Psychological Approaches

SERIOUS INCIDENT INVESTIGATION REPORT

THE CARE AND TREATMENT OF Mr M

August 2021

Table of Contents

CONDOLENCES 4

EXECUTIVE SUMMARY 4

BACKGROUND 5
Provision of Mental Health Services 7

METHODOLOGY 8

ADDRESSING THE TERMS OF REFERENCE 9
The NHS contributions to the Domestic Homicide Review 9
Recommendation 1 11
Referral arrangements, communication, and discharge procedures 11
Years 2001 to 2017 11
Transfer to EPUT November 2017 12
Referred by GP 2018 12
Referral to West Specialist Psychosis Team November 2019 13
Response to the concerns of the GP and the family, February 2020 14
Recommendation 2 15
Recommendation 3 15
Recommendation 4 15
Recommendation 5 15
Recommendation 6 15
Recommendation 7 15
Recommendation 8 16
Compliance with local policies, national guidance, and relevant statutory obligation 16
Recommendation 9 18
Recommendation 10 18
Recommendation 11 18
The effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and his family 18
Care plan 18
Risk assessment 18
Involvement of Mr M and his family 19
Recommendation 12 21
The appropriateness of the treatment of Mr M in light of any identified health needs/treatment pathway 21
Working alongside the Domestic Homicide Review panel 22

SUMMARY OF FINDINGS 22
Best Practice 22
Opportunities for Learning 23
Conclusions 23
Recommendations 23

APPENDIX 1 26
Our Ethos and Our Team 26
Investigators 26

APPENDIX 2 27
Chronology 27

APPENDIX 3 33
Glossary of Terms 33

APPENDIX 4 35
Terms of Reference 35
APPENDIX 5 36
Suggested Action Plan 36

CONDOLENCES

The investigation panel would like to offer their condolences to the family at this incredibly difficult time; it is our sincere wish that this report does not add to their pain and distress and goes some way in addressing any issues and questions raised. Family members in this report are referred to by their role in the family rather than their names and we realise that this form of address may be upsetting. However, we are also concerned about their right to confidentiality and privacy. This approach provides some measure of protection in this regard. We apologise that discussions with family members for this investigation had to take place over the telephone rather than in person due to the COVID-19 pandemic restrictions.

EXECUTIVE SUMMARY

1. Police were called to the home of Mr M and his mother, where his mother was found to have been fatally stabbed. Mr M was subsequently convicted of her murder.

2. Mr M was diagnosed to have schizophrenia - an enduring mental illness - in 2002 following an admission to hospital during which he attempted to take his own life. Mr M's diagnosis of schizophrenia was complicated by abuse of prescribed medications, anxiety, and alcohol. Mr M was known to mental health services in Cambridge Partnership Foundation Trust (CPFT) and subsequently at the time of the homicide to Essex Partnership University NHS Foundation Trust (EPUT).

3. This investigation was commissioned by NHS England and NHS Improvement- Midlands and East of England to carry out an independent investigation into the care and treatment of a mental health service user, Mr M. The independent investigation follows the NHS England Serious Incident Framework and was conducted alongside a domestic homicide review and a safeguarding adults review.

4. This investigation makes several recommendations for the mental health services involved relating to transfers of care, referral processes, care of patients who struggle to engage with services, communication between services, CPA process and safeguarding issues. The specific recommendations are shown in the body of the report against the terms of reference to which they relate and for ease of reading are repeated in the summary section of the report.

5. This investigation found that whilst the homicide could not have been predicted it may have been prevented if Mr M had received care and treatment appropriate to his needs.

BACKGROUND

A detailed Chronology is provided in Appendix 2.

6. Mr M was born in 1971. He grew up with his parents and his younger brother, his older sister lived with grandparents. There was a family history of alcohol dependency and violence in the home.

7. He came to the attention of mental health services at the age of 25, because he had cut his wrists. No clinical records from this contact were available.

