinated and he was not provided with an appropriate care plan.
- Risk information, including threats, aggression and violence, was not properly recorded or acted upon.

Key learning points

1. The Trust should assure itself that the Care Programme Approach (CPA) policy is applied properly in CYPS with reference to standards of CPA reviews, multi-agency care planning and communication with GPs, and the provision of a Care Coordinator for all patients assessed as in need.
2. There should be regular reviews of care plans and increased patient and carer involvement in care plans. Clear policy guidance for clinical networks and pathways of care should be introduced, with appropriate governance and monitoring.
3. Systems should be introduced that ensure carer's assessments are facilitated and care planned.
4. Risk information should be properly recorded and acted upon to ensure adequate support is offered to the victim.
5. Staffing levels must be adequate so that senior clinicians have time to attend to the most complex cases and provide adequate supervision.
6. Communication between the Trust and social services must be clear and coherent with both CAMHS and social services making joint risk assessments.

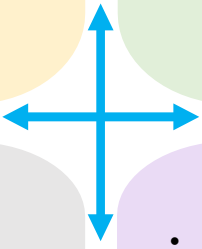
Learning Quadrant – individuals and all agencies

Individual practice reflections

- Have you talked to any accompanying family and listened to what they have to say?
- Have the appropriate risk management interventions been discussed with the family? Have you tested to see if they know what to do if they are at risk?
- Are care plans regularly reviewed and do they involve both patient and carer?

Governance focused learning

- Are there clear systems in place for the sharing of information?
- How do staff shortages influence safe practice?
- What assurances do you have that discharges from services are planned, safe and in keeping with guidance?
- What assurances do you have that NICE guidance on the management of ADHD/ASD is being adhered to?



Board assurance questions

- What assurances do you have that risk assessments for people in crisis are completed to the required standards?
- What assurances do you have that sufficient safeguarding measures are implemented to protect the family from harm?
- What assurances do you have that CPA policies are followed appropriately?

System learning

- How are you supporting improved information sharing between agencies and services?
- Are there clear expectations of joint working across local authority and mental health services in the care and treatment of young people?

Learning Lessons Bulletin - 06

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr S, who committed the homicide of a man with whom he was staying.

Key themes: medication management, communication, risk assessment

Agencies and teams who might benefit from this bulletin:

- **Early Intervention in Psychosis Teams**
- **Mental health commissioners**
- **Mental health provider services**
- **Substance misuse services**

Case background

Mr S was first admitted informally to a mental health hospital following a GP referral and crisis assessment resulting from bizarre behaviour. His diagnosis at this time was severe depressive episode with psychosis and mental and behavioural disorders due to use of cannabis.

He was discharged to his brother's home and prescribed an antidepressant and an antipsychotic and referred to the Early Intervention in Psychosis team (EIPT). Mr S needed a lot of support from the EIPT to maintain his independent living at this time. He often spent long periods in bed, had poor personal hygiene, needed to be prompted to take his medication and was smoking cannabis.

Mr S had multiple incidents with the law involving drug use and possession and was released on bail. During a period of stability, he was discharged from the local rehabilitation unit with a diagnosis of paranoid schizophrenia. His mental health deteriorated again. He was repeatedly aggressive with his mother and his compliance with his medication became more variable.

Mr S was arrested on suspicion of assault on his mother and remanded in custody. During his time in custody, he did not have his depot medication and the EIPT were not informed of his release. Later that year, the EIPT found that Mr S had moved district.

Key findings

Medication management

- Mr S had a history of non-compliance with oral medication since his first referral. He was consistently administered his depot medication every three weeks but on occasion it was administered slightly later than prescribed due to his non-attendance at the agreed appointments. This meant that Mr S was clearly at increased and significant risk of relapse.
- Potential risks associated with the depot medication being overdue were not communicated effectively between agencies. Joint planning could potentially not only have ensured depot administration, but also that other interventions such as housing and monitoring of mental state were in place.

Care delivery

- Formal clinical risk assessments were not scored consistently or updated after risk incidents occurred in accordance with the clinical risk management policy, and the risk assessments did not translate through to the formal care plan. The Care Programme Approach (CPA) procedures were not embedded.
- There was a lack of consistent medical input in discussions around patients receiving antipsychotic medication.
- Despite concerns about Mr S's vulnerability, he was not subject to a formal safeguarding process.
- The system for receiving and responding to messages, and allowing patients to leave messages on individual team members' mobile phones, was not robust.

Substance misuse services

- The substance misuse policy was not adequate for purpose and the opportunity should have been taken to develop an agreed set of local policies and procedures, to be reviewed regularly by key strategic partners in line with NICE guidance on coexisting severe mental illness and substance misuse: community health and social care service.

Key learning points

1. The agreed set of local policies and procedures should be reviewed regularly by key strategic partners in line with NICE guidance on coexisting severe mental illness and substance misuse.
2. The EIPT operational policy should be reviewed in order to agree methods and expectations around multidisciplinary working, and to ensure that senior medical staff are involved appropriately in discussions about patients where staff have concerns and where patients are receiving antipsychotic medication. There should be consistent medical input to the team.
3. CPA policy must be reviewed to ensure that overdue depot medication is communicated effectively in referral procedures and correspondence.
4. Any referral made to an external or internal service should indicate clearly the level of urgency.

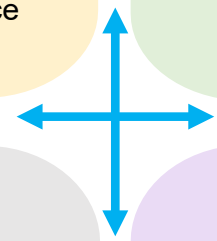
Learning Quadrant – individuals and all agencies

Individual practice reflections

- Are care plans regularly reviewed?
- Does the risk assessment sufficiently consider risk of violence to others and include robust safeguarding interventions?
- How will compliance with medication be monitored? How do you manage non-compliance?
- How do you manage substance abuse? Do you incorporate joint working with the substance misuse service?

Governance focused learning

- What assurances do you have that discharges from services are planned, safe and in keeping with guidance?
- Are there clear systems in place for the sharing of information?



Board assurance questions

- What assurances do you have that CPA policies are being followed appropriately?
- What assurances do you have that sufficient safeguarding measures are implemented to protect any vulnerable individuals involved?
- What assurances do you have that NICE guidance is adequately adhered to within all local policies and procedures?
- How do you know that risk management plans are collaboratively developed, understood and shared with all those involved in the individual's care?

System learning

- How are you supporting improved information sharing between agencies and services?
- Do your transition processes effectively support discharges and dose reductions?
- Does the system provide appropriate support for individuals with complex needs living in the community, particularly where substance abuse may be an issue?

Learning Lessons Bulletin - 07

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr J, who committed the homicide of Miss K and then committed suicide.

Key themes: discharge planning, record keeping, care planning, communication

Agencies and teams who might benefit from this bulletin:

- **Early Intervention in Psychosis Teams**
- **Mental health provider services**

Case background

Mr J lived in the family home with his mother, brother and sisters. He did voluntary work and received income support. He was under the care of the Trust for six years prior to the incident.

Mr J was first detained under Section 2 of the Mental Health Act (MHA) following several arrests and admitted to a Psychiatric Intensive Care Unit (PICU). He was diagnosed with bipolar disorder and prescribed medication, which he was reluctant to take. He often displayed anger and aggression when detained.

Mr J took an overdose the following year and as a result he was referred to the Home Treatment Team (HTT). Although Mr J did not keep all appointments, he appeared to be taking his medication and remained in contact with the HTT staff. There were delays in treatment, such as in allocating Mr J a Care Coordinator by the Community Mental Health Team (CMHT) and in agreeing his care plan.

Mr J was again admitted to a mental health hospital and discharged on Section 17A MHA community treatment order (CTO). A period of stability followed and Mr J was no longer prescribed depot medication. The confirmed diagnosis was bipolar affective disorder.

Following another detention to a mental health ward, Mr J was discharged under a further CTO. He continued to see the Care Coordinator and attended a bipolar disorder support group. A Care Programme Approach (CPA) review documented that Mr J's bipolar disorder was in remission. There was discussion about Miss K, whom Mr J referred to as his girlfriend. Mr J's last CPA review meeting took place two weeks before the incident, he was discharged from CPA and his medication was reduced further.

Key findings

Care delivery

- The decision to discharge Mr J from CPA was high risk. The final set of care plans for Mr J did not involve a true assessment of risk, which would have needed to involve collateral information from his family and girlfriend. Mr J was not provided with adequate aftercare under Section 117 MHA and the monitoring of the CTO fell short of best practice on both occasions.
- There was no evidence that the Care Coordinator had seen the patient at least monthly. The Care Coordinator had also not kept adequate records, with some retrospective entries added after the incident.

Communication with family

- There were inadequate levels of contact between CMHT staff and the family members and girlfriend of Mr J, despite the fact that he lived in the family home and had posed risks to the family at times of previous relapse. There was no documentation on file that any family member had been offered or undergone a carer's assessment or had refused one. No family members were invited to CPA reviews and Mr J's carers and significant others were not involved in care planning.

Service delivery

- The multidisciplinary team, patient and carers did not work together according to the accepted practice of CPA.

Key learning points

1. Section 117 MHA aftercare arrangements should be fully carried out. There should be structured arrangements in place to ensure that the administration and monitoring of CTOs is carried out to meet best practice guidelines.
2. Guidelines should be developed for the integrated care and treatment of bipolar disorder across primary health and secondary mental health services. This should include guidance for GPs on actions to take with regards to uncollected prescriptions in patients under secondary mental health care.
3. The clinical risk assessment policy should be applied consistently in community teams, and there should be systems in place to monitor its application.
4. The health records policy should be fully and consistently implemented in community teams.
5. NICE guidance *Bipolar disorder: assessment and management* should be implemented and monitored.
6. Spiritual and cultural issues should be effectively considered, assessed and incorporated into care plans.

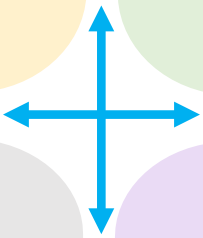
Learning Quadrant – individuals and all agencies

Individual practice reflections

- Do you listen to partners and family members as well as the patient? Do your findings demonstrate professional curiosity about all aspects of the patient and their life?
- Have you considered the patient's cultural and spiritual background and adjusted your approach accordingly?
- Are care plans regularly reviewed and do they involve both the patient and their family?
- Have the patient's family been adequately involved in care planning and CPA arrangements?

Governance focused learning

- Are there clear systems for working together and the sharing of knowledge and skills?
- How do you know that multidisciplinary teams are working well together?
- What assurances do you have that discharges from services are planned, safe and in keeping with guidance?
- What assurances do you have of compliance with the Mental Health Act for those service users who are entitled to 117 aftercare?



Board assurance questions

- What assurances do you have that risk assessments for high-risk service users are completed to the required standards?
- How do you know that risk management plans are collaboratively developed, understood and shared with all those involved in an individual's care?
- What assurances do you have that NICE guidance is adequately adhered to in all local policies and procedures?
- Are there information sharing agreements and joint working practices with other key agencies?

System learning

- Do you have robust transition processes that support effective discharges into the community?
- Do you offer appropriate and up-to-date training on cultural sensitivity to all staff?

Learning Lessons Bulletin - 08

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr P, who committed the homicide of his mother and her friend.

Key themes: communication and coordination, discharge planning, liaison with the CJS

Agencies and teams who might benefit from this bulletin:

- **Early Intervention in Psychosis Teams**
- **Secure units for young people**
- **Substance misuse services**
- **Criminal justice & mental health teams**

Case background

Mr P was 17 when he was first referred to mental health services by his GP. The GP visited Mr P at home where it was noted he was suffering persecutory and paranoid beliefs.

Mr P was under supervision of the local youth offending team due to his forensic history. His risk assessment considered him a mild to moderate risk of self-harm, a low to moderate risk of violence, and a moderate risk of self-neglect. A full Care Programme Approach (CPA) assessment concluded that Mr P potentially had a drug-induced psychosis, paranoid beliefs, thought disorder and passivity phenomena. Mr P was visited on numerous occasions but consistently failed to attend a number of appointments and answer planned telephone conversations.

Mr P was admitted to an inpatient unit under Section 2 of the Mental Health Act (MHA) from A&E, following his arrest the previous day for possession of class A drugs. Following a number of attempts to abscond, he was transferred to a Psychiatric Intensive Care Unit (PICU) where he appeared to improve.

Following his final discharge, it was noted that he still showed signs of poor insight into the relationship between illicit drug use and his mental health. A home visit occurred following threats of suicide, drug use and aggressive behaviour. Mr P continued to fail to attend appointments or answer telephone calls.

Mr P was arrested for criminal damage to his mother's house and his father's van. A few months later the Early Intervention in Psychosis team (EIPT) received a call from Mr P's father to inform them that he had been seriously assaulted by Mr P the night before; as a result, Mr P was arrested and charged with grievous bodily harm. He was subsequently discharged from the EIPT caseload as he was receiving support from a mental health worker in prison.

Mr P denied any mental health concerns and was coherent and well spoken. His case was closed to mental health services. The incident took place two months after his release from prison.

Key findings

Treatment plans

- From the point of transfer to the EIPT, the frequency of contact and intervention decreased significantly. There was a period of 42 days between the point of referral and the initial assessment. It is acknowledged that Mr P was not always compliant with meetings and phone calls, but there were periods of up to 25 days with no contact from the EIPT.
- At no time did the mental health services identify Mr P's behaviour as domestic violence. This would have facilitated expert advice and may have improved management and treatment.
- It would have been appropriate to consider the possibility that this was a person at higher than average risk of developing schizophrenia.
- With regards to Mr P's drug use, his family's reports differed greatly from Mr P's self-reporting. However, services did not suggest or seek support from specialist substance misuse services.

- There was discussion in the EIPT about referring him to the substance misuse service but there is no evidence that this occurred. From the various reviews, it would be reasonable to assume the link between his illicit drug use and his presenting behaviour and symptoms. The care plans and risk management plans recognise this but there is no evidence of specific interventions to ameliorate these problems.

Care Programme Approach (CPA)

- Mr P appears not to have been subject to CPA processes since his discharge from the EIPT after being sent to prison.
- The process of discharge should be planned in coordination with the person and with any other services involved. This did not occur in Mr P's case, and formal liaison should have taken place with mental health services at his initial remand, using the CPA process. The assessment by secondary mental health services after Mr P's release did not take his previous history into consideration.

Involvement of the family

- The care plans relied on the contingency that Mr P's parents would contact services should they require help, however little else in terms of support for the parents was stipulated. There is no recorded offer of a carer's assessment to Mr P's mother after his father made it clear he was not the main carer.

Key learning points

1. Appropriate communication links must be maintained and monitored between Trusts and Multi-Agency Risk Assessment Teams (MARAT).
2. Structures should be implemented to monitor adherence to policy guidance, with regard to transfers of care, transition from services and inclusion of both the service user and carers in the process.
3. CPA and discharge policies should provide clear guidance on how liaison with prison service mental health teams will occur at entry and exit, to maintain continuity of care.
4. Commissioners of prison health services must ensure that robust procedures are in place to maintain continuity of mental health care in prison, on reception and on inter-prison transfer when a prisoner has received secondary mental health care in the community.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- Was it known or recognised that schizophrenia was a possible diagnosis, and if not, why not?
- Have the appropriate risk management interventions been discussed with the family?
- Are care plans regularly reviewed and do they involve both patient and carer?
- Does the risk assessment sufficiently consider risk of violence to family members and include robust safeguarding interventions?

Governance focused learning

- What assurances do you have that discharges from services are planned, safe and in keeping with guidance?
- How do you know that all staff are aware of and able to identify and assess risks involved in domestic abuse?
- Telephone triage is commonly used at initial referral; how is the quality of this assessed? Is it expected that the previous contacts and risk history is reviewed?

Board assurance questions

- What assurances do you have that sufficient safeguarding measures are implemented to protect the family from harm?
- What assurances do you have that CPA policies are followed appropriately?
- What assurances do you have that NICE guidance is adequately adhered to?

System learning

- Does the system provide appropriate support for individuals with complex needs living in the community, particularly where substance abuse may be an issue?
- Does the system have robust multi-agency communication with the criminal justice system to support vulnerable people being discharged from prison?

Learning Lessons Bulletin - 09

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr Z, who killed a female Support Worker.

Key themes: risk assessment, care planning, information sharing, communication

Agencies and teams who might benefit from this bulletin:

- **Mental health provider services**
- **Community forensic services**
- **Supported accommodation providers**
- **Mental health commissioners**

Case background

At the time of the incident, Mr Z was living in supported accommodation while under the care of a Forensic Outreach Service (FOS), on a conditional discharge from a section 37/41 of the Mental Health Act (MHA). He had a significant history of contact with psychiatric services including 10 admissions over a period of 25 years, with two previous conditional discharges. Along with significant reported mental health problems of psychotic symptoms and emotionally unstable personality traits, his contact with mental health services included many instances of non-compliance with conditions, non-compliance with medication, violent and aggressive behaviour, illicit drug use, sexually inappropriate behaviour, absconding from services and numerous threats to disengage or not comply if he perceived he was being unfairly treated. This was most notably the case when he perceived staff were not facilitating visits to his girlfriend.

He had been discharged from a forensic rehabilitation ward four months before the incident. There had been a pattern of non-compliance with house rules, sexually inappropriate behaviour and verbal aggression. There was one significant aggressive outburst three weeks before the killing which involved other staff, but overall by the time of the incident the frequency of his aggressive outbursts was reducing.

On the night of the offence, he had been asked to turn his music down shortly after midnight by the Support Worker. Some hours later, early in the morning, the incident took place.

Key findings

Risk assessment and management

- There was a plan to review Mr Z's care in the event of a crisis or deterioration; however, the threshold for recall to hospital was not made clear in his tribunal.
- Mr Z was known to push boundaries and be verbally threatening and aggressive. Potential thwarting of a visit to see his girlfriend was not given any significance despite it being a previous trigger for recall.
- There had been 18 different incidents related to non-compliance, violence or aggression in the four months of his stay. These incidents, however, were not all escalated to the forensic service, and did not lead to a formal review or sanction of Mr Z's behaviour. There should have been a clear identification of boundaries and thresholds for behaviour which would lead to escalation and review.
- Other key risk assessment details were incomplete or insufficient, and shared information gave insufficient detail on how to manage risks and the thresholds for review and escalation.

Information sharing

- Although there was frequent and regular contact between the supported accommodation and the Social Supervisor, it was not about all aspects of Mr Z's behaviour. The forensic service did not routinely read the supported accommodation provider records concerning Mr Z. The Clinical Supervisor was not made aware of the significant aggressive outburst either by the social supervisor or by the supported accommodation provider when the Clinical Supervisor visited the service.

- The family believe that Mr Z was "*gaming*" the drug testing and believe that they should have been contacted more often to discuss their views on his behaviour.

Service factors

- Mr Z was a tenant in supported accommodation. Despite providing a service to individuals with such complex needs, within a high level of environmental security, the premises were not regulated by the Care Quality Commission (CQC) and staff in the accommodation were not required to be professionally qualified. The community forensic service was also experiencing staffing pressures.

Key learning points

1. Discharge planning for conditionally discharged patients should include clear, measurable guidance and full involvement of family and members of the care team.
2. Joint working practices must be developed between Trusts and organisations so that information sharing is routine practice in both directions.
3. Staff employed as social supervisors must be fully equipped and supported to deliver this challenging and important role.
4. Trusts and commissioners should be clear about the limits of service provision for supported accommodation, and the ability of such services to deal with highly challenging individuals with complex needs.
5. Handover practices between teams and individuals must ensure a proper focus on escalating risk.
6. There must be sufficient record-keeping across all Trusts and services.
7. All risk assessment and management plans should include a proper formulation of risk which includes all of the factors which might increase the risk, evidence of decision-making on risk, and information on what action to take as the result of an escalation of risk.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- Do your risk management plans contain clear instructions about thresholds and escalation if behaviours change?
- Do you challenge the quality of the handover provided to you, to ensure that there is sufficient information on risk?
- If another service mentions an incident for a conditionally discharged patient, how much professional curiosity should you use?
- How do you know that service users aren't "*gaming*" testing for legal highs and new psychoactive substances?

Governance focused learning

- Do you have proper arrangements for supervision of locum staff? And how do staff shortages influence safe practice?
- How do you know that 'risk tolerance' has not set in within your services and what can you do to recognise and challenge this?
- Because you are familiar with an individual with complex needs, do you stop and take a fresh look at their risks and risk management?
- Are your risk escalation thresholds and triggers reliable when service user circumstances change?

Board assurance questions

- Can your services cope safely with demand? How do you know?
- What assurances do you have that risk assessments for high-risk service users are completed to the required standards?
- How do you know that risk management plans are collaboratively developed, understood and shared with all those involved in a high-risk individual's care?

System learning

- How are you supporting improved information sharing between agencies and services?
- Does the system have robust multi-agency processes to support challenging individuals with complex needs in the community? What would improve this?
- How might you recognise and take steps to address a rising risk profile across your system?

Learning Lessons Bulletin - 10

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr H, who committed the homicide of a man he had known since childhood.

Key themes: medication management, liaison with the CJS

Agencies and teams who might benefit from this bulletin:

- **Community forensic teams**
- **Transition planning services**
- **Early Intervention in Psychosis Teams**

Case background

Mr H had repeatedly been in trouble with the police for various crimes since the age of 13, including theft, harassment and the use of illegal substances. He was effectively homeless before being sentenced to six years imprisonment following two offences of robbery. He is said to have been espousing radical extremist views arising from his religious beliefs. In prison he was involved in several assaults and frequently spent time in the segregation unit.