8. At the age of 30 (2001), he developed psychotic and affective (mood) symptoms over a nine-month period, leading to his first admission to psychiatric hospital after cutting his wrists. He tried to strangle himself with a belt while on the ward. He was discharged after four months on a second generation antipsychotic and an SSRI (an antidepressant). He was diagnosed to have schizophrenia, an enduring mental illness.

9. This treatment regime remained largely unchanged up until the homicide, in March 2020.

10. He had further brief admissions in 2004, 2005 and 2007. There is evidence that alcohol misuse had contributed to the necessity for these admissions. By this time, he was living with his parents. His father died in 2014.

11. Mr M had a history of substance misuse, mainly alcohol, recorded in the clinical records dating from his first admission. In 2004 and 2005 his liver function tests were abnormal. In 2007, 2008 and 2010, he was referred to local Drug & Alcohol services for help with his drinking. However, it remained a risk for him because he felt alcohol alleviated his anxiety. This led to the addition of diazepam to his prescription for the last ten years. This use of benzodiazepines was the topic of correspondence between the psychiatrist and the GP. Benzodiazepines are cross-tolerant[1] with alcohol and Mr M probably used both agents to reduce his anxiety.

12. Mr M was in regular out-patient follow-up for the years 2001 - 2010. From 2011 to 2015, he does not appear to have been seen by a psychiatrist until he was re-referred by his GP due to his mood being “low, anxious and

[1] Cross Tolerance occurs when prolonged drug use of one substance decreases the effectiveness of another in this case Benzodiazepines and alcohol

paranoid". This led to more robust engagement with psychiatric services, including a period in 2016 when Mr M was supported to leave his house by a care worker.

13. In August 2017, his GP contacted psychiatric services to say that Mr M appeared agitated, and his sleep was disturbed. It seems that Mr M did not attend the appointment promptly offered in response to this.

14. For some years, Mr M was the main carer for his mother, who became frail due to physical illness; she was unable to negotiate the stairs and for this reason she lived mainly in a downstairs room of the house. She was able to mobilise for short distances with the assistance of a stick or walking frame.

15. Due to commissioning changes, the medical component of Mr M's psychiatric care transferred to EPUT in November 2017. EPUT had been previously providing the community component of his care, so the service should have had some familiarity with his case. Mr M was sent an appointment by his newly commissioned service; he did not attend and was immediately discharged.

16. In May 2018, Mr M's mother was admitted to the local acute hospital with pain to her knee. With her consent, both Mr M and his sister were contacted. Mr M disclosed that he cared for his mother, but she was isolated, not leaving the house and she would benefit by having a befriending service for company once a week, as this would allow Mr M to get out. However, it appears that this support was not put in place.

17. In November 2018, the GP referred Mr M to the Access and Assessment Service because of concerns that his mental health was deteriorating. For the next 12 months, Mr M either did not attend appointments or postponed home visits so no assessment was undertaken.

18. In August 2019 both Mr M's brother and sister, separately contacted the GP service to express concern about Mr M's increased alcohol intake and deteriorating mental health and his failure to care properly for his mother because of this. This was followed up by the GP in the form of a home visit in September 2019. The GP made a referral to the Local Authority early intervention team who in turn made a referral for Mr M and his mother to receive community support to care for the house and garden however no community support was provided.

19. The consultant for the Access and Assessment Service made an unannounced home visit in November 2019. She subsequently referred Mr M to the West Specialist Psychosis Team and asked the GP to refer Mr M's mother to Social Services for social care support. In response to this and

further concerns raised by Mr M's brother, a Safeguarding Assessment visit was conducted by Essex Social Services on 20 January 2020.

20. The West Specialist Psychosis Team sent out an outpatient appointment for 7 Feb 2020, which was not attended. Meanwhile, concerns were increasing about Mr M's mental state among the family and the GP. On two occasions in February these concerns were communicated to the consultant for the Access and Assessment Service who had done the home visit. The psychiatrist passed them on to the West Specialist Psychosis Team who did not respond robustly.