Mr H was first referred for a mental health assessment following bizarre behaviour while in prison. A visiting Consultant Psychiatrist found no evidence of mental illness. Mr H assaulted staff and was said to be involved in dealing cannabis in prison. He repeatedly told staff he felt unsafe, but did not elaborate further. The Consultant Psychiatrist prescribed risperidone, and requested a transfer to a prison with inpatient facilities, on the basis that he was "*becoming mentally unwell*" and that he had "*an antisocial personality disorder*".

Mr H set a potentially serious fire in his cell and was moved to a different unit. He continued to refuse medication and maintain that he was not unwell. It was reported that Mr H was suffering from auditory hallucinations and persecutory and self-referent paranoid ideas. It took him a long time to finally accept the diagnosis of schizophrenia given to him.

Following several months of significant improvement in his condition, Mr H was discharged from hospital by a tribunal and was released on licence. This meant he was supervised by probation, with an order to cooperate with mental health services and supervision in the community.

Key findings

Service factors

- The use of the probation licence introduced a lack of clarity about roles, by avoiding formal health conditions. Trust staff were not formally required to report non-attendances, and in this case it appears that probation did not report them.
- The systems of support and supervision across agencies were not adequately coordinated and should have had a clear lead agency managing information about risk.
- It also became clear after the homicide that Mr H had not been taking the prescribed medication, which historically had contributed to feelings of paranoia and suspiciousness. This could have been more appropriately managed and monitored.
- There had been concerns about his vulnerability to influence while in prison, both to gang culture and religious extremism. The interventions to support him with this were not shared across the providers of care.

Key learning points

1. Where there is a probation licence condition of contact with mental health services, a joint agency care plan with clear communication lines and escalation protocols should be in place and agreed by all parties. Measures should be implemented to ensure that agreed inter-agency care plans are adhered to.
2. Trusts must provide assurance that the guidance on supporting community clients on oral medication in the community has been fully implemented and is effective. It should also be shared with partner agencies and services, and relevant collaborative care plans should be in place.
3. Awareness of risks and gang culture in the catchment area must be improved. Trusts should develop appropriate links with police to ensure that they are connected to local established networks for raising awareness, information sharing and action about those at risk from or engaged in gang activity.
4. Appropriate communications and working relationships should be developed between Trusts and local supportive faith organisations.
5. Carer's assessments must be offered and appropriate action taken, and families must be offered the opportunity to be involved with care planning.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- Do your care plans contain clear instructions for communication with other agencies?
- Are you aware of the risks around gang culture and substance use in the local community?
- Have you made links with other agencies involved in the patient's care (e.g. probation)?
- How do you manage substance abuse? Do you incorporate joint working with the substance misuse service?
- Are lines of communication clear?
- Are you aware of systems in place when there is a risk of radicalisation?

Governance focused learning

- What assurances do you have that discharges from services are planned, safe and in keeping with guidance?
- Have you developed the appropriate links with the police?

Board assurance questions

- What assurances do you have that CPA policies are followed appropriately?
- Are there information sharing agreements and joint working practices with other key agencies?

System learning

- Does the system provide enough appropriate support for individuals with complex needs living in the community, particularly where substance abuse/offending/radicalisation may be an issue?
- How are you supporting improved communication between agencies and services, such as with local supportive faith organisations?

Learning Lessons Bulletin - 11

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr M, who killed his wife and then himself.

Key themes: record-keeping, communication, adult safeguarding

Agencies and teams who might benefit from this bulletin:

- **Mental Health Services for Older People**
- **Mental health provider services**

Case background

Mr M was first admitted to a mental health hospital in the 1970s following symptoms of severe agitated depression and suicidal ideation. He attempted suicide in the 1980s and received outpatient care for around a year until he was discharged.

A year before the incident, Mr M was diagnosed with depression and anxiety and prescribed a low dose of mirtazapine. He later made a self-referral to a counselling service and received four therapy sessions.

Screening questionnaires indicated that Mr M was experiencing moderate depression and severe anxiety. Following an appointment with his GP, Mr M was referred to the Complex Care and Dementia team, where he was seen by a Community Mental Health Nurse. He was transferred to the memory assessment service pathway and the Nurse discussed carer's support with his wife, Mrs M.

The primary care Dementia Practitioner visited Mr M later that year and at this time he reported a decline in his memory over the previous month and stated that he was experiencing night terrors. Mr M was referred for Cognitive Analytic Therapy (CAT) by the primary care Dementia Practitioner but the first appointment was delayed and inadequate.

Mr M described long-standing symptoms, including his limbs going stiff during the night and having a "*turn*" in which he shook as if he were having a seizure. The Nurse noted that she would discuss the matter with a Doctor. The incident took place two days later.

Key findings

Record-keeping

- There were issues of timely record-keeping, including two late entries made by members of staff. Staff later reported that it was difficult to ensure that records were updated in a timely fashion, because of the electronic record-keeping system.

Communication

- The communication with Mr M following the initial therapy appointment at the Trust did not reflect Mr M's individual needs. Mr M struggled with reading and writing and was assured during his first therapy appointment that the therapy would be delivered in a way that was accessible to him. However, the letter that Mr M received following this appointment was very lengthy and detailed. The messages within the letter were not delivered in an accessible format and Mr M's family reported that Mr M did not understand the content.

Adult safeguarding

- Trust staff did not undertake active questioning about domestic abuse of Mr or Mrs M without the other spouse present.

Key learning points

1. Appropriate audits should be undertaken regarding the effectiveness of the new protocol for the Complex Care and Dementia Team, taking any remedial action required if the effectiveness is found to be lacking.
2. The expectations of the clinical record-keeping policy should be met.
3. Now that therapists no longer have access to the GP clinical record system, actions should be taken to mitigate the risk of patients choosing not to share relevant clinical information with their therapist.
4. SBARD (Situation, Background, Assessment of the individual, Recommendation, Decision) should be introduced to Community Mental Health teams, ensuring that relevant learning from implementation in inpatient services is transferred.
5. Staff should be able to identify and recognise the different types of supervision set out in the Supervision Policy ratified in March 2016, in order that staff are able to use supervision sessions appropriately.
6. Staff should explore patients' literacy abilities and communicate information in a way that is accessible and personalised.
7. The therapy strategy should sufficiently address the provision and use of qualified therapy staff across the Trust, ensuring that gaps in access to appropriate therapy are properly addressed.

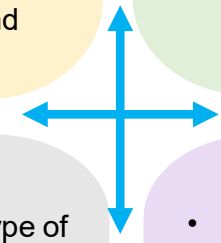
Learning Quadrant – individuals and all agencies

Individual practice reflections

- Have you fully considered the patient's abilities, ensuring that resources are provided in a way that is fully accessible and personalised?
- Are your risk assessments and plans detailed and up-to-date? Do they demonstrate your professional curiosity about all aspects of the patient's life?
- How well do you know the triggers and markers for domestic abuse?
- Have you talked to the patient's family and listened to what they have to say?

Governance focused learning

- What assurances do you have that potential domestic abuse and threats of harm within the family are being considered?



Board assurance questions

- What assurances do you have that the type of therapy offered is appropriate and accessible to each individual patient?
- What assurances do you have that staff supervision sessions are used appropriately?
- What assurances do you have that risk assessments are completed to the required standards? Are there clear procedures in place to address risk to family members?

System learning

- Do you offer appropriate and up-to-date training on record-keeping to ensure that all records are updated in a timely and appropriate fashion?
- How are you supporting improved communication and information sharing between services?
- What steps are you taking to retain competent and qualified staff to provide the Trust therapy service?

Learning Lessons Bulletin - 12

Independent investigation

Introduction

This document provides an overview of findings from a joint Safeguarding Adults Review (SAR) and independent investigation into the care and treatment of service user Miss B, who committed the homicide of her mother, Mrs A.

Key themes: care planning, information sharing, adult safeguarding

Agencies and teams who might benefit from this bulletin:

- **Mental health provider services**
- **Community forensic services**
- **Safeguarding partnerships**

Case background

Both Mrs A and Miss B were receiving care from Trust mental health services. Miss B has a long history of mental health care and treatment dating back to her first psychiatric admission as a teenager. She had many admissions under the care of Trust services, and was diagnosed as suffering from schizoaffective disorder. Her mother, Mrs A, was diagnosed as suffering from a psychotic disorder with delusions due to a known physiological condition (vascular dementia).

20 years prior to the incident, Miss B was admitted to a secure hospital under Section 37/41 of the Mental Health Act (MHA) after stabbing her child. A lengthy rehabilitation process ensued, with a structured reduction in mental health service supervision. She was conditionally discharged and remained on enhanced Care Programme Approach (CPA) for several years while living in the community. She was transferred from the Complex Needs and Recovery Service to the care of the local recovery team.

Following a period of stability, Miss B was transferred to standard CPA. Her risks were described as "*suicide (low), non-compliance to prescribed medication (medium)*". Miss B was later prescribed medication but had fluctuating compliance. The appearance of early warning signs of relapse were frequently associated with her not taking medication. At times of crisis, the Home Treatment Team (HTT) implemented a medication supervision plan, and then arranged for her medication to be supplied in blister packs.

A year prior to the incident, Miss B was regarded as being in crisis and was treated by the HTT for low mood, an increase in paranoia and suicidal thoughts. She was not sleeping, was afraid to go out and admitted to not taking her medication regularly. She was later encouraged to try depot medication but decided against it. Later that year, Miss B started psychological therapy sessions and reported that she no longer felt anxious or paranoid. As a result of an adult mental health care service redesign, she was transferred to the step- down pathway of Intensive Case Management Psychosis (ICMP) and saw a psychologist for cognitive behavioural therapy (CBT). At the last medical review before the service reconfiguration, the Consultant identified that Miss B should be seen for review as a priority but this was not picked up. The psychologist sent an email requesting a medication review for Miss B a month before the incident, but it was not prioritised as urgent.

Organisational issues

- The detail of the service reconfiguration was not adequately planned, leaving the risk to be managed by clinicians who were not familiar with the patients who had been newly assigned to their caseload.

Care planning

- There is confusion in the records about Mrs A's diagnosis and the identification of subsequent care needs by professionals. Information regarding Miss B's care of her mother and other risk assessment information was not shared with all relevant agencies, which meant they were working with incomplete information about Miss B's potential stressors.

Team approaches and responses

In any assessment of her situation, the interests of Mrs A should have been paramount. The Trust had identified "*carer stress*" relating to Miss B and a carer's assessment invitation was sent to Miss B but not followed up, in what was clearly a poorly coordinated approach. There was also a lack of clinical assertiveness in working with Mrs A and with the family.

It would have been reasonable to share information with adult mental health services. This would have allowed both teams to make a more thorough assessment of any potential risk presented by Miss B, and safeguarding concerns for Mrs A could have been raised if Miss B or the family did not participate. Equally the family should have been made aware of the extent of Miss B's mental illness if she was caring for Mrs A.

Key learning points

1. GPs should be fully involved in the sharing of information about individuals with long-term mental health issues.
2. Where there is a question of vulnerability and capacity, a capacity assessment should always be carried out and documented.
3. There should be systems in primary care to monitor the treatment of patients under secondary mental health care.
4. Trusts should agree what routine patient care information will be provided about patients under the care of secondary mental health services, and develop systems to ensure that the agreed information is received and processed in a timely way.
5. The safeguarding policy should be amended to include consideration of whether the service user may present a risk to other vulnerable adults or children.
6. Race and ethnicity, gender and religious issues should be routinely addressed in CPA needs assessment and care planning as per the Trust's policy.
7. Staff must be aware of when they can, and must, share information about individuals whose care they are responsible for.
8. Any large service redesign should be assessed for impact and risk to quality of clinical care, and detailed milestones should be tracked on an appropriate risk register.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- Do you have ongoing contact with the patient's family and are you listening to their concerns?
- Are care plans regularly reviewed and do they involve both the patient and their family?
- How will compliance with medication be monitored? How do you manage non-compliance?
- When assessing a patient, do you demonstrate professional curiosity and clinical assertiveness about all aspects of the patient's life, including their family and/or children?

Governance focused learning

- Do all CPA arrangements and care planning take into account race and ethnicity, gender and religious issues?
- When undertaking a large service re-design, do you complete a full assessment of the redesign in relation to impact and risk to quality of clinical care?
- Because you are familiar with an individual with complex needs, do you stop and have a fresh look at their risks and risk management?

Board assurance questions

- What assurances do you have that risk assessments are completed to the required standards? Are there clear procedures in place to address risk to family members?
- Are there information sharing agreements and joint working practices with other key agencies?

System learning

- Does the system support improved relationships between services?
- Does the system provide appropriate support for individuals with complex needs living in the community?

Learning Lessons Bulletin - 13

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr H, an older man who seriously injured two other men while an inpatient in an acute hospital, resulting in their deaths.

Key themes: care planning, risk assessment, communication and coordination

Agencies and teams who might benefit from this bulletin:

- **Mental Health Liaison teams**
- **Mental Health Services for Older People**

Case background

Mr H was diagnosed with schizophrenia in his teenage years and had managed to live safely into his 70s with the support of regular medication to control the symptoms of his schizophrenia. His stepdaughter was his primary carer and support system. A few years before the incident, Mr H was diagnosed with oesophageal cancer which meant that he was in and out of hospital for various treatments. During one hospital stay, the incident took place.

Key findings

Care delivery

- The Trust did not take into account the knowledge of the next of kin throughout Mr H's acute hospital stays. Medical staff often listened to her concerns but did not give them the weight they should have done.
- Prior to the onset of his cancer, Mr H's GP had not referred him to community psychiatric services when requested to. Had this been completed, Mr H may have been allocated a Care Coordinator and the emphasis on maintaining the management of his schizophrenia may not have been lost.
- Prescription sheets and administration records were also not completed correctly on several occasions during Mr H's hospital admissions.
- The Trust did not refer Mr H for specialist mental health advice with the mental health liaison team when this was needed.
- The level of observation of Mr H in the acute hospital ward was inadequate and ineffective. The care environment was also inappropriate. There was a lack of record-keeping and no evidence of proper assessment of Mr H on the night of the incident. There was no plan of how to care for Mr H if his behaviour escalated again.

Risk assessment and management

- The initial risk assessment was not updated as it should have been and a plan should have been developed to manage the risks more effectively. The management plan was also limited and should have focused on managing the potential of Mr H's agitated behaviour reoccurring, incorporating advice from Trust staff.

Service delivery

- There was a gap in health records policy; the Trust policy did not provide guidance to the Mental Health Liaison team on where and how records of their patient assessments should be documented.
- There was no guidance for staff regarding one-to-one nursing care for patients.
- There were reported staffing issues on the day of the incident, with a shortage of nurses potentially resulting in care not being delivered and poorer patient outcomes. There was also a lack of clarity among staff regarding referral to Mental Health Liaison.

Key learning points

1. Trusts must work together to ensure that the mental health needs of patients are properly addressed when they are admitted to an acute general ward. Mental health, diagnoses and medications should be included in the admission information.
2. The application of risk assessments and risk management in the acute hospital environment must be improved. The work should include training for staff leadership, role modelling from clinical leaders and the regular audit of practice to demonstrate an improvement.
3. Guidance should be issued to staff on general acute wards regarding the criteria to request one-on-one support for patients who are a risk to themselves or others, and the criteria of how and when to access specialist mental health input.
4. GP practices should regularly review all patients on their lists that have a severe and enduring mental health diagnosis to ensure that there are no outstanding referrals to mental health services.
5. Learning regarding listening to families/carers should be incorporated into staff training by all Trusts.
6. Record-keeping in relation to medication prescription and administration should be of the required standard in all Trusts.
7. When patients transfer between wards, their records should be transferred with them to avoid any delay in the receiving staff being able to access patient information.
8. Where Mental Health Liaison teams work in hospital wards, Trusts should work together to ensure that there is clarity about where decisions regarding patients who are being treated by both Trusts are recorded. Both Trusts should adjust their health care records policies accordingly.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- Are care plans regularly reviewed and do they involve both patient and carer?
- Do your care plans contain clear instructions for communication with other agencies?
- Do your findings demonstrate professional curiosity about all aspects of the patient and their life? Have you listened to the patient's next of kin?
- Does the patient's admission information include mental health, diagnoses and medications?

Governance focused learning

- How do staff shortages influence safe practice, particularly on night shifts?
- Are there clear systems for multi-agency and inter-Trust working, documentation and the sharing of knowledge?
- What assurances do you have that all staff are receiving adequate training in risk assessments and risk management?

Board assurance questions

- What assurances do you have that sufficient safeguarding measures are implemented to protect others from harm?
- What assurances do you have that all staff are fully aware of when to access assistance from a specialist?
- What assurances do you have that patients are on the correct medication?

System learning

- How are you supporting improved information sharing between agencies and services?
- Are staff given accurate and up-to-date training in record-keeping in relation to medication prescription and administration?
- Do you offer adequate training to all staff regarding the importance of listening to the patient's family/carer?

Learning Lessons Bulletin - 14

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user L, who committed the homicide of a stranger who had invited L into his house.

Key themes: risk assessment, medication management, discharge planning

Agencies and teams who might benefit from this bulletin:

- **Community forensic services**
- **Adult Community Mental Health Teams**
- **Mental health commissioners**

Case background

L first came into contact with mental health services following a suicide attempt as a young man. He later committed several thefts resulting in a prison sentence, which he served between several prisons on account of his behavioural disturbances. He was released into the community subject to a community supervision licence but returned to prison shortly after.

L was referred to a Forensic Consultant Psychiatrist where he was diagnosed with paranoid schizophrenia and a personality disorder and admitted to a high secure hospital. While there, L began taking illicit clozapine and experienced a reduction in the intensity of his symptoms, which included hearing voices, persecutory beliefs about others and intrusive violent thoughts. He was then formally prescribed clozapine.

After four years in high secure care, L was transferred to a lower security setting and then finally discharged from detention under the Mental Health Act (MHA) the following year after a Mental Health Tribunal. He remained an informal patient at a low security unit before moving to a supported placement, where his presentation remained relatively stable until he began using illicit drugs.

The following year, L's compliance with his medication, presentation and corresponding treatment became increasingly chaotic. Over this period L had many visits to A&E departments which often resulted in admission to an acute ward, and there were many attempts to retitrate him on clozapine. Through the same period, mental health services considered a Mental Health Act (MHA) assessment twice but these did not take place. L's Care Coordinator was relentless in her attempts to support L but due to his continued absconding and disengagement with services, they could only rely on police sightings of L, who often "*appeared settled in his mental state*". L would frequently go AWOL from the ward. While L had been escalated to a 'patients causing concern' agenda on the multidisciplinary team (MDT) meeting, he was discharged from the ward in his absence. The incident occurred a few months later.

Risk and medication management

- L's risks were well known and well documented. There were care plans in place to mitigate these risks, but efforts to ensure he received appropriate treatment were not tried for long enough or assertively enough. This meant he did not get the inpatient care he needed, nor the medication that would help.
- L's Care Coordinator strove to ensure he maintained contact with mental health services. When L was initially admitted to the acute inpatient wards the impression was that he was experiencing a relapse of his psychosis. However, during his second admission, because of the absence of hallucinations and no obvious signs of relapse of his psychosis since his stopping clozapine, it appears that some mental health professionals began to reconsider his diagnosis. They either ignored or were not aware of L's forensic history, and did not consider his behaviours as symptoms of a relapse of his psychosis.
- L should have been maintained on a community treatment order (CTO) and not discharged from his section. He should also have received more assertive treatment to admit him, keep him in hospital and ensure he received his clozapine.

Key learning points

1. Multi-agency public protection arrangements (MAPPA) status should be clarified at the point of transfer to other services for all patients with forensic histories. This should also include identification and involvement of probation/National Offender Management Service (NOMS) for appropriate patients.
2. Clear guidelines should be provided for risk assessment and care planning for the titration of clozapine in the community.
3. When services work with service users who have both a personality disorder and psychosis, they must ensure that they recognise and respond appropriately to both conditions.
4. The Trust AWOL policy should ensure that any decision to discharge an AWOL patient in their absence is explicitly risk assessed, supported by a detailed decision-making tool, to ensure practice is monitored.
5. Discharge planning arrangements should comply with Trust policy. Arrangements should be made to appropriately grade those patients with complex needs and often forensic and/or substance misuse histories who are at high risk of disengagement from mental health services.

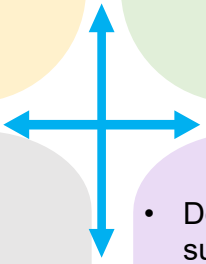
Learning Quadrant – individuals and all agencies

Individual practice reflections

- Are there clear plans that have been shared with the patient about how they will access medication? How will compliance with medication be monitored?
- Do your findings demonstrate professional curiosity about all aspects of the patient and their life, taking into account the patient's forensic history?
- Does the risk assessment sufficiently consider longitudinal risk of violence to others and include robust safeguarding interventions?
- Have you identified the patients most at risk of disengagement from services and taken steps to provide access to support?

Governance focused learning

- What assurances do you have that discharges are planned, safe and in keeping with guidance?
- How do you know that teams from different Trusts and services are working together well?