21. The GP remembers Mr M as someone who would call the surgery in the evenings to request further medication. Mr M was quietly spoken, always polite and clearly concerned for his mother's welfare[2].

22. Police were called to the home of Mr M on 1 March 2020, where his mother was found to have been fatally stabbed.

23. Psychiatric reports provided for the trial differed in their opinion as to whether Mr M demonstrated diminished responsibility due to mental illness at the time of the killing and subsequently, he was convicted of murder at Chelmsford Crown Court on 8 September 2020 and sentenced to life imprisonment.

Provision of Mental Health Services

24. In November 2017, following significant safety concerns, West Essex Clinical Commissioning Group undertook a review of their service model which resulted in the transfer of some mental health services from Cambridge & Peterborough Foundation Trust (CPFT) to North Essex Partnership Trust (NEP). This included the provision of medical psychiatry for community patients which meant that patients who were registered with GPs in Mr M's area were transferred to a psychiatrist in NEP.

25. Although the 2017 transfers had to be undertaken in a short time scale, a rigorous process was put in place and lead by EPUT. 127 patients were identified and a spreadsheet of information for each patient was produced. The most recent medical review was requested for each patient and where patients were under the care of a psychiatrist a face to face review of their needs was undertaken by a specifically designated nurse specialist. If patients did not attend that review, then this was followed up. Mr M was one of the patients whose care transferred from CPFT and he was invited to a face to face review but did not attend. In his case it appears that this was not followed up. It has not been possible to determine why this omission

[2] Interview with Dr I, 24/3/21

happened. NEP and South Essex Partnership Trust (SEPT) subsequently merged and became EPUT.

26. Following a review in 2017 EPUT took the decision to bring services in West Essex in line with other services provided by the Trust. This resulted in separation of Psychosis and Non-Psychosis Services and led to the emergence of the Access and Assessment service. The Access and Assessment service was a 24-hour locality-based service to provide triage and assessment of all new patients referred to the service as well as providing brief interventions. This service did not provide care coordination, but sign posted patients with on-going mental health needs to the most appropriate services including the Psychosis service who could provide care and treatment to patients with psychotic disorders and care coordination. A review of this way of structuring services was already underway when the incident occurred and the structures within West Essex services have now changed again and the psychosis and non-psychosis teams have been disestablished and the services have reverted to Community Mental Health Teams who both assess and treat patients presenting with severe and enduring mental illnesses[3].

METHODOLOGY

A comprehensive review was undertaken of the clinical records including previous reports, assessments, notes, and related correspondence from both CPFT & EPUT as well as psychiatric reports previously prepared for court proceedings.

Lisa Dakin, the lead author of this report was a member of the joint Domestic Homicide Review and Safeguarding Adults Review panel and attended all meetings.

Interviews with key staff.

- CW Operational Service Manager West Essex Community Mental Health
- Dr C Psychiatrist Access & Assessment Team EPUT
- SL Social Worker
- Dr I General Practitioner

It was not possible to interview the CPN from the West Essex Psychosis Team.

An attempt was made to visit Mr M in prison for the purposes of investigation. Although Mr M initially agreed to this, consent was later withdrawn, and Mr M stated he was not ready to contribute to the review at this time.

A review was undertaken of the serious incident investigation undertaken by EPUT including the action plan and witness statements.

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[3] Interview with CW, 2/2/21

Examination of relevant local & national policy & procedural guidance was also undertaken.

- EPUT Discharge and Transfer Clinical Guidance CG24 (01 July 2017 Updated September 2019)
- EPUT Guidance for Service Users who Disengage with Mental Health Services or are non-concordant with prescribed treatment plans CG77 (April 2018, Updated February 2019)
- EPUT CPA Policy CLP30 (July 2017)
- EPUT Clinical Risk Assessment Policy CLP28 (July 2017, updated July 2019)
- EPUT Clinical Risk Assessment Procedures CLPG28 (01 July 2017, updated July 2020)
- EPUT Carer's Assessment Guidelines 2017
- Records Management Policy CP9 (August 2017, updated October 2018)
- NEP Access, Assessment, Brief Intervention and Home Treatment Team Services Operational Policy (April 2015)
- West Essex Specialist Psychosis Team Operational Policy (draft 2016)
- NICE Clinical guideline [CG178] - Psychosis and schizophrenia in adults: prevention and management. Published date: 12 February 2014 last updated: 01 March 2014
- Nice Quality Standard - Psychosis and schizophrenia in adults. Published: 12 February 2015

As per Psychological Approaches' internal protocols, a confidential peer review of the report also took place.

ADDRESSING THE TERMS OF REFERENCE

The NHS contributions to the Domestic Homicide Review

27. In this instance the Domestic Homicide Review (DHR) was combined with a Safeguarding Adults Review (SAR) into the circumstances of the death of Mr M's mother.

28. DHRs were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). Section 9 of the Act was brought into force on 13th April 2011.The purpose of a DHR is to:

    • Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

    • Identify clearly what those lessons are both within and between agencies, how and within what timescales that they will be acted on, and what is expected to change as a result.

- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

- Contribute to a better understanding of the nature of domestic violence and abuse; and

- Highlight good practice.

29. Section 44 of the Care Act 2014 sets out that Safeguarding Boards must arrange a Safeguarding Adults Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

30. A panel was appointed to oversee, and quality assure, the review process. The panel was selected to represent the agencies involved but also organisations that would bring the requisite specialist knowledge to the reviews.

31. Essex Partnership University Trust (EPUT) and West Essex CCG were represented on the panel and Lisa Dakin, the lead investigator for this report was also a member and all parties attended all meetings.

32. The panel drafted and agreed terms of reference for the review, which identified the scope of the review and the organisations who had been involved in the case and included the requirements for this NHS Independent Investigation.

33. Each of the agencies provided a chronology of their contact with Mr M and/or his mother. In addition, they were asked to provide an Individual Management Report (IMR), a summary report, or undertake initial scoping depending on their level of involvement. EPUT and West Essex CCG provided a detailed IMR, Cambridge & Peterborough NHS Foundation Trust (CPFT) and Addenbrookes Hospital provided Initial Scoping Reports.

34. All parties contributed to the production of the final DHR/SAR report and will have the opportunity to review the report prior to final submission for publication.

35. EPUT carried out its own serious incident investigation in line with national requirements following a homicide by a mental health patient, the investigation was undertaken by appropriately skilled investigators and

signed off following Board level scrutiny in October 2020. The COVID-19 pandemic impacted on the investigation in that its completion was delayed and that some interviews/meetings were not able to be conducted in person, in particular with the family. In our view the report was rigorous in its investigation and made clear recommendations, backed up by an action plan[4].

36. The EPUT investigation made recommendations in the following areas:

- Transfers of care
- Allocation of Care Coordinators
- Leadership
- Communication
- Culture
- Multi–disciplinary team meetings
- Safeguarding
- Clinical Systems

37. The EPUT investigation did not address the potential that other patients may also have received a poor handover during the transition caused by service reorganization in 2017.

Recommendation 1

38. EPUT should go back and review the care of all patients whose psychiatric care was transferred from CPFT to EPUT in 2017 (approx. 100 patients) to ensure that their care and treatment has not been adversely affected by inadequate handover of care.

Referral arrangements, communication, and discharge procedures

Years 2001 to 2017

39. For the decade following his first admission, Mr M was in regular contact with a consultant psychiatrist and a Community Psychiatric Nurse (CPN), both of whom addressed his use of alcohol and benzodiazepines in addition to his mental illness.