Board assurance questions

- Do you regularly consider readmission rates or incidents involving patients recently discharged from an inpatient unit?
- What assurances do you have that Care Coordinators are fully equipped and supported to deliver their role?
- What assurances do you have that patients are not discharged in their absence from a ward without a thorough risk assessment?

System learning

- Do you have robust transition processes that support effective discharges and that are inclusive of all community services?
- Does the system have robust multi-agency processes to support challenging individuals with complex needs who are at risk of disengagement in the community?

Learning Lessons Bulletin - 15

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr T, who committed the homicide of his grandson.

Key themes: discharge planning, medication management, communication

Agencies and teams who might benefit from this bulletin:

- **Transition planning services and multidisciplinary teams**
- **Mental Health Liaison teams**
- **Mental Health Services for Older People**

Case background

Mr T had over 20 years of involvement with mental health services. He had been admitted to a mental health inpatient unit a number of times, usually for short periods ranging from one day to two weeks. Assessments found that alcohol was a significant factor in Mr T's offending behaviour and that he had associated mental and behavioural disorders.

Three years prior to the incident, Mr T spent 10 months in a mental health rehabilitation unit, before he was discharged to live in supported housing. Supported housing staff reported that he was confrontational, aggressive and argumentative towards staff and other tenants. Mr T's mental health care and treatment was provided by the Community Mental Health Team (CMHT) at this time.

Mr T was discharged from specialist mental health services into the care of his GP. He continued on his prescribed medication until it was discontinued by the manufacturer. There was confusion about what to prescribe instead. A few weeks later, Mr T's GP made a referral to the older people's Community Mental Health Team but Mr T's mental health deteriorated and he contacted the general adult Community Mental Health Team because he was in crisis.

A home visit and assessment found that Mr T was severely depressed and he was admitted to a mental health ward. He was quickly transferred to a rehabilitation unit but readmitted to the ward following an assault on his Doctor and an assessment completed by an Approved Mental Health Professional (AMHP). There were multiple issues around Mr T's behaviour which presented when he was offered leave as he frequently became agitated, aggressive and violent. Discharge arrangements were made without Mr T's knowledge and he was escorted from the ward by the police. He did not want to use leave or be discharged.

Following an appointment with the CMHT, Mr T's care was handed over to a different crisis and Home Treatment Team (HTT). He reported that things were fine, he was staying temporarily with family, and he was too busy to see staff. Because of this information the crisis and HTT closed the referral to their team and noted they would accept a self-referral if Mr T made contact. This decision meant Mr T did not have a health care professional who had responsibility for oversight of his care and treatment. The incident took place the following day.

Discharge planning

- Mr T was discharged in an unplanned and unstructured way, without the appropriate enhanced package of care in place and with his concerns about his accommodation remaining unresolved. He should not have been discharged without the enhanced package of care being properly planned and implemented.
- Mr T's discharge from the ward was rushed. There is no clearly documented rationale or discussion leading to the sudden decision to discharge him. The CMHT had refused to allocate a Care Coordinator in accordance with the policy covering the Care Programme Approach (CPA) and staff felt that Mr T was too high risk for staff to visit him at home. While staff may have felt that Mr T was unwilling to engage in support mechanisms while he was on the ward, he had clearly articulated that he wanted to be fully looked after when he was in the community. In addition, the inpatient team had recorded their view that Mr T needed an "enhanced package of care".

Medication management on discharge

- At his discharge, staff noted that Mr T had approximately a week's worth of medication; however, he had been provided with seven days medication seven days earlier and therefore should have run out of his medication by the time of this follow-up appointment. A lack of medication, and no registration with a GP surgery in order to obtain more medication, could have contributed to a decline in his mood.

Key learning points

1. Family members should be adequately involved in the decision-making about discharge and should be kept informed about the patient's discharge prior to it taking place. Patients and their families should also be involved in decisions about transferring the patient to other units.
2. Any plans for discharge from an inpatient unit should be planned with the patient, GP and all relevant community services. There must be a clearly documented structured plan which sets out specific roles, responsibilities and timescales.
3. When a GP practice is informed that a patient has been admitted to hospital, a review of that patient's appointments and repeat medication should be undertaken.
4. Prior to removing a patient from a surgery list, the GP surgery should consider all information in their possession regarding the possible whereabouts of that patient. They should clearly document in the records the basis or rationale for that removal with details and/or a copy of the information on which the decision is based.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- Are there clear plans that have been shared with the patient about how they will access medication?
- Do you have ongoing contact with the patient's family and are you listening to their concerns? Are they appropriately involved in decision-making and planning?
- How do you manage alcohol abuse? Do you incorporate joint working with the alcohol service?
- Does the risk assessment sufficiently consider risk of violence to others and include robust safeguarding interventions?

Governance focused learning

- What assurances do you have that discharges are planned, safe and in keeping with guidance?
- What triggers an alert when a patient has been inappropriately discharged from a service?

Board assurance questions

- How do you know that risk management plans are collaboratively developed, understood and shared with all those involved in a high-risk individual's care?
- What assurances do you have that CPA policies are being followed appropriately?

System learning

- Do you provide adequate training on the importance of discharge planning?
- Do your transition processes effectively support discharges, inclusive of all community services?

Learning Lessons Bulletin - 16

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user N, who, along with his friend, committed the homicide of Mr S.

Key themes: care planning, risk assessment, communication, medication management

Agencies and teams who might benefit from this bulletin:

- **Substance misuse services**
- **Mental health commissioners and provider services**

Case background

N was referred to Child and Adolescent Mental Health Services (CAMHS) while at boarding school. He self-harmed and was sometimes verbally and physically aggressive. Following recurring issues at school, N was referred to a Youth Offending Service initiative. He did not complete his schooling and did not appear to find work.

While a teenager, N had several episodes of care from the Early Intervention Team (EIT) of between three and six months duration. He was discharged due to lack of engagement on all but one occasion. N had a history of a previous assault, making threats to kill himself, possession of an offensive weapon and a knife in a public place, and three incidents with a previous pregnant girlfriend which resulted in a Multi-Agency Risk Assessment Conference (MARAC) and a pre-birth assessment by social services. He was also reported to have been violent to his mother and to animals in the past.

N was reportedly using large amounts of cannabis and appeared to have "*reduced emotional management skills*". CAMHS referred him to the EIT following a period in custody. He started antipsychotic medication following an assessment by the EIT and CAMHS but he was reluctant to take it. His first episode of EIT care ended when N was discharged as a result of his failure to engage. N's housing situation was unstable and he moved between various flats and the YMCA.

After N's girlfriend gave birth to their baby, a detailed multi-agency child protection plan was developed. As a result, N was only able to see his baby at the family centre on a weekly supervised basis. He continued to take his medication erratically but then began to engage with the drug service as he wanted to be drug-free so that he could live with his girlfriend and baby.

N later told his drugs workers that he had taken other drugs. He intended to move out of the YMCA and into his mother's flat. He appeared paranoid and anxious.

Key findings

Care planning and assessment

- There was a lack of individualised care planning for N and there had been no comprehensive mental health assessment completed in the earlier part of his care. Due to his disrupted education, N's literacy level should have been reviewed. It may also have been appropriate to consider an assessment for adult attention deficit hyperactivity disorder (ADHD).
- Neither N's girlfriend nor his mother were offered involvement in family meetings or educational groups, although these were available. The team also did not make contact with his mother or his previous girlfriend to gather further information about his presentation or any concerns they may have had.

Risk assessment

- There was sufficient risk information in the records for staff to make a reasoned assessment on N's risk, but this information was largely scattered and not located in one place. This could have diluted the usefulness of such information as it could not be viewed as a whole.

- The reference to animal cruelty does not appear to have been given significant weight in subsequent risk assessments. N's mother's allegation should have been explored and recorded, so that it could inform a comprehensive risk assessment.

Communication and multi-agency working

- There did not appear to be any joint working between the EIT and the drug service during the final few months in terms of joint meetings or a shared care plan. There also does not appear to have been any attempt to develop a shared understanding of the relationship between N's substance use, his mental health and his emotional responses. Such an understanding may have helped the services to work with N to address some of his difficulties.
- The EIT and drug service teams lacked a clear sense of direction to guide practice.

Key learning points

1. If a service user is receiving care and treatment from more than one Trust service, there should be collaboration and joint meetings between these services, and consideration given to a shared care plan.
2. Trusts should have protocols in place to support clinicians focusing on when to use depot antipsychotic medication in patients with active psychosis who are unable to dependably use oral antipsychotics.
3. Where a patient has an active psychosis and fails to engage in treatment, he or she should be considered for assessment under the Mental Health Act (MHA), and this discussion should be fully documented.
4. Trusts should ensure that they have appropriate policies and guidance in place on the discharge of patients who are failing to engage but are actively psychotic and have a moderate risk of violence exacerbated by substance misuse.
5. Trusts should ensure that they have appropriate policies and guidance on when contact with relatives/partners becomes essential as part of the care of patients, particularly when patients fail to engage yet are clearly ill.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- Are you liaising effectively with other services who are supporting patients on your caseload?
- Do you have ongoing contact with the patient's family and are you listening to their concerns?
- How do you manage substance abuse in service users? Do you incorporate ongoing joint working with the substance misuse service?

Governance focused learning

- What assurances do you have that discharges are planned, safe and in keeping with guidance?
- Are there clear systems in place for working together and the sharing of knowledge and skills?
- How do you know that teams from different Trusts and services are working well together?

Board assurance questions

- What assurances do you have that risk assessments are completed to the required standards?
- How do you know that risk management plans are collaboratively developed, understood and shared with all those involved in the individual's care?
- What assurances do you have that all staff are fully aware of the Mental Health Act and its detention processes?

System learning

- Are you providing adequate training in understanding and awareness of when to incorporate the Mental Health Act?
- How are you supporting improved information sharing between agencies and services?
- How do medical staff know when to consider depot medication for actively psychotic service users?

Learning Lessons Bulletin - 17

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user P, who committed the homicide of a young girl on a bus.

Key themes: communication, information sharing, record keeping, discharge planning

Agencies and teams who might benefit from this bulletin:

- **Supported accommodation providers**
- **Adult mental health services and Early Intervention teams**
- **Court liaison and diversion teams**
- **Prison in-reach services**
- **Police and probation services**

Case background

P had been in contact with, and assessed by, several different mental health services over the previous decade but had never fully engaged with or received consistent mental health care and treatment for his emerging severe mental illness.

P was last in contact with mental health services the year before the incident, when he was seen by the Consultant Psychiatrist and his Nurse Key Worker when in prison. At that time P denied hearing voices but was difficult to engage with. He was not presenting with any active or acute mental health problems nor any immediate risk of self-harm or suicide. The plan was to refer P to the homeless team on his release. It was the Consultant Psychiatrist's intention to review P's notes but this did not happen before he was released.

P was released from prison the next day. The healthcare team were not informed that P was being released. It is not known where P lived during the three months preceding the incident. It is thought he was homeless.

Key findings

Service delivery

- There were a number of missed opportunities to initiate a more appropriate response for P's mental health care, starting with his initial contact with Child and Adolescent Mental Health Services (CAMHS), then from primary care services, and his later contact with prison health and criminal justice services.
- Service design and delivery needs to reflect that individuals suffering from mental disorder will not always have the capacity to initiate and participate in their own care. Provider organisations involved failed to consistently and adequately listen to, respond to and support carers/significant others.

Risk assessment and information sharing

- The full extent of P's health and risk history was not known to either assessing team. Not all of the available information was utilised, including the full prison health records; information about P's health history should have been more readily available. Information known by the police about P's conduct and their repeated concerns about his mental health were not known to mental health services.
- Organisations' information recording and storage arrangements were evidently not sufficiently robust to facilitate good care/management. The accessing and sharing of information between key agencies was ineffective. Critically, the GP was not consistently updated or considered as the primary care provider and record holder.

Key learning points

1. Prison healthcare staff undertaking the initial Care Programme Approach (CPA) plan should liaise with all agencies who have been involved with the prisoner, in order to obtain an accurate profile of their needs and risks to themselves and others.
2. Street triage services can work to reduce the impact of mental health crises on local police and emergency services.
3. There remains a need to improve discharge planning of vulnerable prisoners with mental health problems who are released earlier than planned, and produce clear guidelines for all healthcare staff to refer to other mental health services.
4. There continues to be a need to find a way to share relevant healthcare information about prisoners at risk of mental health problems who refuse consent to share information with GPs.
5. Agencies working in health and criminal justice should work collectively to develop the information sharing protocol to support appropriate information sharing.
6. The current pathway for released prisoners with mental health problems must ensure that those in need have access to appropriate mental health care and accommodation after release.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- When completing your assessment, do you make sure you have information from all services involved with the service user? Do you listen to the family?
- Does the risk assessment sufficiently consider risk of violence to others and include robust safeguarding interventions?
- How do you engage with someone who is quiet and not willing to engage, but who has a history of risk of serious violence? How do you escalate any concerns?

Governance focused learning

- What assurances do you have that discharges from services are planned, safe and in keeping with guidance?
- Are your risk escalation thresholds and triggers reliable when service user circumstances change?
- Are there clear systems in place for the sharing of appropriate information across services?

Board assurance questions

- What assurances do you have that sufficient measures are implemented to protect the public from harm when dealing challenging services users with complex needs who do not want to engage?
- What assurances do you have that CPA policies are followed appropriately?
- What assurances do you have that referral and escalation processes are effective for service users identified as at risk of violence to others?

System learning

- Does the system provide appropriate support for challenging individuals with complex needs and mental health problems released from prison?
- How are you supporting improved information sharing between agencies and services working in health and justice?
- Do your transition processes effectively support discharges, inclusive of all community services?

Learning Lessons Bulletin - 18

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr A, who injured a fellow patient, Mr O, at the hospital, resulting in Mr O's death.

Key themes: care planning, risk assessment, observations

Agencies and teams who might benefit from this bulletin:

- **Mental health provider services**
- **Emergency departments**

Case background

Mr A had first presented to adult mental health services provided by the Trust around a month before the incident. He was referred to the crisis team by staff at A&E where he had attended complaining of abdominal and chest pain. He reported to A&E staff that he had been hearing voices.

Mr A was then placed under the care of the Home Treatment Team and was seen by a number of different staff over the following few weeks. During this time, a Mental Health Act (MHA) assessment was conducted which determined that Mr A would not be detained and that he should continue to receive care and treatment from the Home Treatment Team (HTT).

A further MHA assessment was conducted around a week later that resulted in Mr A being detained on Section 2 MHA. He was admitted to a mental health inpatient unit. Two days later, Mr A was transferred to a second mental health inpatient unit where he continued to be detained until the incident.

Key findings

Staffing issues

- There was insufficient clinical leadership on-site and a consistent problem with inadequate staffing levels and inappropriate skill mix. The Locum Consultant leadership on the ward created a changing environment where staff were uncertain or unclear about how to carry out care. This was further exacerbated by the attitude of the whole care team that tolerated incomplete or out-of-date risk assessment and care plans.
- Staff were inconsistent in their approach to caring for both Mr A and Mr O and were not sufficiently cognisant of the risks; that Mr A had made threats to kill and that Mr O was a vulnerable person.

Risk management

- There was a poor application of care planning, risk assessment and risk management processes.
- Risks were not adequately controlled and caused staff to be anxious about their own and patients' safety. There were issues of patients being brought to the unit without adequate consideration of their motivations for admission or previous criminal activity; staff raising concerns that one part of the ward was not safely staffed; and inconsistencies in how risk assessments and risk ratings were applied. This tolerance of uncontrolled risk meant that staff did not have the resources or plans in place to manage risks effectively.

Observation policy and guidance

- The Trust observation policy indicated rigid routines for observations that patients could circumvent and that did not convey to staff the need to randomise observations and make observations part of the caring process. Staff could have used their professional judgement to apply a different approach within the guidelines given. The ward layout also meant that parts of the ward were not in view if staff were based in the ward office. Staff were not sited in the long patient corridor overnight and there was no CCTV.

- If the observations had been carried out differently it would have reduced the likelihood that Mr A would have been able to go into Mr O's room and be undisturbed for 15 minutes.

Key learning points

1. Observations must form part of a patient's electronic record.
2. Front line staff should receive appropriate support from managers both in hours and out of hours, when dealing with serious incidents.
3. Clinical staff should have the skills and knowledge to be able to provide appropriate physical health care, or be able to access appropriate physical health care from other organisations in a timely fashion.
4. Staff should be fully aware of and execute their responsibilities for safeguarding when there are concerns about the vulnerability of patients.

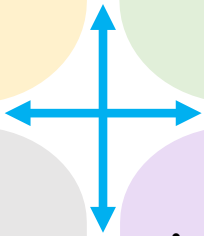
Learning Quadrant – individuals and all agencies

Individual practice reflections

- Does the risk assessment sufficiently consider risk of violence to others and include robust safeguarding interventions?
- How are you supporting adherence to the observation policy guidance? Do you encourage staff to use their professional judgement to apply a different observational approach within the guidelines given?
- Are your frontline staff adequately supported to deal with this individual?
- Does each shift team incorporate an appropriate skill mix?

Governance focused learning

- How do staff shortages and targets influence safe practice? Do you tolerate high levels of risk on a day-to-day basis?
- How do you know that 'risk tolerance' has not set in within your services and what can you do to recognise and challenge this?



Board assurance questions

- Can your services cope safely with demand? How do you know?
- How do you know that risk management plans are collaboratively developed, understood and shared with all those involved in an individual's care?
- What steps are you taking to retain experienced staff? Is there a strategic plan?
- What assurances do you have that risk assessments are completed to the required standards?

System learning

- Do you offer appropriate training to all relevant clinical staff on physical health care?

Learning Lessons Bulletin - 19

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr A, who committed the homicide of a man he had met earlier that evening.

Key themes: communication, risk assessment, medication management

Agencies and teams who might benefit from this bulletin:

- **Early Intervention teams**
- **Transition planning services**
- **Adult multidisciplinary teams**

Case background

Mr A was in contact with Child and Adolescent Mental Health Services (CAMHS) following behavioural issues at school and was diagnosed with ADHD.

As an adult, Mr A was under the care of a number of teams over the six years prior to the incident, including the Early Intervention Team (EIT). Mr A was admitted to hospital seven times; on four occasions this was as an informal patient, and on three occasions he was detained under Section 2 of the Mental Health Act (MHA). During one period in hospital, Mr A's detention was converted to Section 3 of the MHA.

Mr A had a diagnosis of paranoid schizophrenia and there was a general view held by staff that the psychosis was drug-induced, as he was a known user of illicit substances. He frequently rejected offers from staff for support from substance misuse services. He was often non-compliant with his treatment.

Mr A took a significant overdose of paracetamol and attempted to hang himself while in prison during this period. Mr A was treated by prison mental health services and it was while in prison that significant concerns were expressed about his risks to other people on release from prison.

The incident took place shortly after his release from prison.

Key findings

Dual diagnosis

- There was no evidence indicating that the EIT had considered that Mr A's psychosis was present in addition to his substance misuse, rather than because of it. This was a failure by the Trust to properly understand the nature of Mr A's psychosis.

Care delivery

- There was a lack of consistency in implementing Mr A's treatment plans and there was disagreement around Mr A's diagnosis between staff in the EIT and the ward-based staff.
- Mr A remained unmedicated for a number of months. In the period of time leading up to the incident, Mr A was not in receipt of any medication except for when he was in inpatient or prison settings. The lack of effective treatment for Mr A's psychosis most likely contributed significantly to his increasing aggression and violent behaviour.

Risk assessment

- The decision not to proceed with a MHA assessment without any first-hand knowledge of Mr A's mental state since his release from prison was flawed. A face-to-face assessment might have led to a closer examination of risk and a detailed enquiry into Mr A's mental state while in prison.

Key learning points

1. It should be made clear to all staff which approach to take when there is diagnostic uncertainty. Trusts should clarify the process for seeking a second opinion and/or formal consultation with another clinician or team when a patient has not responded to treatment for a prolonged period of time and where risks are escalating.
2. When there are doubts or differences of opinion about the use of the MHA, a formal discussion that involves an Approved Mental Health Professional (AMHP) should take place and be properly recorded.
3. The AMHP teams on duty during normal working hours and out of hours should have a system to record all requests for MHA assessments.
4. All clinical teams should follow Trust safeguarding policies when they are made aware of safeguarding concerns about children or adults, and appropriate referrals should be made to the relevant social care department.
5. When recording that a patient is being treated under the Deprivation of Liberty Safeguards (DoLS) framework, the appropriate documentary detail must be in place to apply the Mental Capacity Act lawfully.
6. An appropriate prescribing plan should be developed and implemented when patients are at risk of becoming homeless or are not registered with a GP.

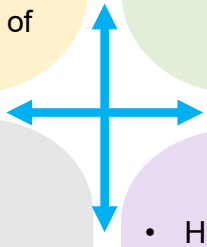
Learning Quadrant – individuals and all agencies

Individual practice reflections

- How is compliance with medication monitored, and how do you manage non-compliance?
- How much do you consider the possible contribution of the underlying mental illness when dealing with patients who have a dual diagnosis, e.g. substance misuse and mental health problems?
- Are care and treatment plans regularly reviewed and do they involve both the patient and their carer?
- Has an appropriate prescribing plan been developed with the patient if they are at risk of becoming homeless?

Governance focused learning

- Are there clear systems in place for working together, and the sharing of knowledge and skills?
- Are your risk escalation thresholds and triggers reliable when service user circumstances change?
- What assurances do you have that multidisciplinary teams are working well together?