40. He was lost to follow up from 2010 to 2015. No reason for this is recorded. He was re-referred by his GP and he benefitted from his psychiatric contact in that he had individual help with leaving the house in the Spring of 2016. This shows that he did have the capacity to work with services within a care plan tailored to his needs. Mr M's sister also recollected that this was a point

[4] It was noted that EPUT's investigation wrongly referred to Mr M's mother as suffering with dementia. This was raised at the DHR panel and EPUT agreed to amend their report accordingly.

in time when Mr M did well with the help, he received from psychiatric services[5].

41. However, his use of alcohol and benzodiazepines was no longer reviewed, and it appears that this complication of his mental illness came to be overlooked by psychiatric services.

Transfer to EPUT November 2017

42. The independent investigators were informed that the community mental health team component of Mr M's care remained unchanged as EPUT staff were providing this prior to and following the service changes, although at the time of transfer Mr M was only open to the psychiatrist's caseload [6]. Nonetheless, it is difficult to understand why there was not a formal handover process. The lack of a consultant handover, in the opinion of the investigators, facilitated the all-too-quick discharge from EPUT. Transition between services is recognised to be a time of increased risk for people who are vulnerable due to mental disorder and who find difficulty in forming relationships with new service providers. Mr M had an enduring mental illness complicated by alcohol dependency, anxiety, and social phobia for which his service had implemented a specific care plan during the previous year. His difficulties in attending appointments were clearly documented. Although the overall system put in place to manage the transition of patients appeared rigorous, in the case of Mr M, for reasons we have been unable to determine, his transition failed and his needs were not reviewed.

43. In their serious incident investigation report EPUT said that, '*Whilst it is acknowledged that transfer of services happened quickly and without additional resources, the resultant structural change should not have affected clinical care. This was a missed opportunity to share information across organisational boundaries and to undertake a robust assessment of Mr M's needs.*'

Referred by GP 2018

44. The GPs were diligent in informing secondary care about Mr M's needs, first in 2015, but more frequently during recent years. In fact, the GP had conveyed concerns to secondary care in August 2017, but this did not prevent the prompt discharge of Mr M from EPUT services within a few days of Mr M's transition, so there is no record of a response to the concerns of primary care at that time.

45. The GP reported that Mr M's mental health was deteriorating in November 2018, but Mr M was not seen until November 2019 because he cancelled or postponed contacts scheduled for March, May, July, and October 2019. In

[5] Telephone call with Mr M's sister 9/2/21
[6] Interview with CW, 2/2/21

the opinion of the investigators, this response time is too long and did not initially take into account Mr M's own and the GP's information that Mr M was struggling to leave the house and required a home visit. Mr M was first offered a home visit in May 2019 and was finally assessed by the consultant making an unannounced home visit in November 2019.

46. In November 2019 the consultant made a referral to the West Specialist Psychosis Team, in recognition of his care needs in the longer term. She completed the electronic clinical record pro-forma (Paris), noting that Mr M had been diagnosed as having 'harmful use of alcohol' in 2007, and recording that he was at risk of dependency on tranquillizers. She did not however include an account of the part that alcohol was playing in his life when she met him in 2019.The summary of this assessment and the referral letter were not typed until 10 January 2020, and it is therefore unclear what information was known to the West Essex Psychosis Team before that date.

47. In their serious incident investigation report EPUT identified that, '*The electronic patient records system used by the Access and Assessment team and the Psychosis team does not follow the standard structure of a psychiatric assessment in line with national best practice'*.

Referral to West Specialist Psychosis Team November 2019

48. Mr M's case was allocated to an Associate Practitioner (AP), a relatively junior, member of the team, on 2/12/19 despite the complexity of Mr M's condition. The AP made telephone contact with Mr M, who asked for his previous support worker (who had moved on) and then requested a phone call with the consultant who had done the home visit. It seems that no arrangements were in place between the West Specialist Psychosis Team and teams referring to their service during the interim period following the referral, even though the time taken to provide care for new patients by the West Specialist Psychosis Team could be appreciable. For example, the appointment letter sent to Mr M on 10th February 2020 had an appointment for 10 weeks' time.

49. In their serious incident investigation report EPUT recognised that it was inappropriate to allocate an Associate Practitioner as Mr M was suffering from a severe mental illness and was subject to CPA; he should have been allocated a Care Coordinator, a role which the allocated AP was unable to undertake.

50. According to the clinical records the task of the AP was to 'engage' Mr M. This could have been a positive plan of care similar to the work undertaken by the support worker in 2016 but in the opinion of the investigators, this work should have been undertaken supplementary to and under the supervision of a care coordinator not in place of one.

51. The appointments sent to Mr M from the West Specialist Psychosis team for February and April 2020 were both in outpatient clinics several miles away from Mr M's home and did not take into account the information from the referring psychiatrist that Mr M was not leaving the house.

Response to the concerns of the GP and the family, February 2020

52. It is difficult to understand why there was seemingly no mechanism for a robust response to the GP and family concerns by the West Specialist Psychosis Team, even though Mr M had been referred to them by a consultant colleague two months previously and communications from the GP and family indicated Mr M was potentially relapsing.

53. This apparent lack of responsivity by the West Specialist Psychosis Team is worrying. The investigators understand that the referring consultant attempted to highlight the concerns that were conveyed to her by the GP on 18/2/20 and 24/2/20 but again, the concerns were given to the AP to manage on 27/2/20, despite his observation that he did not have the seniority to request an assessment under the MHA, should one be necessary. The AP asked a CPN colleague to visit but the CPN went to the wrong address and apparently did not have the resources to obtain the correct address. Once identified, attempts were made to telephone Mr M also without success. This was not escalated to a senior member of staff nor was a visit requested over the weekend to assess Mr M.

54. Mr M's family contacted the Consultant Psychiatrist from the Access and Assessment team after his care had transferred to the West Essex Psychosis team. The EPUT investigation appropriately found that an identified staff member (ideally a Care Coordinator) from the West Essex Psychosis team should have established contact with the family. This would have enabled better communication and response to the family's concerns.

55. The local authority investigation found that no information regarding their own safeguarding assessment undertaken on 20 January was shared with EPUT prior to Mr M's mothers' death.

56. This review of the management of Mr M shows that his GP and his family raised concerns on multiple occasions but the response of psychiatric services in 2018, 2019 and 2020 lacked urgency or was effectively non-existent. The primary care GP with care of Mr M and his mother commented to the investigators that they were not surprised that psychiatric services had not responded; this was not untypical. In the opinion of primary care, the model of specialist care in which people who services find difficult to engage

are simply discharged following non engagement, seems to be unhelpful for the very patients who need help most[7].

Recommendation 2

57. This investigation fully supports the recommendation from the EPUT investigation that the Trust should ensure that all transfers of care for patients subject to CPA should be in accordance with the CPA Policy and should ensure that a robust hand over from Care Coordinator to Care Coordinator takes place.

Recommendation 3

58. An audit of referrals is conducted within services for working age adults to explore the current time periods from receipt of the referral to providing a service which addresses the concerns of the referrer. This audit should include referrals both from colleagues in secondary care and primary care.

Recommendation 4

59. EPUT should embed a process to ensure that when a referral is accepted to their community mental health teams the care coordinator or other relevant professional working with that patient makes contact with the patient's family/carers at the earliest opportunity to provide a point of contact for the family and to listen to the families' views on the care the patient needs.

Recommendation 5

60. In relation to patients who transition between primary and secondary care; EPUT Mental Health, Primary Care and Social Services should work together to produce collaborative processes and consider joint training which would also enable staff to build their networks of professionals to contact when support is required.