Board assurance questions

- What assurances do you have that risk assessments for high-risk service users are completed to the required standards, including a face-to-face appointment if needed?
- How do you know that risk management plans are collaboratively developed, understood and shared with all those involved in the individual's care?
- What assurances do you have that sufficient safeguarding measures are in place to protect the public from harm?

System learning

- How are you supporting improved communication and information sharing between agencies and services?
- When dealing with complex dual diagnosis referrals, how is the system going to understand the impact of the mental illness on the presentation?

Learning Lessons Bulletin - 20

Independent investigation

Introduction

This document provides an overview of findings from an individual management review of the care and treatment of a mother, V, and her son, J. J killed V and then committed suicide.

Key themes: safeguarding, discharge planning, communication and coordination

Agencies and teams who might benefit from this bulletin:

- **Domestic abuse organisations and safeguarding partnerships**
- **Mental health commissioners**
- **Adult social care**
- **Substance misuse services**

Case background

The year prior to the incident, J and V were victims of financial fraud. This incident led to increased risk of losing the family home and caused J to become depressed. The police stated that the burden of caring for his mother was clearly too much for J; he was neglecting his own health and hygiene to care for her. V was allocated a Social Worker and referred to her GP, who gave her a diagnosis of dementia.

Following a serious suicide attempt by J, V was admitted multiple times to the hospital, but she always returned to live with him after her release. J acknowledged the difficulties in providing care himself and was willing to accept the help offered by the Home Treatment Team (HTT).

J was diagnosed with mental and behavioural disorder, alcohol use and adjustment disorder with a negative reaction to stress. He was not prescribed any medication apart from thiamine and he was thought to be at low risk of self-harm, despite having chronic thoughts of suicide. He described his mother and his close friend as protective factors.

Ten days later, J appeared to be relapsing in his mental state and his mother was not coping well. Assessments stated that J knew where to seek help if his mental state relapsed and that the risk to himself and others was low. J did not want to take antidepressants, said he was sleeping well and had good support from his friends. V later went into respite care following concerns; J was found to be a possible risk to others and was struggling to cope with his caring responsibilities. A safeguarding alert was completed for V, and J was prescribed an antidepressant. A care package had been put in place for V ready for her discharge.

Multiple concerns were raised about J and his caring role with V. A safeguarding alert was raised and the agreed response to the situation was to put in extra support. The incident took place 10 days later.

Key findings

Care delivery

- There were missed opportunities to assess and manage potential risk by raising safeguarding alerts that would have offered a multi-agency view, advice and support and the joining up of concerns about the circumstances associated with V and J as a whole. There was no consideration made to refer the situation involving V and J to the Multi-Agency Risk Assessment Conference (MARAC).
- There were multiple failures in discharge planning for V. There was a lack of coordinated discharge planning between Trusts and there were issues around assessing V's mental capacity in this complex circumstance. V's capacity was not formally assessed at the point of discharge and it should have been fully demonstrated in the assessment.
- The application of the Care Programme Approach (CPA) was not considered for J. This was a missed opportunity for J to benefit from the process of CPA and the appointment of a Care Coordinator.

- There was no detailed crisis plan for J, and the risk related care plan for J was inadequate. The goals were not specific enough and the actions associated with the goals were very general.

Service delivery

- There was a lack of professional ownership of J's alcohol problem. The whole responsibility of the referral to alcohol services was placed on J and there is no evidence of joint working.
- There were further service delivery problems (SDPs) associated with the risk assessment and management training requirements. Staff were not clear on training requirements.
- The Assessment and Brief Intervention team's caseload was too high and the resources needed for a joint assessment were not available. There was also a lack of professional challenge about decisions caused by a poor relationship between services resulting in passivity.

Key learning points

1. Procedures for domestic violence should be reviewed against the 2016 NICE Quality Standard (QS116) and opportunities should be sought for specific multi-agency training in how to identify and respond to domestic violence.
2. Partnership arrangements between agencies, substance misuse services and inpatient and community services should be reviewed to ensure that discharges are coordinated appropriately where there are mental health concerns, and with regards to substance misuse services that risks associated with comorbidity are recognised and responded to as an area for joint working.
3. The requirements for assessing capacity, safeguarding, risk assessments, care plans and crisis plans must be in place, up-to-date, and meet the quality standards set.
4. The policy requirements for assessing capacity, DoLS, safeguarding and care support planning, and carer's assessments should be in place and meet the quality standards set.
5. The adult social care understanding of mental health issues should be expanded through further promotion of joint working and by using the learning from this case.

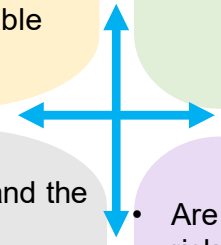
Learning Quadrant – individuals and all agencies

Individual practice reflections

- How do you manage alcohol abuse? Do you incorporate joint working with the alcohol service?
- Are your risk assessments and plans fully detailed and up-to-date? Do they include a documented assessment of the patient's mental capacity?
- Do your crisis and risk related care plans incorporate specific and measurable goals and actions?
- Are your caseloads too high? Are there resources available for any necessary assessments?

Governance focused learning

- What assurances do you have that discharges are planned, safe and in keeping with guidance?



Board assurance questions

- What assurances do you have that staff fully understand the high-risk report process and its benefits?
- What assurances do you have that sufficient safeguarding measures are implemented to protect vulnerable family members from harm?
- What assurances do you have that risk assessments are completed to the required standards? Are there clear procedures in place to address risk to family members?
- What assurances do you have that CPA policies are followed appropriately?

System learning

- Are all staff members fully trained in risk assessment and management?
- Does the system provide appropriate support for individuals with complex needs living in the community, particularly where alcohol abuse may be an issue?
- Does the system support improved relationships between services?

Learning Lessons Bulletin - 21

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of mental health service users N and G, who were housemates when G killed N.

Key themes: safeguarding, discharge planning, risk assessment

Agencies who might benefit from this bulletin:

- **Mental health commissioners**
- **Early Intervention in Psychosis Teams**

Case background

G and N lived in temporary accommodation and had been there for several years at the time of the incident. They were both unemployed and in receipt of welfare benefits.

G had suffered from depression while at university, where he was first referred to mental health services by his GP. He appeared to fit the criteria for a diagnosis of adult attention deficit hyperactivity disorder (ADHD). He had no history of contact with police or the criminal justice system until his mental health started to deteriorate two years prior to the incident. During G's first documented experience of psychosis, he made threats and damaged property at his workplace because of bizarre beliefs about harm to his family; as a result, he was briefly admitted to hospital under Section 3 of the Mental Health Act (MHA).

G was discharged to the care of the local Early Intervention in Psychosis Team (EIPT) and referred to the Home Treatment Team (HTT). He had a diagnosis of paranoid schizophrenia and harmful use of substances.

Similarly, N had a diagnosis of paranoid schizophrenia and was known to abuse crack cocaine, heroin and cannabis. N suffered multiple incidents of assault believed to be related to drugs and money he owed, including one instance where he was kidnapped by a gang that he allegedly owed money to.

Key findings

Care delivery

- There was a lack of evidence-based treatment by the EIPT, associated with a lack of appropriate staffing resources. This meant that G did not receive appropriate care during his recovery from a significant psychotic episode. He refused to take antipsychotic medication and was felt to be close to a full relapse. His capacity to refuse treatment was thought to be marginal, but was not properly reassessed. There was insufficient follow up after this review, which led to an increased possibility of violence.
- There was also a lack of evidence-based treatment for the diagnosis of ADHD for G.
- There was insufficient support for both individuals with regard to the financial exploitation which had been reported at the house. A safeguarding referral should have been made at the time of G's disclosure about possible financial exploitation. The temporary housing, which was provided as a private house in multiple occupation (HMO), was allocated by the local authority after an inpatient stay, and its suitability was never revisited.
- There were failings in Care Programme Approach (CPA) and Section 117 MHA aftercare for both individuals. Expectations of the CPA policy with respect to regular timely documented CPA reviews were not met. The discharge letter sent to G contained a significant amount of typographical errors in relation to dates.
- The care plan for someone experiencing a first episode psychosis should include a significant amount of psychoeducation about psychosis, the nature of the diagnosis and the need for a range of measures focused on relapse prevention. There is no evidence of this in G's community care plans or contacts.

Care planning

- While there were detailed mitigation and crisis management plans for G, there was no proactive focus on educating him about his diagnosis, developing his understanding of the possible future course of his mental illness, and increasing his ability to keep himself well. The risk management plans did not acknowledge that G denied that he needed any help with substance abuse.

Service factors

- The inappropriateness of the housing was of great concern to both families. It was judged unsuitable for vulnerable people with mental health issues and there were concerns that the other residents may have been dealing drugs.

Key learning points

1. The commissioners of services should ensure that the care and treatment of people with psychosis is delivered to meet the expectations of NICE guidance *Psychosis and schizophrenia in adults: prevention and management*.
2. There should be clear standards for the accuracy, quality, and timeliness of discharge letters from mental health hospitals. Expectations of CPA policy should be met and there should be a system in place to maintain these standards.
3. The clinical risk assessment policy should be applied consistently in community teams, and there should be systems in place to monitor its application.
4. Where there is a question of capacity to consent to treatment, a structured process should be used to assess and record capacity, with action plans as appropriate.
5. There should be clear pathways for the diagnosis, medication prescription and management of ADHD in adults.

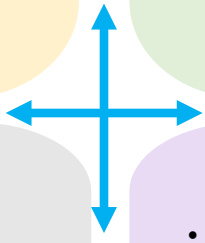
Learning Quadrant – individuals and all agencies

Individual practice reflections

- Are you demonstrating professional curiosity about all aspects of the patient and their life, including their relationships with the people around them?
- Are you aware of the risks around substance use and exploitation in the community? Have you developed the appropriate links with the police?
- Are interventions within the care plan in keeping with evidence-based practice and national guidance such as NICE?
- Is adequate support offered for individuals with regard to financial exploitation?

Governance focused learning

- What assurances do you have that discharges from services are planned, safe and in keeping with guidance?
- What assurances do you have of compliance with the Mental Health Act for those service users who are entitled to 117 aftercare?



Board assurance questions

- What assurances do you have that CPA policies are followed appropriately?
- What assurances do you have that NICE guidance is adequately adhered to across all relevant policies and procedures?
- What assurances do you have that risk assessments for high-risk service users are completed to the required standards?

System learning

- Does the system provide appropriate support for individuals with complex needs living in the community, particularly where substance abuse may be an issue?
- How are housing decisions made at discharge from inpatient units?

Learning Lessons Bulletin - 22

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user B, who was pregnant when she and her unborn baby died.

Key themes: care planning, risk assessment

Agencies and teams who might benefit from this bulletin:

- **Mental health commissioners**
- **GPs and maternity services**
- **Perinatal mental health services**
- **Children's social care and Early Help services**

Case background

B's first contact with mental health services was when she was admitted to an acute mental health unit, where she was diagnosed with bipolar affective disorder and prescribed medication. She stopped taking any psychiatric medication two years later because she and her husband planned to have a baby. As a result, she had not taken medication for approximately 18 months when her first son was born. At this time she was diagnosed as having postpartum psychosis.

She had eight admissions to mental health hospitals over the decade. Three of these were directly related to giving birth or becoming pregnant. When low in mood she reported suicidal thoughts.

B had a long period of care from the same Consultant Psychiatrist, and in eight years only had three different Care Coordinators consecutively. A focus of the Community Mental Health Team (CMHT) work was on further developing her insight into the risk of relapse if she did not adhere to her medication regime as prescribed by the Consultant Psychiatrist. There was a history of agitation and verbal aggression when she was relapsing.

Although B was always reluctant to take medication, she appeared to be very well engaged with the CMHT and attended most appointments and review meetings. She regularly voiced concerns about the possible effects of taking psychiatric medication during pregnancy, on both herself and on the unborn baby. There were no documented discussions after her relapse about future possible pregnancies and the risks to her mental health, and there were no agreed contingency plans for pregnancy.

B was under the care of CMHT as an outpatient for two years until her death.

Key findings

Treatment of pregnant women in mental health services

- When B shared with her GP that she was pregnant, there was a lack of focus on her previous mental health history, which included both postpartum psychosis and bipolar affective disorder, and her potential risk of relapse. Her clinical history was not handed over in detail to professionals in the maternity pathway, and there was an emphasis on physical health care in pregnancy that did not give adequate consideration to her mental health issues.

Perinatal mental health

- B was not assessed or treated by mental health services appropriately during her pregnancy. There was a disjointed pathway for antenatal care and unclear perinatal mental health care pathways. The sharing of the results of a fetal anomaly scan did not take her mental health history into consideration.

Key learning points

1. All pregnant women with a history of bipolar disorder should be under the care of the Perinatal Mental Health (PNMH) team.
   - GPs must have relevant training regarding the risks associated with bipolar disorder and other serious mental illness in pregnancy and the postnatal period.
   - Everyone who comes into contact with a pregnant or postnatal woman must have relevant and up-to-date training regarding the risks associated with serious mental illness in pregnancy.
2. Maternity booking records must include a section on mental health and illness.
3. Accurate records must be maintained by all GP providers.
4. There must be a clear system for planning and implementing antenatal care, in line with NICE guidance, which is conveyed to women at the first discussion with primary healthcare.
5. Trusts must develop a protocol for the emotional support of parents who are found to have a possible fetal abnormality, and appropriate training in supporting parents should be provided.
6. Care Programme Approach (CPA) discussion with women of childbearing potential, must include information about contraception and pregnancy plans, how their mental health problem/treatment might affect them and their baby if they become pregnant, the option of a preconception appointment, and organisations that can provide support.
   - Families and carers should also be given the option to be involved in discharge planning.
   - Discharge from Section 117 MHA aftercare must be formally recorded and carried out.
   - Medication concordance must be considered before discharge decisions are made.
7. Commissioners of services for pregnant women must ensure services are meeting standard expectations in regard to safeguarding guidelines and domestic abuse awareness.
8. All services must ensure that aspects of diversity and culture are incorporated into assessments.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- Are interventions within the care plan in keeping with evidence-based practice and national guidance such as NICE?
- Have you collated and reviewed all historic and current risk information? Do they demonstrate professional curiosity about all aspects of the patient and their life?
- When forming pregnancy plans, has there been adequate discussion with the patient about mental health issues in pregnancy?
- Have you shared the appropriate information with all appropriate agencies and services, such as midwives, GP etc.?
- Are cultural issues adequately considered?

Governance focused learning

- What assurances do you have that all GP practices contain accurate records for their patients?
- How have you implemented updated training regarding the risks associated with serious mental illness in pregnancy/postnatal period for all staff?
- What assurances do you have of compliance with the Mental Health Act for those service users who are entitled to 117 aftercare?
- What assurances do you have that discharges from services are planned, safe and in keeping with guidance?
- Are there clear systems for working together and the sharing of knowledge?

Board assurance questions

- What assurances do you have that CPA policies are being followed appropriately?
- What assurances do you have that sufficient safeguarding measures are being implemented for all family members?
- What assurances do you have that best practice guidelines are being adequately followed by all staff?

System learning

- How are you supporting improved information management and sharing between agencies and services?
- What assurances do you have that learning is embedded across systems?
- Are you providing adequate training in perinatal mental health and relevant safeguarding awareness to all staff involved?
- Are you providing adequate training on the breaking of bad news and awareness of risks to all staff involved?

Learning Lessons Bulletin - 23

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user J, who committed the homicide of his partner, H.

Key themes: risk assessment, care planning, medication management

Agencies and teams who might benefit from this bulletin:

- **Transition planning services**
- **Adult multidisciplinary teams (MDT)**
- **Substance and alcohol misuse services**

Case background

J first described the onset of mental health issues when he was a teenager. He started taking illicit substances at school and continued at university, where his mental health worsened. He was admitted voluntarily to an acute inpatient unit for two weeks, with a diagnosis of drug-induced psychosis. After discharge, he was referred to the Community Mental Health Team (CMHT).

Over the following 10 years, J had four admissions to hospital and received treatment in the community. Although there were changes in psychiatrist during his care under the CMHT, he had the same Care Coordinator throughout this period. J was diagnosed with paranoid schizophrenia, generalised anxiety disorder and mental and behavioural disorder due to alcohol use. He received psychological therapy and medication for his mental health issues, including being treated with clozapine along with other antipsychotic medication.

J and H had been in a relationship for 10 years and lived together. H supported J at mental health service meetings about his care and was noted to be his carer.

Shortly before the incident, J and H moved to a new area and J was transferred to a new team. He had blood test results which meant that clozapine had to be discontinued and he was advised to increase his other medication until clozapine could be reinstated. Over the next few weeks, there were changes in his mental state which indicated J was relapsing.

Key findings

Risk assessment

- An up-to-date risk assessment with risk mitigation plans was not undertaken in either of the specialist psychosis teams. Systems to manage escalation in a patient's risk, with respect to the need for potential admission to inpatient mental health beds, were unclear.

Continuity of care

- Service changes contributed to a lack of timely Care Programme Approach (CPA) and medical review. The transfer of care between teams was not carried out in a timely manner with appropriate detailed handover and plans for continuity of care. It was not supported by a full care plan and risk assessment review. Due to these service changes, J did not have a medical review for over a year.
- Recording of clinical information was not carried out consistently within and between teams.

Medication management

- Following the sudden cessation of clozapine, neither appropriate professional monitoring of physical health, or education and guidance for service users and families was provided.

Family education

- Family education and interventions, as in NICE guidance *Psychosis and schizophrenia in adults: prevention and management*, was not provided by the Trust.

Key learning points

1. NICE guidance for the care and treatment of patients with psychosis should be adequately adhered to, with specific reference to structured family education. Trusts should revise clozapine administration guidance in order to include the education of patients and families, and the management of risk if clozapine is stopped suddenly.
2. Community teams should have structures and processes in place to ensure that the CPA policy is fully adhered to; there should also be systems in place to monitor compliance. Trusts should provide clarity about protocols and responsibilities with respect to responding to increased need for interventions, zoning, and the process for considering and effecting inpatient admissions from the community.
3. When going through large-scale service changes, risks to patient care should be assessed, documented and mitigated.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- Are interventions within the care plan in keeping with evidence-based practice and national guidance such as NICE?
- How do you manage alcohol and substance abuse? Do you incorporate joint working with the alcohol and substance misuse service?
- Do you have ongoing contact with the patient's family and are you listening to their concerns?
- Do your risk management plans contain clear instructions about thresholds and escalation if behaviours change?

Governance focused learning

- What assurances do you have that discharges from services are planned, safe and in keeping with guidance?
- Are there clear systems for working together and the sharing of knowledge?
- Are your risk escalation thresholds and triggers reliable when service user circumstances change?
- Do your care transfer processes include appropriate detailed handover and plans for continuity of care?

Board assurance questions

- What assurances do you have that CPA policies are being followed appropriately?
- What assurances do you have that risk assessments are completed to the required standards? Are there clear procedures in place to address and mitigate risk to partners and family members?
- What assurances do you have that NICE guidance is adequately adhered to within the care and treatment of patients with psychosis?
- When service changes are planned, are risks identified and mitigated?

System learning

- How are you supporting improved communication and information sharing between agencies and services?
- Are there adequate systems in place to monitor compliance with CPA policy?
- Do you offer adequate staff training on risks around clozapine administration?

Learning Lessons Bulletin - 24

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr A, who committed the homicide of his wife.

Key themes: communication, liaison with the CJS

Agencies and teams who might benefit from this bulletin:

- **Early Intervention in Psychosis Teams**
- **Adult social care**
- **Domestic abuse organisations**
- **The police and Ministry of Justice mental health units**

Case background

Mr A first came into contact with mental health services while on remand following his arrest for the rape and assault of his ex-wife. He received a diagnosis of paranoid schizophrenia and was subject to a hospital order under Section 37/41 of the Mental Health Act (MHA) and supervision from the Police Dangerous Persons Management Unit.

He was consequently treated with antipsychotic medication and reported no more psychotic symptoms. Mr A's ex-wife reported a history of violence and controlling behaviour towards her; as a result of this information being reported, Mr A started to become reticent to allow further exploration of his understanding of his illness. There was a comprehensive risk formulation that clearly indicated that while he was seen as suffering from a psychotic illness, there were aspects of his personality that indicated a high risk of violence to women. However, these risks were not necessarily related to mental illness.

Mr A was transferred to a different mental health unit and a programme of gradually increasingly leave. At this time, a healthcare Support Worker disclosed that she had developed a sexual relationship with Mr A; the view taken at the time was that Mr A was seen as the victim in the situation. There were no signs of any psychotic symptoms or relapse in mental state at this time.

Mr A was conditionally discharged to community mental health services the following year. He was allowed to travel out of the country several times on compassionate grounds.

Mr A was seen two days before the incident, with no reported psychotic symptoms or concerns about his mental health. A large amount of unused antipsychotic medication was found in the house following the incident, so it appears likely that he had not been taking his medication.

Key findings

Multi-agency communication

- The formulation of Mr A's presentation was communicated sufficiently on his transfer between mental health units. However, he showed a degree of skill in successful subversion of boundaries and these were not always addressed effectively, or communicated clearly to the Ministry of Justice (MoJ).
- There was a significant missed opportunity to review risk assessments and communicate effectively with the MoJ following the development of the relationship with the staff member. The move to community care from the mental health unit was not managed in a way that provided detailed information and robust care planning.
- The Trust was not commissioned to provide a community forensic team, and Mr A's care was allocated to the caseload of a generic Community Mental Health Team (CMHT) which lacked the knowledge and resources to adequately supervise his care and manage risk. Consequently, the resulting care plans did not reflect the previous risk assessment and formulation.

- The GP practice did not have any contextual information about Mr A. Primary care were not seen as partners in the overall plan of multi-agency care.

Cross-cultural issues

- Care planning and communication was not culturally sensitive, and did not foster open communication with the family.

Key learning points

1. All risk management information should be included in care planning.
2. The healthcare unit must ensure that all the expected standards are met when arranging conditional discharges for patients on Section 37/41, including communication with the local GP.
3. Trust forensic teams should include effective supervision structures, audit of family contacts, and quality standards for MoJ reporting.
4. There must be primary care involvement in the multi-agency public protection arrangements (MAPPA) process for appropriate individuals.
5. Healthcare units must ensure that standards for reporting to the MoJ regarding the progress of conditional discharged patients are maintained.
6. Race and ethnicity, gender and religious issues should be routinely addressed in Care Programme Approach (CPA) needs assessments and care planning.
7. The perspective of families and the provision of collateral information should be included in care planning. Appropriate cultural awareness should be applied when communicating with families.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- Are your staff appropriately supported to deal with this individual?
- Have you considered the patient's cultural background and adjusted your approach accordingly, taking into account cultural norms when communicating with the patient and their family?
- Have you collated and reviewed all historic and current risk information, incorporating ongoing contact with the patient's family? Do your findings demonstrate professional curiosity about all aspects of the patient and their life?
- Are your systems communicating appropriate information with other agencies, e.g. MoJ?

Governance focused learning

- What assurances do you have that discharges from services are planned, safe and in keeping with guidance?
- Are there systems in place to ensure communication with the MoJ is timely and accurate?

Board assurance questions

- What assurances do you have that race and ethnicity, gender and religious issues are addressed in CPA needs assessments and care planning?
- What assurances do you have that risk assessments for high-risk service users are completed to the required standards?
- What assurances do you have that NICE guidance is adequately adhered to?
- What assurances do you have that all staff are strictly adhering to professional boundaries in all aspects of their work?

System learning

- How are you supporting improved information sharing and communication between agencies and services?
- Does this system have robust multi-agency processes to support and supervise individuals with complex needs in the community?
- Do you offer appropriate and up-to-date training on cultural sensitivity to all staff?
- How are you ensuring robust supervision of mentally disordered persons living in the community?

Learning Lessons Bulletin - 25

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user A, who committed the homicide of her partner.

Key themes: communication, safeguarding, discharge planning, medication management

Agencies and teams who might benefit from this bulletin:

- **Early Intervention in Psychosis teams**
- **Transition planning services**
- **Local authority mental health teams**

Case background

Service user A had a history of depression and was diagnosed with persistent delusional disorder (PDD) . She was treated in the community and was detained and admitted to hospital on four occasions due to poor compliance with medication, a fixation on physical issues and clear paranoid and persecutory delusions.

Her partner's safety and his ability to speak freely in front of A was a concern raised by her family. It was previously reported that she had tried to poison him on multiple occasions.

Just prior to the incident, A asked to be discharged from services. This request was supported by her partner. She was deemed to have capacity and her discharge was agreed by the Care Coordinator and team manager, without the involvement of medical staff. The incident took place shortly after discharge.

Key findings

Communication and safeguarding

- A single, comprehensive summary or overview of service user A's past and recent concerns and presentation to services was not available. Ideally this would have included key symptoms, identified risks, relapse signatures, and potential safeguarding and third-party concerns.
- There were limitations in multidisciplinary working and a lack of process for the allocation of, and handover to, Community Mental Health Team (CMHT) Care Coordinators, which exacerbated this lack of collective knowledge relating to risk-relevant clinical issues. As a result, frontline staff were not fully aware that service user A's partner felt unable to speak freely to staff in her presence.
- There were missed opportunities to safeguard A's partner through formal safeguarding processes and a lack of recognition that domestic violence and/or abuse was a risk.

Care Programme Approach (CPA)

- The CPA policy was not applied when service user A requested discharge from mental health services. The CPA policy and relevant procedures were not embedded in practice.

Key learning points

1. There should be effective communication between team members about risks for service users. This should include ensuring that CMHTs have access to dedicated senior medical expertise. Where there is a handover of care in multidisciplinary working, there must be effective pathways in place to ensure that the receiving staff are fully aware of any risks. A one page summary within the electronic record system would support this and would enable any practitioner to understand at a glance the key risk factors and relevant information about the service user.

2. Trust policies and procedures should be reviewed to ensure that staff know how to recognise, respond to, and safeguard all parties in domestic violence situations. All policies and procedures must adequately adhere to NICE guidance.
3. Trust staff should fully understand mental capacity, how to apply the MCA, and its relationship with the MHA. This is especially important where there are complex clinical cases with delusional or other morbid beliefs which may affect the person's ability to consent to treatment.
4. Trust staff must properly apply the principles of the CPA on discharge, to ensure their MDT review and a comprehensive discussion and recording of the relevant issues, including the concerns raised by the family, and agreement about the care plan and way forward.

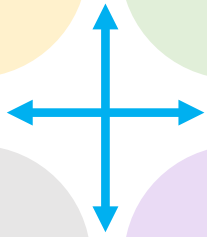
Learning Quadrant – individuals and all agencies

Individual practice reflections

- Does the risk assessment sufficiently consider risk of violence to others and include robust safeguarding interventions?
- Are there clear plans that have been shared with the patient about how they will access medication?
- How will compliance with medication be monitored, and how would you manage non-compliance?
- Do you listen to partners and family members as well as the patient? Do your findings demonstrate professional curiosity about all aspects of the patient and their life?

Governance focused learning

- Are there clear systems for working together and the sharing of knowledge and skills?
- What assurances do you have that discharges from services are planned, safe and in keeping with guidance?
- What assurances do you have that key policies around risk, CPA and safeguarding are embedded in practice?



Board assurance questions

- What assurances do you have that risk assessments are completed to the required standards?
- What assurances do you have that sufficient safeguarding measures are implemented to protect family members from harm?
- How do your services recognise and respond to the risks of domestic abuse?
- What assurances do you have that NICE guidance is adequately adhered to within all local policies and procedures?
- Are there information sharing agreements and joint working practices with other key agencies?

System learning

- How are you supporting improved communication and information sharing between agencies and services?
- Do you have robust transition processes that support effective discharges into the community?
- Do you offer appropriate and up-to-date training to all staff on mental capacity, the MCA and its relationship with the MHA?

Learning Lessons Bulletin - 26

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr N, who committed the homicide of a peer, Mr L, at the unregistered supported accommodation where they were residents.

Key themes: discharge planning, medication management, care planning

Agencies and teams who might benefit from this bulletin:

- **Children and Adolescent Mental Health Services**
- **Secure units for young people**
- **Early Intervention in Psychosis teams**
- **Local authority Leaving Care teams**
- **Mental health commissioners**

Case background

Mr N was 18 years old at the time of the homicide, and under the care of an Early Intervention in Psychosis Service (EIPS). He lived in unregistered supported accommodation that was commissioned by the local authority and was on bail for a number of offences.

Mr N had been using cannabis from a young age. At the request of his parents, he had been under the care of his local authority under Section 20 of the Children Act 1989. Mr N was described as a quiet and vulnerable individual and he may have been in a gang or influenced by gang culture. Mr N had a history of offences that included possession of a bladed weapon in public and theft.

Mr N was under the care of Child and Adolescent Mental Health Services (CAMHS) when he was detained to a young persons mental health secure unit under the Mental Health Act (MHA) and diagnosed with first episode psychosis. Prior to his discharge from hospital, he was prescribed antipsychotic medication in a depot injection, but he was not established on this before he was discharged.

The local authority Leaving Care team supported Mr N and his family post discharge. EIPS were reluctant to accept Mr N because he was not yet 18, so Mr N was placed under the interim care of CAMHS.

Mr N's engagement with CAMHS was limited. After committing several criminal offences and displaying non-compliance with his medication, it was agreed that the EIPS would consider completing an assessment under the MHA and look for suitable accommodation for Mr N. The EIPS had no face-to-face or telephone contact with Mr N. He was reviewed on a weekly basis in the EIPS multidisciplinary team (MDT) meetings and he was assessed as being at a high level of risk of a relapse in his mental health because of his non-compliance with medication and disengagement from services. However, no robust plan was put in place to engage with Mr N.

Mr N was briefly housed in a bail hostel and the family home before moving to the unregistered supported accommodation. Mr L was also a resident at the accommodation and there were tensions between them. The day before the incident, Mr N had been taken to the local A&E by ambulance for an injury to his mouth. It was unclear how he sustained this injury and he did not stay for treatment.

Admission and discharge arrangements

- The procedures for admission to a secure CAMHS unit were inappropriately flexible, allowing an admission to take place under the MHA without the required commissioning oversight. An unstructured discharge process then followed which led to Mr N not being given the appropriate treatment.
- In preparation of Mr N's discharge from the inpatient mental health service, there was a lack of effective interagency working between NHS mental health services and local authority structures. This resulted in unstable accommodation, contributing to a lack of effective assessment and care planning. There was no relapse plan in place, identification of clear relapse indicators or a contingency plan.

Medication management

- Licensed medications for the treatment of psychosis for the under 18s are very limited, particularly as depot prescriptions. More research is needed to guide the use of antipsychotic oral and depot medication in under 18s.

Bullying and gang culture

- Despite system-wide programmes in place to identify and intervene in child criminal exploitation (CCE), grooming and radicalisation, there was a lack of curiosity about the 'red flags' in this case. It was clearly possible for these issues to be hiding in plain sight, but systems should be much more aware of the issues at hand, and the risks posed to vulnerable young people by these criminal gangs.

Key learning points

1. Prior to discharge from impatient units for young people, there must be clear plans developed with the young person and community services about how the patient will access prescribed medication; consideration given to the young person's accommodation needs; robust communication and agreement with other agencies; and the patient's family.
2. Discharge planning should be benchmarked against the relevant national guidance.
3. The Care Programme Approach (CPA) must be fully adhered to and there should be joint working agreements with other organisations including how information about risk and care planning is shared. All young people prescribed long-lasting antipsychotics should have a plan in place that describes how the depot will be provided and how missed doses will be managed.
4. Assessment and care planning policies and procedures must be designed to reflect the family perspective and incorporate policy expectations regarding risks to family members.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- Is the care provided driven by the needs of the patient, not the service?
- Are your risk assessments and plans up to date? Do they demonstrate your professional curiosity about all aspects of the patient's life?
- Are there clear plans that have been shared with the patient about how they will access medication? How will compliance with medication be monitored and managed?
- Are you liaising effectively with other services who are supporting patients on your caseload, e.g. CAMHS?

Governance focused learning

- Do you have proper arrangements for supervision of CAMHS and EIPS team staff?
- Are there clear systems for working together, and the sharing of knowledge and skills?
- How do you monitor the quality of service provided by Tier 4 and community CAMHS and EIPS teams?
- How are discharges from Tier 4 care managed?

Board assurance questions

- What assurances do you have that the care of young people in transition to adult services follows best practice (i.e. NICE guidance)?
- What assurances do you have that risk assessments are completed to the required standards?
- What assurances do you have that discharges from your inpatient units are robust?
- Do you regularly consider readmission rates or incidents involving patients recently discharged from an inpatient unit?

System learning

- Do you have systems and services that support young people to access appropriate inpatient services close to their home?
- Do you have robust transition processes that are inclusive of all community services, e.g. social care?
- Are EIPS commissioned to reach younger people with emerging psychosis?
- Do you have robust multi-agency policies that address child criminal exploitation (CCE) and county lines?

Learning Lessons Bulletin - 27

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr K, who committed the homicide of Mr P, who worked at a local chapel.

Key themes: misuse of MHA, communication and coordination

Agencies and teams who might benefit from this bulletin:

- **Mental health commissioners and liaison services**
- **Approved Mental Health Professionals**

Case background

Around a year prior to the incident, Mr K saw his GP for a planned appointment, during which he presented with behaviours that the GP considered to be delusional and paranoid. The GP referred Mr K for a Mental Health Act (MHA) assessment and got in touch with the Approved Mental Health Professionals (AMHP). He recommended a face-to-face assessment for Mr K. The following day, the Home Treatment Team (HTT) contacted Mr K but they were not able to arrange a face-to-face appointment. Mr K denied any mental health problems. The HTT documented that it was likely he held some long-term and chronic suspicious beliefs.

The GP reiterated his concerns about Mr K's paranoid delusions. The GP documented that he understood that the HTT would arrange for a MHA assessment due to Mr K's lack of insight. However, the AMHP team and HTT concluded that it was not appropriate to proceed with a MHA assessment.

The GP expressed his frustration at the lack of action from mental health services. The HTT advised that they had tried again to arrange a face-to-face appointment with Mr K, but he had again refused. As a result, the HTT documented that it was evident that Mr K was delusional, but that it was difficult to assess whether this was a new or longer-term presentation.

The referral was discussed again with the AMHP hub, but they did not feel that Mr K required a MHA assessment. There was no further contact with mental health services until the incident.

Key findings

Referrals and response

- There should have been a more proactive and robust response from the health and social care system following the GP's request for an urgent MHA assessment. The GP made extensive attempts to secure an assessment and believed that Mr K would be followed up by mental health services, even if a MHA assessment was not conducted. The local authority also did not properly discharge their duty under Section 13 MHA.
- Despite Mr K being seen by a GP with experience in mental health care, his assessment was not given sufficient weight by Trust and local authority staff who had not assessed Mr K. When mental health staff did make contact with Mr K they did not take the advice of the GP, which was to make face-to-face contact, not telephone contact.

Management of delusional disorders

- Mr K presented with a delusional disorder that appears to have been persistent in nature. Had a proper assessment of his mental state been undertaken, it would have been more likely that this delusional disorder could have been identified. The way that Mr K's delusions manifested around the time of his interactions with the GP and the AMHP were similar to those described following the incident.

Key learning points

1. Trusts, clinical commissioning groups (CCGs) and local authority partners should work together to better understand MHA assessments, and the reasons behind a reduction in the number of them. There also needs to be full understanding of what happens to those service users who are assessed but not detained under the MHA, and how their mental health needs are being met.
2. The AMHP service working practices should comply with the Mental Health Act Code of Practice.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- Have you listened to other staff members and given their patient assessment sufficient weight?
- Are your systems communicating appropriate information with other key agencies?
- Have you collated and reviewed all historic and current risk information? Have you demonstrated professional curiosity about all aspects of the patient and their life?

Governance focused learning

- Are there clear systems for working together and the sharing of knowledge and skills?

Board assurance questions

- Are there information sharing agreements and joint working practices with other key agencies?

System learning

- How are you supporting improved information sharing between services?
- Does the system have robust multi-agency processes to support individuals in crisis in the community?
- Do you offer appropriate and up-to-date training to all staff on MHA assessments?

Learning Lessons Bulletin - 28

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user W, a young person who had been subject to criminal exploitation by a drug gang and committed the homicide of G.

Key themes: safeguarding, risk assessment, communication and coordination

Agencies and teams who might benefit from this bulletin:

- **Child and Adolescent Mental Health Services**
- **Safeguarding partnerships**
- **Youth offending services**

Case background

W first began using alcohol, cannabis and other illicit drugs after a difficult transition to secondary school. His first contact with Child and Adolescent Mental Health Services (CAMHS) took place shortly after, following a referral from a School Nurse. While W was at school, his family had significant concerns about his safety as a result of episodes of agitation, low mood and suicidal ideation. He was referred by the police to the local Youth Justice Liaison and Diversion Service (YJLDS). Shortly after, W was the victim of an assault, implied to be of a sexual nature, but this was not acted on.

Soon after he had left school, W was arrested on suspicion of involvement in an attempted robbery. He was assessed by a Senior Nurse Practitioner from the local Trust's CAMHS, to whom he disclosed recent thoughts of suicide and related behaviour. W did not attend follow-up CAMHS appointments. He was briefly reported as missing by the reparations team following periods of disappearance lasting for days at a time.

Youth offending team support was extended to W while he was on police bail relating to a betting shop robbery, and W's keyworker in the drug service successfully facilitated his participation in therapeutic work for his substance misuse. However, W continued to refuse appointments with CAMHS.

W was involved in an accident which meant that he was unable to continue his work placement. After this accident, W's drug use and links with criminality became more established and his relationships with family members became more strained. CAMHS decided that W should be referred to adult mental health services given his age and the need for long-term intervention highlighted by YJLDS. There was confusion over the next two months as the local mental health services assessed and reassessed W.

Following a confusing CAMHS assessment, W made a serious suicide attempt and was admitted voluntarily to an inpatient CAMHS facility. while there, he disclosed guilt about drug misuse and gang-related activity and a wish to dissociate himself from it to the Trust's Early Intervention team (EIT).

Two months after engaging with the EIT, W told professionals that he had been feeling better and was going away to find work. Soon after, however, he became verbally aggressive towards his family. He did not attend many of his youth offending team appointments over the following months and was issued with a formal warning about non-compliance with the order. Days later, a few weeks after his discharge from the early intervention team, W killed G.

Safeguarding

- There were missed opportunities by the youth offending services and the Trust to invoke safeguarding procedures. There were references to a sexual assault and repeated threats from others, but none of the involved services appear to have expressed curiosity about how much of W's presenting symptomatology was connected to these external threats. The main approach was advice to W, who was still a child during most of the period under consideration, to avoid his previous "*friends*".

Risk assessment and management

- The Trust's risk assessments could have included more information and there could have been much better coordination of the services involved in repeatedly assessing W, few of whom offered him and his family the support they needed. Closer joint working between Trust services and the youth offending team would have been of benefit to W and his family.
- If they were not going to engage in direct work, CAMHS should have taken a consultative brief with the other services to help them manage risk. CAMHS should have helped the other services create a longer-term management plan for W. This leadership and coordination role was needed particularly during the confusing multi-agency episode preceding the involvement of the EIT.

Engagement

- There were multiple barriers to engagement in W's case. Coordination of care within and between services was inadequate. Services should have demonstrated better awareness of the manifestations of county lines child criminal and sexual exploitation and of the multi-agency frameworks available to children and their families.

Key learning points

1. When safeguarding issues are raised by children, young people and their families, staff members must follow the safeguarding policy.
2. The interface between CAMHS, substance misuse and youth offending services should be seamless. Substance misuse and youth offending services should not be seen as separate, but as essential components of a comprehensive service for young people.
3. Protocols for service transitions should be well designed and adhered to; the basic principle should be that the services follow the patient and artificial boundaries do not hinder the meeting of clinical need.
4. When a transfer is made from one service to another, the referring service should ensure that the patient is appropriately reviewed and treated by them until the new service takes over. The two services have a responsibility to ensure that they effectively communicate with one another.
5. Trusts should formally educate staff working with young people about drug and gang culture, with particular reference to the mental health implications, safeguarding implications and risk assessment of county lines gangs and their potential impact on vulnerable young people.

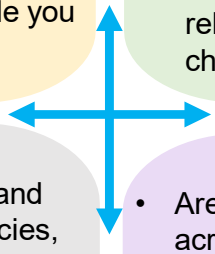
Learning Quadrant – individuals and all agencies

Individual practice reflections

- Are your care plans regularly reviewed and do they contain clear instructions for communication with other agencies?
- Does the risk assessment sufficiently consider risk of violence to others and include robust safeguarding interventions?
- Are you aware of the threat of county lines drug gang exploitation to vulnerable young people you may have in your care?

Governance focused learning

- How do you know that teams from different Trusts are working together well, particularly in periods of transition and transfer of care?
- Are incidents of violence and threat towards the service user given appropriate consideration and acted on?
- Are your risk escalation thresholds and triggers reliable when service user circumstances change?



Board assurance questions

- Are there information sharing agreements and joint working practices with other key agencies, e.g. substance misuse and youth offending services?
- Are you confident that there is appropriate liaison between Trust services and primary care in relation to the management of service user's treatment?
- What assurances do you have that sufficient safeguarding measures are implemented to protect any vulnerable individuals?

System learning

- Are there clear expectations of joint working across local authority and mental health in the care and treatment of young people?
- Does the system have robust multi-agency processes to support challenging individuals with complex needs in the community? What would improve this?
- What assurances do you have that staff training includes adequate focus on drug and gang culture and the effects of this on a service user's presentation?

Learning Lessons Bulletin - 29

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr P, who committed the homicide of his friend Mr G.

Key themes: risk assessment, care planning

Agencies and teams who might benefit from this bulletin:

- **Mental health provider services**
- **Community forensic services**
- **Local authority mental health teams**
- **Substance misuse services**

Case background

Mr P is an individual with complex mental health and substance misuse problems who has been well known to mental health and substance misuse services for some time. He is unable to recall most of his 20's due to significant drug use, and has reported that he was unemployed for 10 years.

Mr P was referred by his GP to the Drug and Alcohol service multiple times in the three years prior to the incident, and spent some time in a detoxification and stabilisation unit. He requested a methadone prescription. He reported to his GP that he was low in mood, experiencing thoughts of self-harm and suicide and was hearing voices. Mr P was subsequently commenced on other medication.