Recommendation 6

61. EPUT should ensure that communication with mental health patients about prospective or missed appointments takes into account the potential that the patient may be vulnerable due to mental disorder and may have difficulty in engaging and forming relationships with service providers and as a result may need more assistance/support to ensure that they attend.

Recommendation 7

62. This investigation fully supports the recommendation from the EPUT investigation that the Trust should ensure all failed urgent home visits are communicated to a team leader or equivalent to agree an appropriate plan of action including, if necessary, the use of out of hours services.

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[7] Interview with Dr I, 24/3/21

Recommendation 8

63. This investigation fully supports the recommendation from the EPUT investigation that they should ensure any significant concerns from the GP regarding a patient's health must be brought to the attention of the patient's consultant Psychiatrist.

Compliance with local policies, national guidance, and relevant statutory obligation

64. The report of the National Confidential Inquiry into Suicide and Homicide by people with a Mental Illness, July 2009, found that non-attendance, loss of contact with services and non-compliance with medication are significant causal factors that contribute to findings of inquiries into suicide and homicide[8].

65. Care Programme Approach (CPA) in the United Kingdom is a system of delivering community mental health services to individuals diagnosed with a mental illness. It was introduced in England in 1991. The approach requires that health and social services assess need, provide a written care plan, allocate a care coordinator, and then regularly review the plan with key stakeholders, in keeping with the National Health Service and Community Care Act 1990. In 1999 the approach was simplified to include standard and enhanced levels.

66. Mr M had previously been detained in hospital under the Mental Health Act and had made serious attempts to end his life by hanging in 2001 whilst in hospital. He also had secondary needs in relation to substance misuse, in line with both national policy and EPUT's local policy[9] his care therefore should have been subject to CPA arrangements and resulted in a handover between Care Coordinators when his care transferred from CPFT to EPUT in 2017. The investigators found that this failure to apply CPA to Mr M was fundamental as it contributed to a lack of interagency communication and coordination of his care.

67. At the time of Mr M's discharge from EPUT services on account of non-attendance in November 2017, there were in place clinical guidelines on discharging patients (including those on CPA) which described discharge in the absence of the patient, as a result of non-engagement, as an exceptional event which, *'Should only happen based on an up to date assessment of risk*

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[8] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Making Mental Health Care Safer (Annual Report and 20-year Review, October 2016)

[9] EPUT CPA Policy CLP30 (July 2017)

and only when all attempts have been made to re-engage the service user in treatment and re-negotiate a new plan of care.'[10]. This did not happen.

68. At the time of Mr M's discharge from EPUT services for non-attendance in November 2017, no specific policy was in place regarding patients who disengage from services. A policy was introduced in April 2018[11] . This policy offers clear and thorough guidance in relation to discharging disengaged patients, actions to take following non-attendance to appointments and concerns raised by carers in relation to disengaging patients all of which could have applied to Mr M. Whilst the policy was not in place to prevent the 2017 discharge, had the Trust consistently followed its own policy in 2019/20 in relation to missed appointments then the West Specialist Psychosis team would have been guided to liaise with carers and the GP following the missed appointment in February and to offer Mr M the additional support he may have needed to attend (a home visit). They would also have been specifically guided in how to liaise with carers who had raised concerns as Mr M's siblings had. In particular the policy states*, 'If a carer has expressed concern about risk to the service user and/or others, then a case review should be held to address these concerns and a plan agreed. If the concerns cannot be dealt with through a care co-ordination case review, then a plan must be agreed with the carer. This should include: Clearly stated methods for engagement and monitoring of the Service User, a contact point and contingency arrangements for the carer'.*

69. Had clinicians recognised Mr M as a 'Disengaging Patient' and followed local policy then Mr M's family and GP would have been more involved in decisions about his care and received the feedback and follow up from their concerns/referrals that they felt was lacking.