A Drug and Alcohol Service risk assessment documented that Mr P had a history of assault when he was intoxicated and identified him as a vulnerable person due to a lack of support. He continued to abuse drugs and alcohol. Risk of suicide was documented and the GP also documented a recent suicide attempt. Mr P was referred to the Home Treatment Team (HTT) and staff reported that they considered Mr P's voices to be pseudo-hallucinations rather than psychosis.

Mr P was discharged from the HTT into the care of the Community Mental Health Team (CMHT) and his GP, and awaited allocation to a Care Coordinator. A Consultant Psychiatrist documented that there were no clear symptoms of schizophrenia but that Mr P had complex mental health issues including emotionally unstable personality disorder, psychosis, query ADHD and probable autistic spectrum disorder. Staff tried on a number of occasions to see or speak to Mr P, but he often did not respond or attend appointments. Mr P continued to wait for a Care Coordinator to be allocated to him.

Mr P appeared physically unwell. The clinical manager reported that Mr P was using substances to manage an increase in auditory hallucinations and that his mental state was deteriorating. A Mental Health Act (MHA) assessment was requested but declined. The incident was discovered a few days later.

Key findings

Compliance with NICE guidance

- Mr P did not receive NICE compliant treatment for the management of his psychosis. The lack of a supportive and empathic relationship with a Care Coordinator was a significant absence in Mr P's treatment plan. Mr P also did not receive care and treatment for post-traumatic stress disorder (PTSD) that was compliant with NICE guidelines.

Risk assessments

- Mr P's risk assessments were poorly completed, and were missing pertinent information. His risk assessments were appropriately reviewed during contact with inpatient services and the HTT; however, there is no evidence of any risk assessments being completed or reviewed in the year prior to the incident. Mr P waited more than 120 working days for a Care Coordinator to be allocated and in this period his risk was not reviewed; this was a breach of policy.

Care planning

- There was consistently poor care planning and care planning was not completed in accordance with the Care Programme Approach (CPA). Mr P was not always present for CPA review meetings and it is unclear how Mr P could have remained on CPA when the decision had been taken to discharge him into the care of his GP. These two factors are incompatible and therefore in breach of policy.
- There was also an absence of crisis and contingency plans which is concerning given that Mr P frequently disengaged with services and then presented when in crisis.
- There was no link between Mr P's care plan and the Community Order with Mental Health Treatment Requirement, and there was an inappropriate response to the MHA assessment request.

Service delivery

- There was a significant delay in allocating a Care Coordinator to Mr P. Trust staff did not comply with organisational policy about remaining in contact with patients who were waiting to be allocated to a Care Coordinator.

Key learning points

1. Care and treatment for psychosis, schizophrenia and PTSD should be delivered in accordance with the relevant NICE guidelines.
2. Risk assessments and discharge decisions should be undertaken and documented in accordance with organisational policy.
3. Crisis/contingency plans should clearly describe the actions required by patients and staff when a patient is in crisis.
4. A system should be put in place to ensure that any patient waiting longer than 10 days for allocation to a Care Coordinator is identified, and the issue escalated to an appropriate manager for action.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- How much do you consider the possible contribution of the underlying mental illness when dealing with patients who have a dual diagnosis, e.g. substance misuse and mental health problems?
- Does the risk assessment sufficiently consider risk of violence to others and include robust safeguarding interventions?
- Are your systems communicating appropriate information to other agencies, e.g. National Probation Service?
- How do you manage alcohol and substance abuse? Do you incorporate joint working with the Drug and Alcohol Service?

Governance focused learning

- What assurances do you have that discharges from services are planned, safe and in keeping with guidance?
- What assurances do you have that key policies around risk, CPA and crisis/contingency are embedded in practice?
- Are there clear systems for working together and the sharing of knowledge and skills?

Board assurance questions

- What assurances do you have that NICE guidance is adequately adhered to within all local policies and procedures?
- Are there information sharing agreements and joint working practices with other key agencies?
- How do you know that risk management plans are collaboratively developed, understood and shared with all those involved in a high-risk individual's care?

System learning

- How are you supporting improved information sharing between agencies and services?
- Does the system have robust multi-agency processes to support individuals in crisis in the community? What would improve this?
- Do you offer appropriate and up-to-date training to all staff on the importance of adhering to NICE guidelines?

Learning Lessons Bulletin - 30

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user M, who committed the homicide of her child.

Key themes: risk assessment, safeguarding

Agencies and teams who might benefit from this bulletin:

- **Mental health provider services**
- **Early Intervention teams**
- **Safeguarding partnerships**

Case background

M had a history of nerve pain, migraines and asthma. She developed fibromyalgia and chronic back pain in the few years before her first pregnancy. She was reluctant to take psychiatric medication and preferred to use cannabis, which she believed helped with pain control.

Over the two decades prior to the incident, M moved GP surgery three times. She was referred for physiotherapy and prescribed many different medications. Prodromal or negative symptoms of schizophrenia may have been missed because some of the symptoms were attributed to fibromyalgia. GP records note "*severe depressive episode with no psychosis*".

There are no notes of antenatal or postnatal care around the birth of her first child. Three years later, M attended the GP surgery with the child's father, F, saying she was unable to cope, that she had depression and was again awaiting pain management help. She was referred to a pain management clinic and to an Improving Access to Psychological Therapies (IAPT) service but did not engage. Her diagnosis at this time was non-organic psychotic disorder.

M was later diagnosed as suffering with severe depression and severe anxiety. She took a serious overdose of her prescribed medication and presented at A&E. As a result, she was referred to the Rapid Assessment Interface and Discharge team (RAID). The RAID assessment reported that she had a three-year history of paranoia and visual hallucinations, with delusions that were not fixed but constantly returning. It was stated that she required further assessment of psychosis and appropriate intervention.

M's parents contacted the RAID team and reported a deterioration in M's mental health. She was regarded as suffering from a "*major anxiety disorder*" which also interfered with her sleep; she continued to use cannabis as well as her medication. She was subsequently allocated a Care Coordinator and her mother was offered carer support. Risk assessment and care plans were unchanged.

M continued to report delusions and paranoia. A Care Programme Approach (CPA) meeting followed and the care plan was updated. She had regular input from the Care Coordinator. M displayed signs of a relapse of her psychotic illness. The incident took place shortly after.

Patient factors

- M described a long-term diagnosis of fibromyalgia and used cannabis to manage pain. Her psychotic symptoms had responded well to antipsychotic medication, although this exacerbated her chronic pain. She had a preference for holistic approaches to her health and was reluctant to take antipsychotic medication.

System factors

- There were delays in prescribing antipsychotic medication. When M and her mother attended A&E to obtain antipsychotic medication, they were informed that the Mental Health Liaison team did not prescribe out of hours. They were directed to her GP to request medication, but no feedback was given to the GP.

- Some of the staff involved had not completed mandatory refresher training and some staff were not compliant with receiving mandatory supervision.
- When M was reported by family to be showing signs of relapse, there was no structured team approach, such as a traffic light system. The care and risk management plans were not effective in treating her condition or mitigating risk. The views of family members were not routinely sought, and actions were not taken on family views where they were provided.

Risk assessment

- The assessment of risk did not include any exploration of the makeup of the household, or the potential impact of M's mental health issues on her children. Her children are noted to be "*protective factors*" without any depth of assessment. The history taking should have identified the extent of her previous lack of functioning and the need for F to move back in with M as she could not cope a few years prior to the incident; this should have been taken into account in terms of considering parenting capacity and risk to the children.
- M attributed an increase in physical symptoms to her psychiatric medication, and this was accepted at face value by the Early Intervention Team (EIT), without exploration with M, the family or the GP. This contributed to some diagnostic overshadowing, and a lack of consideration that an assessment of negative symptoms of schizophrenia was needed as well as the impact of these on her daily functioning and ability to meet the needs of her children.

Key learning points

1. Early Intervention Teams (EIT) must meet the expectations of best practice guidance and standards.
2. The Community Mental Health Teams (CMHTs) should have a structure and systems for responding to relapse or an increase in risks, such as a clinical traffic light rating tool.
3. If there are children in the household, there must be an exploration of living arrangements and relationships. Children should not be regarded simplistically as a protective factor.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- Have you collated and reviewed all historic and current risk information?
- Does the risk assessment sufficiently consider risk of violence to others, including children, and include robust safeguarding interventions?
- Is there a reliable structure in place for responding to relapse or increase in risk?
- How will compliance with medication be monitored? Has the patient been offered the appropriate medication to fit their needs and preferences?

Governance focused learning

- How is family intervention managed for families of patients with psychosis, and is it in accordance with NICE guidelines?
- Is your 'Think Family' approach well understood and embedded? How do you know?

Board assurance questions

- What assurances do you have that risk assessments are completed to the required standards? Are there clear procedures in place to address risk to family members?
- What assurances do you have that sufficient safeguarding measures are implemented to protect the family from harm?

System learning.

- Have all staff received up-to-date refresher training? Do all staff members receive adequate supervision?
- Does the system provide support for patients who are reluctant to engage with standard medical treatments and prefer a holistic approach to healthcare?
- Is there regular communication with primary care about mental health care plans?

Learning Lessons Bulletin - 31

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr J, who committed the homicide of a man involved in a drug transaction.

Key themes: care planning, communication and coordination, safeguarding, discharge planning

Agencies and teams who might benefit from this bulletin:

- **Early Intervention in Psychosis teams**
- **Substance misuse services**
- **Mental health commissioners**

Case background

Mr J was initially referred to secondary mental health services by his GP three years prior to the incident. He presented with thoughts of self-harm and harming others but denied having acted on these. He described a history of using illicit drugs. He was accepted onto the caseload of the Trust's Early Intervention in Psychosis Team (EIPT); the impression at assessment was of a mental and behavioural disorder due to street drug use.

He was asked to leave the family home and became estranged from his family and at risk of homelessness. A residential drug rehabilitation placement broke down and he was placed in social housing accommodation. He reported being afraid of people who continually called at his flat, whom he said had a grudge against him. He would not give any names, and these were not reported to the police or addressed under safeguarding policies.

Mr J continued to use illicit substances while under the care of the EIPT. He was discharged after three years of contact with the EIPT, without a discharge Care Programme Approach (CPA) review meeting.

One month after discharge, Mr J was arrested along with four other men following the homicide of a man involved in a drugs transaction.

Key findings

Treatment plans

- Care plans were not reviewed using outcome measures, or in a timely and meaningful way. Interventions did not adhere to expectations of relevant NICE guidance.
- There was no formal review of diagnosis during his care, and no medical reviews were carried out for a year, despite there being plans for discharge. Care coordinator contact was intermittent with long gaps with no contact.
- Better inter-agency working could have provided Mr J with support particularly with regards to his vulnerability to pressure from peers and others in the local drug culture. At this time there was less awareness of the emerging phenomena of criminal exploitation known as county lines and cuckooing in relation to drug dealing.
- It could be seen that Mr J was at risk of exploitation by drug dealers, particularly as he spoke of people threatening him and being afraid to talk to the police because of threats to his family.
- Formal safeguarding procedures were not followed through. Mr J would not disclose any names, and because of this it was felt that the police could not be informed.

Discharge process

- The CPA policy was not followed in the planning of Mr J's discharge; there were no medical review or discharge planning meetings. His GP was not invited to contribute to discharge plans and was later informed that discharge had taken place. Neither the accommodation provider, substance misuse service or housing service were involved in discharge planning.

- EIPT had developed an informal step in the discharge planning process which had not been agreed by the Trust and was not described in the operational policy.

Partnership working

- The Trust did not have an agreed partnership working arrangement with substance misuse services in the locality. This meant that it was not clear how communication about Mr J's care should be shared.
- EIPT did not contact the police to discuss Mr J's vulnerability, and there was no strategy to address working with vulnerable people who did not want police involvement.
- Care plans did not incorporate contact with all agencies involved in Mr J's care, and there were missed opportunities to develop a care plan that included perspectives from all the other agencies involved.

Service factors

- The pathways for communication between the providers of substance misuse services and the Trust locally were not well established.
- The EIPT operational policy had not been reviewed in a timely way, and the service had developed informal pathways of care that were not monitored.
- There was a lack of oversight of the quality of the service, particularly in relation to regular medical reviews, Care Coordinator contacts and the implementation of the CPA policy.

Key learning points

1. Patients under the care of EIPT must receive care and treatment that meets the expectations of NICE guidance for first episode psychosis.
2. EIPT should meet the requirements of the CPA policy regarding discharge from secondary care, and there should be systems in place to monitor this.
3. Trust staff training should include awareness of risks regarding patients who appear to be under duress due to criminal exploitation/cuckooing/county lines.
4. Formal safeguarding procedures should be followed through. Guidance should be developed and provided for the management of safeguarding issues and safety concerns where the individual refuses the involvement of the police. The safeguarding policy should be fully implemented in EIPT.
5. Robust monitoring systems should be in place that evidence that CPA policy standards are maintained.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- Do your care plans contain clear instructions for communication with other agencies?
- If the individual mentions that they are afraid of other people in the community, how much professional curiosity should you use?
- How do you know whether these are real fears or expressions of mental health issues? What would trigger you to undertake a fresh look at risks?

Governance focused learning

- Do you have proper arrangements for supervision of Care Coordinators?
- Are your operational policies in date and reviewed regularly?
- Does your discharge planning include: psychiatric review with clear diagnosis and recommendations for future care; liaison with primary care, substance misuse and housing providers?

Board assurance questions

- What assurances do you have that Care Coordinators are fully equipped, supported and supervised to deliver this challenging and important role?
- How do you know that risk management plans are collaboratively developed, understood and shared with all those involved in the care of people in EIPT?
- Are there information sharing agreements and joint working practices with other key agencies?

System learning

- Does the system have robust multi-agency processes to support challenging individuals with complex needs in the community? What would improve this?
- Does the system provide appropriate support for individuals with complex needs living in the community?
- Are the resources properly skilled and competent to deal with this behaviour?

Learning Lessons Bulletin - 32

Independent investigation

Introduction

This document provides an overview of findings from a joint Domestic Homicide Review and independent investigation into the care and treatment of service user Mr M, who committed the homicide of his mother.

Key themes: communication, discharge planning, medication management, risk assessment

Agencies and teams who might benefit from this bulletin:

- **Mental health provider services**
- **Substance misuse services**
- **Safeguarding partnerships**

Case background

Mr M had a long history of paranoid schizophrenia, harmful use of amphetamine and cannabis, and dependency on stimulants. In the time that Mr M had been under the care of mental health services, he had been prescribed a range of antipsychotic medication including depot medication and clozapine. Mr M also had a history of offending, both as a juvenile and as an adult.

Approximately two years before the incident, Mr M was being managed by the Community Mental Health Assessment and Recovery Team (CMHART) under the Care Programme Approach (CPA). He had an allocated Care Coordinator but the Care Coordinator was absent from work for a period of six months in the year before the incident. An interim Care Coordinator was not identified, and Mr M was managed through the CMHART duty system.

Mr M reported having daily thoughts of suicide. The Associate Practitioner said that he did not observe any evidence of psychosis, despite Mr M informing him that he was constantly hearing voices. Mr M was drinking heavily and sporadically abusing substances. Concerns were raised by his parents and the Consultant Psychiatrist concluded that Mr M was an imminent risk to others and a potential high risk to himself. He was admitted to hospital following a Mental Health Act (MHA) assessment and discharged after several weeks. Mr M was arrested for Actual Bodily Harm (ABH) four months prior to the incident. Mr M had not been seen regularly or taken his prescription medication for around a six months prior to the incident.

Family involvement

- There were missed opportunities to explore whether Mr M required support as a carer or had any concerns about her own safety. No routine enquiries about domestic abuse were made and there was no referrals made for a carer's assessment. The GP practice did not have policies in place to support enquiries about domestic abuse or offer any risk assessment tools. Risk concerns were not conveyed in appropriate detail or incorporated into risk assessments. Adult child to parent violence and mental illness should be incorporated into domestic abuse strategies.
- There was a lack of detail and continuity in the police approach to communicating with other agencies about Mr M, given their awareness of his mental health issues and information about risk. Risk management considerations were not applied to his family. The family was not involved in care planning for Mr M, despite their requests to be involved and informed.

Communication

- The GP dealt with physical health issues but mental health concerns were dealt with completely by secondary care. Mr M's GP had very little communication from mental health services.
- The inpatient ward held the belief that Mr M's admission was as a result of his substance misuse. There was lack of continuity in care planning, admission, and discharge between the inpatient ward and CMHART. There was no liaison between the ward, CMHART or his family to plan and agree Mr M's discharge plan. There was poor communication following discharge.

Care Programme Approach (CPA)

- The CPA policy was not followed with respect to Care Coordinator provision, care planning and reviews, and Trust systems did not identify or address these deviations from expected policy within CMHART. There is no documentation of an evidence-based treatment plan that was in line with the NICE guidance *Psychosis and schizophrenia in adults: prevention and management*.
- In the 18 months prior to the homicide, no CPA review was completed for Mr M, and there was no holistic assessment of his needs. Mr M and his parents were not involved in the development of care plans in the 18 months prior to the incident.

Medication management

- The administration of depot medication was not recorded in the electronic clinical records. Depot medication was missed, and there was no robust system for ensuring these were administered at the correct times or that missed injections were followed up.

Risk assessment

- Mr M's risk assessments were not updated as expected by the Clinical Risk Policy and did not reflect current risks. The system for allocation of medical reviews was reactive and not fit for purpose, and waiting lists were lengthy and unmanaged. This resulted in a lack of medical oversight of Mr M's care.

Key learning points

1. Referrals for carer's assessments should be routinely part of care planning and risk assessment, and should be made by GPs when carer responsibilities are indicated.
2. Where an external referral is made for an adult at risk, the content of the referral should include all relevant detail. Safeguarding plans should be created for offenders identified as adults at risk and/or vulnerable.
3. For patients on the CPA, the GP practice should be kept informed of care planning, CPA reviews and developments. There should be systems in place to ensure consistent monitoring and maintenance of expected standards within the CPA policy.
4. Trusts should ensure that all patients receive depot medication as prescribed, and that records are made both in the medication chart and the electronic clinical record.
5. Families and carers should be appropriately involved in care planning and risk assessment.
6. Risk to families should always be considered as part of risk assessment and management, with collateral information from family members.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- How well do you know the triggers and markers for domestic abuse?
- Are your risk assessments and plans detailed and up-to-date?
- Do you have ongoing contact with the patient's family and are you listening to their concerns?
- How will compliance with medication be monitored? Has the patient been offered the appropriate medication to fit their needs?

Governance focused learning

- Do staff responsible for managing service users with forensic histories have access to specialist risk assessment tools and training?
- Are your risk escalation thresholds and triggers reliable when service user circumstances change?
- What assurances do you have that Trust electronic records contain accurate and up-to-date information for all patients?

Board assurance questions

- What assurances do you have that risk assessments are completed to the required standards? Are there clear procedures in place to address risk to family members?
- Are there information sharing agreements and joint working practices with other key agencies?
- What assurances do you have that NICE guidance is adequately adhered to within all relevant policies and procedures?

System learning

- Have you addressed the needs and risks of service users with a forensic history within your system so you can deliver appropriate care locally?
- Do your systems monitor compliance with policy and sufficiently include quality assurance?
- Do you have systems in place to ensure the consistent monitoring of expected standards within CPA policy?

Learning Lessons Bulletin - 33

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr J, who killed two of his neighbours and wounded one other.

Key themes: care planning, risk assessment

Agencies and teams who might benefit from this bulletin:

- **Early Intervention in Psychosis teams**
- **Substance misuse services**

Case background

Mr J had been under the care of the Early Intervention in Psychosis Team (EIPT) for a year prior to the incident. He had received treatment in the community and as an inpatient, and had been inconsistent in his reports of compliance with his medication.

Mr J had been allocated a Care Coordinator and was seen regularly for his medication to be reviewed. He was initially treated with oral aripiprazole. After several months under EIPT care, Mr J's mental state declined significantly and he was admitted to an acute mental health inpatient unit, where his medication was changed to monthly aripiprazole depot injection. Mr J appeared to be suffering from a psychosis that was possibly drug-induced. He admitted to having previously used significant amounts of cannabis.

On discharge from inpatient services, Mr J was initially seen by both the EIPT and the Crisis Resolution and Home Treatment Team so that assertive follow-up care could be provided. He frequently complained about receiving his medication via depot injection and made numerous requests to return to oral medication, which were later approved.

Concerns were expressed by Mr J's mother about his mental state when she reported that he had been using cannabis again and that he had not been taking his medication. At Mr J's last face-to-face assessment, his Care Coordinator documented concerns about his presentation being similar to when he had previously been unwell. He was irritable, agitated and guarded. Mr J's mother later contacted his Care Coordinator to express further concerns about Mr J, as there had been no face-to-face contact with Mr J himself. His Care Coordinator attempted to meet with him the following day, but Mr J stated he was not available.

Key findings

Care planning and delivery

- There was a lack of formal care planning and consideration of substance misuse issues, which should have been dealt with.
- Appropriate carer support was not offered to Mr J's mother. A carer's pack was provided to her when Mr J was admitted to hospital but there is no evidence that she was advised about her right to a formal carer's assessment.
- There was also a lack of structured risk assessments and management plans. There was insufficient oversight of risk following Mr J's transfer from depot medication back to oral medication, and an inappropriate response to Mr J's reluctance to engage with mental health services.

Service delivery

- There was a clear lack of management oversight of service provision within the EIPT. There was also a lack of timely completion of action plans and insufficient assurance of the effectiveness of actions taken.

Key learning points

1. Within the Early Intervention in Psychosis Service (EIPS), risk assessments and risk management plans should be completed, reviewed, updated and documented in accordance with organisational policy.
2. The Dual Diagnosis Policy must be understood and actively implemented by clinical staff.
3. Formal operational procedures should exist for all services, and those procedures should be reviewed within the appropriate timeframe in accordance with each Trust's own policy on the management of policies.

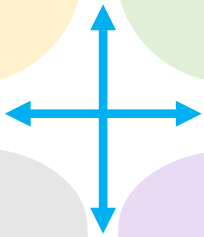
Learning Quadrant – individuals and all agencies

Individual practice reflections

- Have the appropriate risk management interventions been discussed with the family?
- How do you respond to a patient's reluctance to engage with mental health services?
- How will compliance with medication be monitored? How will you deal with non-compliance?
- How do you provide extra support for service users who struggle with addictions? Do you take this into account when assessing their risks?
- Have you offered the patient's carer appropriate support and considered a carer's assessment?

Governance focused learning

- Are your risk escalation thresholds and triggers reliable when service user circumstances change?



Board assurance questions

- What assurances do you have that risk assessments and management plans for high-risk service users are completed to the required standards?
- How do you know that risk management plans are collaboratively developed, understood and shared with all those involved in a high-risk individual's care?

System learning

- How might you recognise and take steps to address a rising risk profile across your system?

Learning Lessons Bulletin - 34

Independent investigation

Introduction

This document provides an overview of findings from an investigation into the care and treatment of service user Ms C, who committed the homicide of her neighbour.

Key themes: care planning, risk assessment, medication management

Agencies and teams who might benefit from this bulletin:

- **Mental health commissioners**
- **Community mental health teams**
- **Community forensic services**

Case background

Ms C had 25 years of (often limited) engagement with two mental health teams. Her first contact with mental health services was following the birth of her child. Her initial diagnosis was puerperal psychosis but she was subsequently diagnosed with bipolar affective disorder (BPAD). Throughout her experience with mental health services, Ms C was described as having poor insight into her illness and demonstrated intermittent engagement with her care teams.

Ms C was under the care of mainstream community mental health services and had an allocated Care Coordinator. Her partner was also a service user and was living with Ms C at the time of the offence.

Ms C had been admitted to hospital on more than 20 occasions, including several periods of detention under the Mental Health Act (MHA), an episode under the Supervision Register and two periods of care under a community treatment order (CTO). These admissions were often precipitated by relapses attributed to psychosocial triggers and non-compliance with prescribed medications. At times of relapse, Ms C often became violent and aggressive towards others and had a significant forensic history.

Varying antipsychotic depot medications had been prescribed to Ms C to support her with medication compliance. However, these were discontinued mainly due to her experiencing significant neuroleptic side effects. Predominantly, Ms C had been prescribed lithium tablets.

Just over a week before the incident, Ms C contacted her care team asking for help for her partner, who was experiencing a relapse in his mental health. Ms C's partner had caused damage to her property and she had raised concerns that living with him was affecting her own mental health. Ms C received her last visit from her Care Coordinator a week before the incident and her partner was admitted to hospital.

Key findings

Care planning

- Throughout Ms C's involvement with the services, few interventions were adjusted or implemented as changes in her needs occurred, and her community care plans were not reviewed in a timely or meaningful way. Ms C was not offered psychoeducation to address her chronic poor insight into her illness and to promote engagement with services and compliance with prescribed medications.
- Her care plans should have included more focus on the underlying aspects of her significant mental health issues and unmet psychological needs. No carers were identified within any of Ms C's care plans.

Risk assessment

- Ms C did not have a comprehensive or up-to-date formal risk assessment. There had been missed opportunities for her risk assessment to be reviewed by the multidisciplinary team (MDT) particularly when there were emerging risk triggers in the time leading up to the offence.
- Changes to risk involving Ms C's partner had not been factored into her risk assessment, despite her concerns about her partner's behaviour and mental state and the impact these had on her own mental state.

- At the time of the offence, Ms C had chronic unmet psychoeducational needs. Ms C had poor insight into her illness and there was a known long standing history of poor compliance with her prescribed medications that had on many occasions resulted in relapse and significant acts of violence towards others.

Care provision and the community treatment order (CTO)

- There were missed opportunities to refer Ms C for a forensic psychiatric assessment and opportunities to consult with specialist forensic services in respect of Ms C's risk and treatment plan. The MDT did not place adequate emphasis on Ms C's longitudinal risk profile and management plan.

Medication management

- Ms C's prescribed medication was in keeping with NICE guidance for the pharmacological treatments recommended for BPAD. However, there was an over-reliance on lithium plasma level testing, conducted every three months, as the sole means of monitoring her compliance with medication.

Key learning points

1. For service users with a significant history of violence towards others, there should be early consultation with specialist forensic services and/or the police to support the review and development of risk assessment and treatment plans. Referrals to multi-agency public protection arrangements (MAPPA) should be considered by the MDT to help to reduce violent reoffending behaviour.
2. A biopsychosocial approach should be employed when developing care and treatment plans for service users with complex needs, to ensure these are truly individualised and holistic in content.
3. Robust discharge planning and ongoing monitoring of their mental state are required for those service users with a severe and enduring mental health diagnosis. MDTs must ensure that ongoing medical review continues with service users when a CTO is rescinded, and that Section 117 aftercare is arrange and implemented for services users entitled to receive this.
4. The MDT should explore and agree comprehensive medication monitoring arrangements for those service users with chronic histories of poor compliance.

Learning Quadrant – individuals and all agencies

Individual practice

- Do I have all the current risk history? Have I reviewed it? Do I need to consult with specialist teams needed to inform the assessment and risk assessment?
- Are interventions in keeping with evidenced based practice and national guidance such as NICE?
- Am I aware of assertive interventions and pathways to promote engagement? Have these been exhausted before discharge is considered?
- If my patient is a carer how will this role impact on their mental health? Do they have any unmet caring needs that they need support with?

Governance focused learning

- Are we assured that service users entitled to 117 aftercare receive it?
- Do local governance arrangements ensure compliance with policies such as CPA and Clinical Risk?
- Does the quality of care documentation meet expected quality standards?
- How are we assured that discharges from services are planned, safe and in keeping with guidance?
- Do staff responsible for managing service users with forensic histories have access to specialist risk assessment tools and training? How do we know this is used effectively?

Board assurance

- Are we aware of the proportion of patients with forensic histories under mainstream services? Are current resources sufficient to safely manage this client group?
- How are we assured that sufficient safeguarding measures are implemented to protect the public from harm?

System learning points

- Do local community mental health services have the right skills and capacity to provide care for service users with lengthy forensic histories?
- Do our systems to monitor compliance with policy, sufficiently include quality assurance?

Learning Lessons Bulletin - 35

Independent investigation

Introduction

This document provides an overview of findings from an independent review of the internal investigation into the care of service user Mr T, who killed his wife and them himself.

Key themes: risk assessment, information sharing, liaison with A&E services

Agencies and teams who might benefit from this bulletin:

- **Emergency departments**
- **Mental Health Liaison teams**
- **Mental health commissioners**

Case background

At the time of the incident, Mr T presented to an A&E department in crisis. He had no history of treatment by secondary mental health services. 12 months earlier he had been referred to mental health services by his GP after a crisis in which he threatened to kill himself. He was not accepted for secondary mental health care at that time, but advice on medication and management was provided to his GP.

He presented at A&E four weeks before the incident with insomnia and anxiety but declined an assessment by the Mental Health Liaison Service (MHLS). In the four weeks before the incident there were six contacts with crisis services: two face-to-face contacts and four telephone contacts.

On the night of the incident, Mr T and his wife had been seen at A&E, the referral to the Mental Health Crisis team had been refused, and they were advised to return home to await contact from the Psychiatric Liaison Service. The homicide/suicide occurred early in the morning after they returned to their flat.

Key findings

Risk assessment and management

- Mr T's risk assessment identified the following concerns: risk of suicide; risk of deterioration of his mental state if he refused to take medication; risk of violently reacting to his delusions. This suggests that if there were any further unplanned emergency presentations (e.g. to A&E) by Mr T, a further risk assessment/review would have been appropriate.
- Only one risk assessment was undertaken over the course of Mr T's brief involvement with secondary mental health services (not including the triage risk assessments undertaken by the A&E department). Other key risk assessment information was incomplete. Neither the A&E records or Mental Health Crisis team records mentioned knives.

Information sharing

- On the night of the incident, Mr T and his wife were taken to A&E, but a series of communication failures took place between the Triage Nurse, the A&E Coordinator and the on-site Mental Health Crisis team, resulting in vital information not being passed on.

Service factors

- A&E was provided in an acute hospital by an acute Trust; the crisis team was provided by a mental health Trust. There was no local operational policy with explicit guidance on the interface between A&E and the crisis team.
- The crisis team was in a separate building from A&E, making face-to-face discussions about referrals more challenging. The crisis team also did not have an evidence-based structured approach to assessing referrals, but relied on previous practices.
- The care pathway at night for patients with mental health problems presenting through A&E and requiring referral to the crisis team was disjointed.

Key learning points

1. Trusts must ensure that A&E mental health assessments include:
   - The clinical opinion of the A&E staff on the information provided.
   - All patients assessed as high-risk by the referrer should be seen face-to-face by the crisis or liaison service to inform a management plan for each patient.
   - Clear pathways of communication for Crisis/Mental Health Liaison team reviews in A&E.
   - Crisis team advice on management in A&E while awaiting an assessment.
   - A structured evidence-based framework for assessing referrals that takes account of the patient's history, risk assessment, mental state, behaviours associated with mental illness, signs and symptoms of mental illness.
   - The perspective of any family accompanying the patient.
2. Joint working practices must be developed between Trusts and organisations so that information sharing, including information about risk and care planning, is routine practice in both directions.
3. Staff employed in A&E crisis/liaison services must be fully equipped and supported to deliver this challenging and important role.
4. Trusts and commissioners should be clear about the need for a joint approach between acute and mental health Trusts for the joint management of A&E referrals, to include:
   - Communications that enable early discussion between the A&E Triage Nurse/Doctor as soon as possible to avoid unnecessary delay through phone calls and long waiting times with call back systems, and provide A&E with prompt advice on managing a patient while waiting for assessment by crisis teams.
   - A system whereby the referring Triage Nurse/Doctor receives feedback on the proposed management plan for the patient and discharge arrangements from A&E, with the opportunity for further discussion to ensure that there are no outstanding concerns or new information affecting the plan and the wellbeing of the patient.

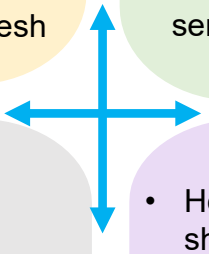
Learning Quadrant – individuals and all agencies

Individual practice reflections

- Does your risk assessment include information from each of the services that the patient has encountered that day?
- If another service mentions risk information, are you clear that this should be communicated explicitly at each stage? Do you press for more detail or do you assume that it has been passed on?
- Have you asked any accompanying family for information?
- What would trigger you to undertake a fresh look at risk?

Governance focused learning

- Do you have proper arrangements for supervision of A&E and crisis team staff?
- Are there clear systems for working together and the sharing of knowledge?
- How do staff shortages and targets influence safe practice? Do you tolerate higher levels of risk on a day-to-day basis?
- How do you know that teams from different Trusts are working together well?
- How do you monitor the quality of the service provided by a crisis team?



Board assurance questions

- Can your services cope safely with demand? How do you know?
- What assurances do you have that risk assessments for people in crisis are completed to the required standards?
- How do you know that risk management plans are collaboratively developed, understood and shared with all those involved in an individual's care?
- What steps are you taking to retain experienced staff? Is there a strategic plan?

System learning

- How are you supporting improved information sharing between agencies and services?
- Does the system have robust multi-agency processes to support individuals in crisis in the community? What would improve this?
- Does the system provide appropriate support for people in crisis in the community?
- Are the resources properly skilled and competent to deal with common presentations?

Learning Lessons Bulletin - 36

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr Z, who killed his neighbour after starting a fire in his block of flats.

Key themes: risk assessment, medication management, care planning, communication

Agencies and teams who might benefit from this bulletin:

- **Adult mental health services**
- **Crisis response and A&E mental health liaison**
- **GP and primary care services**
- **Clinical Commissioning Groups (CCGs)**

Case background

Mr Z had a diagnosis of paranoid schizophrenia for which he received depot medication for over 20 years, administered by his local GP practice. He refused to engage with mental health services. He had been detained three times under the Mental Health Act (MHA) and had spent a number of months as an inpatient following an arrest for which charges were later dropped.

Mr Z registered with a new GP practice shortly after moving into a new area but was advised that it did not administer depot medication. His medication was changed to oral antipsychotic medication. He was referred to the mental health services of a different Trust for depot medication, but they rejected the referral, stating that Mr Z was stable.

The matter was unresolved when Mr Z later changed to another GP practice and remained on oral medication. Mr Z's family became concerned that his mental health was deteriorating and repeatedly contacted Trust mental health services and his GP to raise concerns, but both services advised the family to contact the other agency for help. Mr Z's sister wrote to his GP, setting out her concerns in detail and advising she was worried that he, or a member of the public, might get hurt. The assessing clinicians did not review the letter during their assessment. Mr Z was not accepted by Trust services but his GP was asked to restart his depot medication. The Trust mistakenly sent the outcome of the referral to Mr Z's previous GP and it was two weeks before the mistake was identified by Mr Z's family and his GP.

Mr Z was assessed by the Criminal Justice Liaison and Diversion Team (CJLDT) on the day before the incident following his arrest for an unrelated matter. The team concluded he was stable and discharged him with no follow up at his request.

Key findings

Risk assessment and management

- Mr Z's risk was not comprehensively assessed by Trust mental health services or the CJLDT. The clinicians did not take into consideration the family's concerns as part of their assessment. The assessments did not reflect his mental health history, recent events, behaviour, or detail the family's concerns. Mr Z did not have a risk management plan in place at the time of the incident.

Care planning

- Mr Z was not under the care of Trust mental health services and therefore did not have a care plan.

Medication management

- There was no local shared care agreement between primary and secondary care in relation to depot medication. Some GP practices administer depot medication whereas others direct patients to depot clinics or secondary mental health services.

Information sharing with primary care

- There were three occasions when Trust services sent information about Mr Z to the wrong GP practice despite having the correct details in his notes. The Trust had an information governance policy but it would not mitigate against the administrative mistakes in Mr Z's care, which were caused by human error.

Family engagement

- The Trust did not take adequate steps to engage with Mr Z's family despite their regular attempts to raise concerns about his mental health. The failure to act on the family's concerns, particularly those set out in writing by his sister, was a missed opportunity by the Trust to undertake a thorough assessment of his mental health and explore treatment options.

Key learning points

1. Trusts should develop a shared protocol for the administration of depot medication in the community. This should include agreement as to which party is responsible for undertaking the initial patient assessment, and for the initial and ongoing administration of depot medication.
2. The senior primary care Mental Health Nurse Practitioner role should be evaluated, to establish whether it facilitates the management of depot medication and mitigates the risk of patients not receiving depot medication.
3. Electronic patient records should only give staff access to the patient's current GP contact details and all other out-of-date contact details should be archived.
4. Concerns submitted by families or members of the public regarding a patient should be documented, subject to assessment and review and, where appropriate, proactively acted on. In instances where action is not taken, the rationale should be documented.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- Does your risk assessment adequately document the service user's history, recent events, and any family concerns?
- Have you established what services the service user is willing to engage with?
- How do you ensure family concerns about service users are recorded and acted on?
- Are your electronic patient records accurate and up-to-date?
- How do you ensure decisions pertaining to a service user are shared and acted on by other healthcare professionals (e.g. primary care)?

Governance focused learning

- Are there clear systems for working together and the sharing of knowledge and skills?
- Do you have the correct system in place to ensure staff are accessing up-to-date patient information and GP details?
- Are you confident historic patient information has been archived?
- How do you ensure risk assessments are comprehensive and reflect patient risk factors including family concerns?

Board assurance questions

- What assurances do you have that risk assessments for high-risk service users are completed to the required standards?
- In the absence of a shared care agreement, are you confident there is adequate agreement and understanding between Trust and primary care services in relation to the assessment for, and administration of, depot medication?
- Are you confident there is appropriate liaison between Trust services and primary care in relation to the management of service user's treatment?

System learning

- How are you supporting improved information sharing between services?
- How effective is Trust communication with primary care? Does the Trust provide adequate support and signposting to primary care to help its management of mental health service users?
- Are primary care and Trust services working together to support families who are concerned about a relative's mental health, Is there clarity between primary care and the Trust as to who is responsible for administering depot medication?

Learning Lessons Bulletin - 37

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user B, who committed the homicide of his son, A.

Key themes: information sharing, discharge planning

Agencies and teams who might benefit from this bulletin:

- **Child and Adolescent Mental Health Services**
- **Early Intervention teams**
- **Transition planning services and multidisciplinary teams**
- **Learning disabilities services**
- **Safeguarding partnerships**

Case background

A's parents, B and C, were in a relationship. C had a normal pregnancy and it was reported that both parents were supporting each other during this timescale. Maternity records documented that no other agencies were involved with the family and no information was available to them other than that disclosed by B and C. The incident occurred while C was pregnant with the sibling of child A. At this time the family had been relocated to a new borough and the relationship between B and C had started to break down.

B was not receiving any mental health support at the time of the incident but he had previously had significant contact, including 18 months under the care of Child and Adolescent Mental Health Services (CAMHS) inpatient services. Following discharge from CAMHS he was transferred to the care of the adult Early Intervention Service (EIS) and then to a learning disability service. He was discharged from the service due to non-engagement. Previously, while under the care of CAMHS, B had been under a community treatment order (CTO) and was detained under the Mental Health Act (MHA). This meant he was entitled to Section 117 MHA aftercare, but because they had been rehoused, responsibility for the provision of aftercare was not applied.

Following the birth of A, in the months leading up to the incident, B presented on four occasions to the A&E department of his local acute hospital. He was assessed by the Mental Health Liaison team twice. On his fourth presentation at A&E he was referred to the Mental Health Liaison team, but an assessment did not take place. The incident occurred three days after the referral.

Key findings

Information sharing

- Information sharing between mental health services and the family GP was consistently poor as a result of a fragmented and complex adult health and social care system. Information regarding B's previous mental health history, including details of care needs, risks and his previous contact with forensic services, should have been shared. This resulted in ineffective inter-agency communications, case transfer and continuity of care for B. The lack of a whole system approach and coordination between services involved was exacerbated by services having different information systems.

Family assessment

- The assessment of the family by Child and Family Services lacked sufficient consideration of B's known risk factors (poor medication compliance, use of cannabis, significant intellectual impairment). There was an over-reliance on self-reporting from parents and a lack of triangulation with other agencies, especially mental health and learning disability services.

Section 117 MHA responsibilities

- B was discharged by the Learning Disability service without a Care Programme Approach (CPA) review. This should have occurred as he was subject to Section 117 aftercare. The discharge from services resulted in a loss of a coordinated multi-agency/multidisciplinary team (MDT) approach to the planning, implementation and review of his Section 117 plan under CPA. The lack of an allocated Care Coordinator resulted in minimum information sharing between services and contributed to B's disengagement from services. A key contributing factor to this was the lack of local guidance around agency roles and responsibilities in regard to Section 117, working within a multi-agency context.

Service factors

- At the time of the incident the Mental Health Liaison Service (MHLS) was in the process of transitioning to offering an all age service and as a result was embedding staff whose prime experience was in CAMHS. The induction for staff new to MHLS did not identify and address all the learning needs for this group of staff. This change to an all age response also increased the workload of the existing liaison staff.
- Standard Operational Procedures (SOPs) were in place but lacked detailed guidance for staff on criteria and thresholds when responding to referrals and on when assessments should be completed.

Human factors

- The MHLS had previously carried out comprehensive mental health assessments but the assessments failed to focus on the lived experience of the carers and children in the household where mental illness was a factor. There was no liaison with safeguarding adults and children services.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- When you are assessing a service user and their risks, how do you ensure that you are not simply 'taking things on trust' from the service user and you seek information from other agencies involved?
- If your calls have not been returned by another agency, how would you escalate?
- How do you know that service users understand what you are suggesting to them?
- When somebody moves area, how much effort is made to ensure you identify and pass on relevant information?

Governance focused learning

- Do you have proper induction and support arrangements for newly qualified staff? Are they properly equipped to do the job expected of them? Do they receive appropriate supervision?
- How do staff shortages influence safe practice? How do you know that 'risk apathy' has not set in within your services?
- What work has been undertaken to ensure contingency planning on risk?
- Are your risk escalation triggers reliable when family circumstances change?
- What triggers an alert when someone has been inappropriately discharged from a service?

Board assurance questions

- What assurances do you have that risk assessments are completed to the required standards?
- How do you know if staff are complying with safeguarding and domestic violence training and associated policies?
- Do you know that your teams have sufficient management oversight?
- How do you know that important recommendations and directives have been met by your teams and services?
- What steps are you taking to retain experienced staff? Is there a strategic plan?

System learning

- Do your policies and procedures provide guidance to staff on recognising, responding to and alerting appropriate safeguarding services in situations where there is domestic violence?
- Do you have clarity across the system on both the agency and the lead professional that should take charge on a Section 117?
- How do you make sure that risk assessments are comprehensive, robust and lead to the right threshold of intervention?
- How are you supporting improved information sharing between agencies?

Learning Lessons Bulletin - 38

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr M, who committed the homicide of his mother.

Key themes: care planning, risk assessment

Agencies and teams who might benefit from this bulletin:

- **Mental health commissioners**
- **Early Intervention in Psychosis teams**
- **Community forensic services**

Case background

At the time of the homicide, Mr M was a single, long-term unemployed man who lived alone in a rented flat. He had been under the care of the Psychosis Community Mental Health Team for 10 years.

Mr M began his continuous contact with mental health services when he was a teenager. He was regarded as clearly psychotic and a diagnosis of schizophrenia was ascribed. He was released from custody with follow up by the Early Intervention team (EIT), who continued to regularly review him, with a supplementary role for the Forensic Community Mental Health Team (FCMHT). Mr M was prescribed oral antipsychotic medication but demonstrated varying compliance. He was also an illicit drug user.

Mr M was admitted to hospital care multiple times, including one episode that lasted nearly three years during which he was detained under Section 3 of the Mental Health Act (MHA). He spent time in a Psychiatric Intensive Care Unit (PICU) and on an open general ward, where he was prescribed a different antipsychotic medication and reviewed by forensic services.

Mr M raised concerns about violence risk and non-compliance with medication and was again referred to forensic services. He was transferred to a low secure ward where he continued to express bizarre and violent ideas. He was later transferred first to medium secure conditions and then to a forensic rehabilitation ward. Mr M's team were exploring post-discharge accommodation options when it was realised that his Section 3 had inadvertently been allowed to expire some nine months earlier.

Mr M then began a period of community care that lasted nine years. Medical oversight and care coordination was provided initially by the Assertive Outreach Team (AOT), with additional input provided by the Adult Forensic Outreach Service, before Mr M was discharged to the Psychosis Community Mental Health Team (CMHT). He received regular visits from the Care Coordinator and his care was later regraded from enhanced CPA to standard care, which remained the case until the incident.

Care planning

- There was a substantial disparity between actually recorded and apparently intended care planning, including supervision arrangements. There was also a potential contradiction in professional views about the role and operation of clozapine clinics.

Family situation assessment

- Community staff did not at any point document a discussion with Mr M around the potential benefits of involving his mother in care arrangements. There is no record of staff ensuring his mother would know how to contact services in the event of a crisis, nor is there a record of any community team discussion about the relative demerits and merits of such an approach.
- The issue of potential risk to Mr M's mother does not seem to have been formally revisited at any point after the hospital admission. Records suggest that for years before the incident, potential risk to her was not regarded as an active issue, and she essentially failed to appear in his records despite remaining an important person in his life.

Key learning points

1. There should be frequent recorded consideration or review regarding the potential vulnerability of the service user's family, and whether this vulnerability needs to be escalated as a safeguarding concern.
2. Internal policies and procedures relating to the functioning of clozapine clinics should be revised, in order to be satisfied that any function relating to formal assessment of attendees' mental health status is clearly described and supported.
3. Care plans should be up-to-date and accurate.

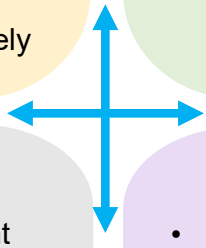
Learning Quadrant – individuals and all agencies

Individual practice reflections

- How will compliance with medication be monitored, and how would you manage non-compliance?
- Do your findings demonstrate professional curiosity about all aspects of the patient and their life, taking into account the patient's forensic history?
- Does the risk assessment sufficiently consider risk of violence to others and include robust safeguarding interventions?
- Do you have ongoing contact with the patient's family and are they appropriately involved in care planning?

Governance focused learning

- What assurances do you have that clozapine clinics are offering the most effective support possible?
- Because you are familiar with an individual with complex needs, do you ever stop and have a fresh look at their risks and risk management?
- How are discharges from the secure unit managed? What assurances do you have that discharges are planned, safe and in keeping with guidance?



Board assurance questions

- How do you know that risk management plans are collaboratively developed, understood and shared with all those involved in an individual's care?
- What assurances do you have that risk assessments for high-risk service users are completed to the required standards?

System learning

- Does the system have robust multi-agency processes to support challenging individuals with complex needs in the community? What would improve this?
- Do you have robust transition processes that support effective discharges and that are inclusive of all community services?

Learning Lessons Bulletin - 39

Safeguarding Adult Review with mental health input

Introduction

This document provides an overview of findings from a Safeguarding Adult Review into the care and treatment of service user M, a man with dementia who injured a fellow care home resident, L, resulting in her death.

Key themes: safeguarding, risk assessment, care planning

Agencies and teams who might benefit from this bulletin:

- **Mental Health Services for Older People**
- **Safeguarding partnerships**

Case background

M was 75 at the time of the incident, residing in a care home for urgent respite for his wife, due to his aggressive behaviour related to his dementia. M was first referred to the Memory Assessment Service a year prior to the incident. He was suffering with episodes of confusion, disorientation and aggression. M and his wife received input from the Home Treatment Team (HTT) for older people because of M's threats, verbal intimidation and aggression.

Initially, M responded well to memantine, but by April that year he was again noted to be increasingly aggressive towards his wife. By June, his wife was reported to be terrified of him, and there were reports of physical aggression. M was referred to the local Multi-Agency Safeguarding Hub (MASH) and allocated a Social Worker. By July, M was in a specialist Elderly Mentally Infirm (EMI) care home for respite. He was noted to be more settled but unpredictable. A Best Interests meeting noted that M lacked capacity and it was agreed to make the placement permanent. Deprivation of Liberty Safeguards (DoLS) were applied for, but M was seen as low priority and this was never completed. Over the next few months there were episodes of violent verbal and physical aggression, often after entering other residents' rooms and mistaking them for his wife. However, when the Community Mental Health Team (CMHT) visited, they were given reassurance by the care home that M was not a management problem. These episodes of aggression continued, and staff and other residents were reported to be afraid of M, but the CMHT were not informed of this, despite a whistleblower informing the Care Quality Commission (CQC) about their concerns. Instead they were told that the care home was managing M and that staff had received training in challenging behaviour.

In February (just over a year after the referral for memory assessment), the incident took place. M dragged L, a 90 year old fellow resident, out of her bed and she sustained a fractured neck of femur. L was treated in hospital but later died from her injuries.

Identification of safeguarding concerns

- The review identified that although the instances of aggression in the care home were reported to the local MASH, they were reported under each victim's name, so there was no opportunity to triangulate the safeguarding referrals made that involved M.

Risk assessment and management

- Although the risk of aggression was identified and shared with the care home, it was not shared as an explicit risk of violence. Once in the care home, the risk assessment was not updated with new information. M had began to misidentify other female residents in the July of the previous year. The risk of violence to female residents, due to mistaking them for his wife, was not identified as a discrete risk.
- CMHT staff were not fully informed about changes in M's presentation and the number and frequency of instances of aggression. When the CMHT did check, they were reassured the care home was managing M. Many instances were not reported and care home staff often downplayed the severity and frequency of aggression.

Deprivation of Liberty Safeguards (DoLS)

- The initial DoLS application was never completed. There were at least two further occasions when DoLS should have been applied for M, in October and November, when M was placed under increasing restrictions and continual one-to-one supervision. After the incident with L, M was considered for detention under the Mental Health Act (MHA), but the application was not completed, and again M was placed under greater restrictions with supervision. A misunderstanding about the 'least restrictive principle' meant that M was not afforded the protections and safeguards of either the MHA or DoLS.

Key learning points

1. Local safeguarding teams should find a way of triangulating information about perpetrators when receiving safeguarding referrals.
2. When placing someone in a care home for respite because of a history of violence and aggression, there must be a full and in depth risk assessment which is shared and understood by the care home. This must be followed by regular and effective communication between the care home and mental health services about changes in presentation and instances of violence and aggression so appropriate care interventions can be developed.
3. When older people without mental capacity are placed in care homes, and they are subject to restrictions to their liberty, DoLS must be applied for. Where these restrictions are in place because of the need to protect other residents from violence from residents with dementia, the MHA must be considered as a way of obtaining more appropriate lawful intervention and treatment.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- Have you shared appropriate information about risk assessment and management for your service users with the care home/other services?
- Are you sure the care home/other service is telling you the complete history regarding risk and violence of the service user? How else can you check?
- Do you fully understand the interface between the MHA and Mental Capacity Act (MCA) and when to use which Act?
- Do you know when to pursue an application for DoLS?

Governance focused learning

- Is safeguarding information about perpetrators being shared appropriately between services?
- How do you know if people should have had DoLS applied for?

Board assurance questions

- How do you know if your teams are sharing and receiving adequate information concerning risk of older adults being violent in care homes?
- How do you make sure your older people's mental health services fully understand the difference between, and the interfaces with, the MHA and the MCA? Do you fully understand the 'least restrictive principle'?

System learning

- Do local safeguarding processes allow for the triangulation of information to identify perpetrators, not just victims, of safeguarding referrals?
- Do local processes facilitate the rapid application for DoLS when needed? Are all staff fully aware of this?
- Do staff in care and nursing homes report instances of violence and aggression appropriately? Are you getting a true picture of the frequency and nature of these incidents in care homes?

Learning Lessons Bulletin - 40

Independent investigation

Introduction

This document provides an overview of findings from a Domestic Homicide Review (DHR) with mental health expertise examining service user A, who committed the homicide of his grandmother.

Key themes: safeguarding, risk assessment, record-keeping, care planning

Agencies and teams who might benefit from this bulletin:

- **Early Intervention in Psychosis teams**
- **Substance misuse services**

Case background

A lived with his grandmother B from the age of six. In the early stages of his life, A was known to Children's Social Care.

Years later, police attended an incident where A was aggressive in his local community. Following advice, A saw his GP shortly after this and a referral was made to the local mental health team single point of access. This referral was screened and a telephone triage appointment was arranged for nine weeks after the original referral.

Shortly before the triage appointment, police and ambulance services attended the family home following a call from A's mother; A had been mentally distressed, and had stated that he was Lucifer, chasing the family from the house. A agreed to attend hospital on a voluntary basis where he underwent a mental health assessment before being discharged home.

In the following week the family submitted a letter to both the GP and the mental health team which expressed concerns for A and a request for urgent help with his mental health. A had a telephone triage appointment with the single point of access just after this letter was received. Following the call, a face-to face appointment was offered. There was no timescale for this appointment. The incident took place seven weeks later.

Safeguarding concerns

- The review identified that A's family raised concerns about the escalation in his behaviour with a variety of professionals. These incidents were seen by professionals as being related to his mental health and the wider context of domestic abuse was not recognised; therefore, his family were not identified as victims, or provided with details of appropriate support services.

Risk assessment

- When assessed in A&E, the information on the risk assessment was brief and did not explore the identified risks in any depth. That A avoided answering any questions during the mental health assessment was not seen as a cause for concern. An opportunity to explore his mental state in more detail which may have revealed evidence of concerning psychotic symptoms was missed.
- Violent, aggressive and sexually inappropriate incidents were not incorporated into the risk management plan, which focused instead on alcohol and substance misuse reduction. Following A's discharge home, his family contacted the mental health team to express concerns about the decision. However, the information shared by the family did not lead to any change in the management plan despite the concerning nature of that information.

Human factors

- Prior to A's attendance at A&E, services who had attended the family home had collected detailed information from A and his family regarding events. This information was placed on another person's Electronic Care Record due to an incorrect spelling of A's name, and was therefore not available to the clinical team that assessed him in A&E. This also led to the assessment outcome letter not being sent to A's GP.

- The staff member who carried out the telephone triage later did not fully read or comprehend the letter sent by the family earlier that month which clearly documented their concerns regarding A. They also did not access A's clinical records to inform and document their decision-making.

Service factors

- The referral to the single point of access was classified as routine and an appointment was made for approximately nine weeks later, which was in excess of the standard operating procedure. Appropriate services were not offered or provided, and relevant enquiries were not made to support assessments and did not take account of information that was available at the time. The Domestic Homicide Review (DHR) panel concluded that A should not have been placed on the waiting list for allocation to a Specialist Mental Health Practitioner and a more urgent and proactive response should have happened.

Key learning points

1. Risk assessments should not rely solely on patient self-reporting, but should be based on information gathered from all agencies involved, and triangulated with information provided by family and carers.
2. Professionals need to ensure that when engaging with individuals at crisis point, they consider the wider context and impact on all who are affected by the situation.
3. When assessing dual diagnosis patients, clinicians need to ensure that careful consideration is given to the possible contribution made of the underlying mental illness, and that not all symptoms are routinely attributed to the effects of drug intoxication.
4. Clinical services need to have monitoring procedures in place to ensure not only that referrals are seen within the timescales set out in their standard operating procedures but that more urgent assessments can be completed if urgent information is subsequently received.
5. Record-keeping is vital for agencies when obtaining and gathering information from individuals or other professionals. Clinical teams need to have robust supervision structures in place to support learning, reflection and any required changes to individual clinicians' clinical practice.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- How well do you know the triggers and markers for domestic abuse?
- How professionally curious are you when dealing with a new assessment in a crisis?
- Do you actively seek information from other sources and read it to inform your assessment or do you take things at face value?
- How much do you consider the possible contribution of the underlying mental illness when dealing with patients who have a dual diagnosis, e.g. substance misuse and mental health problems?

Governance focused learning

- Do you routinely monitor waiting times for assessment from first referral? How adequate are your processes if assessments are required sooner in the light of new information?
- What assurances do you have that potential domestic abuse and threats of harm within the family are being considered?
- How do you know that 'risk tolerance' has not set in within your services?
- Are your standard operating procedures flexible enough to facilitate rapid early assessment when service user circumstances change?

Board assurance questions

- How do you know that urgent assessments are completed on an 'as needed' basis?
- What assurances do you have that risk assessments for high-risk service users are completed to the required standards?
- How do you know that risk management plans are collaboratively developed, understood and shared with all those involved in a high-risk individuals care?
- How do your services recognise and respond to the risks of domestic abuse?

System learning

- Does the system have robust processes to rapidly assess and support serious emerging psychosis in young people?
- Are services cooperating and collaborating enough to provide appropriate support for young people with first presentation of serious mental illness?
- When dealing with complex dual diagnosis referrals, how is the system going to understand the impact of the mental illness on the presentation?

Learning Lessons Bulletin - 41

Independent investigation

Introduction

This document provides an overview of findings from an independent investigation into the care and treatment of service user Mr L, who committed the homicide of his neighbour.

Key themes: discharge planning, risk assessment, communication and coordination

Agencies and teams who might benefit from this bulletin:

- **Substance misuse services**
- **Adult Community Mental Health Teams**
- **Local authority Leaving Care teams**
- **Housing services**

Case background

Prior to the incident, Mr L had 11 admissions to mental health services including several single-night stays at an acute psychiatric hospital. Following an assault on another patient and various threats, he was transferred to a Psychiatric Intensive Care Unit (PICU) and detained under Section 3 of the Mental Health Act (MHA). Mr L was discharged and later disengaged with mental health services.

Mr L was placed under the care of the Early Intervention Service (EIS). He was subject to several MHA assessments and was readmitted to the psychiatric ward under Section 3 of the MHA. During this stay, he received psychological therapy to address his drug and alcohol use. The bizarre ideas expressed by Mr L were in keeping with the diagnosis of paranoid schizophrenia and his medication was increased.

Mr L was discharged into temporary supported accommodation before moving into a flat. His discharge plan included regular meetings with his Care Coordinator and regular urine drug screening and breathalyser tests. His care was transferred to the Assertive Outreach team (AOT).

Mr L was later arrested and spent 11 months on remand. He received a community order for two years, with supervision, a "*residence requirement*" and a "mental health requirement". Mr L was in contact with his probation officer, his Community Psychiatric Nurse (CPN) and a specialist registrar. A period of compliance and engagement followed which then deteriorated following sustained periods of alcohol use.

Mr L started to present with auditory command hallucinations, paranoid delusions and some suicidal ideation. He was compliant with his medication and received extensive support from mental health services to prepare him to live independently.

Mr L's Care Coordinator changed several times. Following a period of erratic, antisocial and aggressive behaviour, including threats to his neighbours, Mr L was admitted to a psychiatric hospital and then transferred to a PICU where he presented as argumentative, verbally abusive and verbally and physically aggressive to staff and other patients. It was reported that he was having a schizoaffective presentation with dissocial traits exacerbated at time by a manic relapse. He was later discharged and the incident took place a few days later.

Discharge planning

- Mr L should not have been discharged from the PICU without an adequate and robust care plan. This care plan should have included plans to mitigate any risks Mr L posed to his neighbours or family. It should have been developed in advance of the discharge and by consultation with all agencies involved in Mr L's care, as required by Care Programme Approach (CPA) policy. The decision to expedite the discharge interfered with the process of a considered and planned discharge.
- There is no evidence of victim safety planning. Concerns about Mr L's neighbours' fears were not considered as part of the discharge plan. Referral to multi-agency public protection arrangements (MAPPA) was also not discussed.

- While there were some plans in place to commence psychological interventions for his substance use and anger, these interventions should have been introduced and evaluated prior to discharge.
- Mr L was discharged directly into the community on a Friday, with no support over the weekend, instead of being moved to a low secure setting or developing a phased discharge process from an acute ward. This decision relied on Mr L's compliance with abstinence from alcohol and concordance with medication. This compliance was untested other than on prior day leave with his parents. Mr L's behaviour and progress while on leave with his parents was also never assessed or discussed with his parents.

Risk assessment

- Mr L did not undergo an assessment by clinical psychology and therefore no psychological formulation of risks was available as a basis for treatment or risk management interventions.
- The improvement in risk behaviours was based upon interventions where he had little choice but to comply if he wished to be discharged. The situation was further exacerbated by the decision to discharge him on a Friday without substantial contingency and risk management plans in place.

Key learning points

1. When a violent patient is admitted to a Trust's services, their risks should be assessed appropriately and care plans should be developed to address antisocial behaviours towards members of the public. There should be a robust discharge planning process that fully involves these agencies prior to discharge.
2. Service users should not be discharged from a PICU into the community on a Friday, with no support over the weekend. Instead, they should be provided with periods of step-down care and leave to test their independence in the community.
3. Trusts should work in partnership with key agencies involved to ensure that there are processes in place to support the routine sharing of information regarding any potential antisocial behaviour of suspected/known service users.
4. Consideration about referral to MAPPA should take place for patients with violent histories and convictions for serious violent offences. Such referrals should consider safeguarding issues and potential risks of domestic violence for wider family members.

Learning Quadrant – individuals and all agencies

Individual practice reflections

- How will compliance with medication be monitored, and how would you manage non-compliance?
- Does the risk assessment sufficiently consider risk of violence to others and include robust safeguarding interventions?
- How do you manage alcohol abuse? Do you incorporate joint working with the alcohol misuse service?
- Have you discussed a referral to MAPPA?

Governance focused learning

- What assurances do you have that discharges from services are planned, safe and in keeping with guidance?
- Are your risk escalation thresholds and triggers reliable when service user circumstances change?
- Are all staff members fully trained in risk assessment and management?

Board assurance questions

- What assurances do you have that risk assessments for high-risk service users are completed to the required standards?
- What assurances do you have that sufficient safeguarding measures are implemented to protect the public from harm?
- What assurances do you have that referral and escalation processes are effective?

System learning

- How are you supporting improved information sharing between agencies and services?
- Does the system have robust multi-agency processes to support high-risk individuals with complex needs in the community?
- Do you have robust transition processes that support effective discharges into the community, inclusive of all community services?

APPENDIX A
List of Abbreviations

ADHD	Attention deficit hyperactivity disorder
AMHP	Approved Mental Health Professional
AOT	Assertive Outreach Team
ASD	Autism spectrum disorder
BPAD	Bipolar affective disorder
CAMHS	Child and Adolescent Mental Health Services
CAT	Cognitive Analytic Therapy
CBT	Cognitive behavioural therapy
CCE	Child criminal exploitation
CDP	Care Delivery Problems
CJLDT	Criminal Justice Liaison and Diversion Team
CMHART	Community Mental Health Assessment and Recovery Team
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
CTO	Community treatment order
CYPS	Children's and Young People's Service
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
EIPT	Early Intervention in Psychosis Team
EIPS	Early Intervention in Psychosis Service
EIT	Early Intervention Team
FIRT	Forensic Integrated Resource Team
FOS	Forensic Outreach Service
HMO	House in multiple occupation
HTT	Home Treatment Team
IAPT	Improving Access to Psychological Therapies
ICMP	Intensive Case Management Psychosis
LLB	Learning Lessons Bulletins
MAPPA	Multi-agency public protection arrangements
MARAC	Multi-Agency Risk Assessment Conference
MARAT	Multi-agency risk assessment teams
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MDT	Multidisciplinary team
MHA	Mental Health Act
MHLS	Mental Health Liaison Service
MHSOP	Mental Health Services for Older People
MoJ	Ministry of Justice
NICE	National Institute for Health and Care Excellence
NPSA	National Patient Safety Agency
PDD	Persistent delusional disorder
PICU	Psychiatric Intensive Care Unit
PNMH	Perinatal Mental Health
RAID	Rapid Assessment Interface and Discharge
SDP	Service delivery problems
STP	Sustainability and transformation plans
YJLDS	Youth Justice Liaison and Diversion Service

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