70. The Care Act 2014 means that people who undertake a caring role for someone are entitled to have their own needs assessed. EPUT does routinely offer assessments to the carers of its patients but in the case of Mr M they failed to recognize a change in caring responsibilities in the relationship between Mr M and his mother. In May 2016 they undertook a carers assessment with Mr M's mother but there is no record that they ever undertook a carers assessment for Mr M as he took on responsibility for looking after his mother as her health deteriorated. This led to a missed opportunity to offer him support in this role.

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[10] EPUT Discharge and Transfer Clinical Guidance CG24 (01 July 2017 Updated September 2019)

[11] EPUT Guidance for Service Users who Disengage with Mental Health Services or are non-concordant with prescribed treatment plans CG77 (April 2018, Updated February 2019)

Recommendation 9

71. EPUT should ensure that their own policy in relation to placing patients with multiple needs and serious risk on CPA is robustly implemented.

Recommendation 10

72. EPUT should ensure that their own policy in relation to discharging patients in their absence due to non-engagement is robustly implemented.

Recommendation 11

73. EPUT should ensure that their own policy in relation to patients who disengage with services is robustly implemented.

The effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and his family

Care plan

74. Mr M was cared for within the framework of the Care Programme Approach (CPA) between March 2004 and October 2015. For the period between 2004 and 2010, this framework was effective. There is evidence in the record of sustained and supportive care until 2010, when he seems to have been largely lost to follow-up, despite, it seems, as being on record as being subject to CPA.

75. He was not judged to need the level of care offered by CPA between Oct 2015 and Dec 2016 when he was discharged from the service. The last records of care planning, in 2016, are difficult to follow. There is a letter dated 6th September 2016 to the GP, discharging Mr M from the service because he had not attended appointments, but there is also a Care Review recorded on 22nd September 2016 which states that the plan is for weekly telephone contact and a monthly meeting in person. In the opinion of the investigators, the care plan was appropriately written but unrealistic in its expectations and there is no contingency plan for Mr M's care if engagement at this level could not be sustained.

76. From that date, there is no evidence of care planning because Mr M was either out of touch with services or services could not engage with him.

Risk assessment

77. In September 2016, a risk assessment was completed that makes reference to the risk that Mr M might become dependent on his tranquillizers but there is no mention that he was almost certainly drinking in a dependent manner at that time. The assessor estimated that there would be no difficulty for Mr M in engaging with his care plan, but the assessor does not refer to the many missed appointments over the years. This risk assessment states that Mr M

believed he had been involved in the terrorist events of 9/11, and he described himself as paranoid. The assessor records that Mr M was continuing to require help in leaving the house.

78. This care record makes it difficult to understand why Mr M was discharged at the end of 2016.

79. There does not appear to be a record of another risk assessment until November 2019. This was completed by the consultant who conducted the home visit. She recorded that the risks associated with a deterioration in Mr M's mental state included self-neglect and an unspecified risk to his mother, who he cared for. She endorsed evidence of neglect, a historical risk of self-harm and the risk of dependency on tranquillizers and codeine. Alcohol was not recorded as a risk factor, although mention was made that Mr M 'reportedly had harmful use of alcohol in 2005'. Appropriately, she did not think there was a risk of violence to others.

80. The consultant told the investigators that she thought Mr M and his mother were being 'neglected' by services and she attempted to correct this with her referral to the West Specialist Psychosis Team and her request to the GP to refer to Social Services for a social care needs assessment for the family.

81. Once allocated to the West Essex Psychosis team Mr M's risk rating was assessed as amber on 28 November 2019, 19 December 2019, 09 January 2020, and 16 January 2020. However, the rating was changed to green on 23 January 2020 despite no further contact with him and Mr M having failed to attend an appointment with them on 7 February.

82. Mr M abused his prescribed medication and there was significant concern that he sometimes took medication which was prescribed to his mother; this also posed a risk in terms of a potential cause of relapse in his illness.

Involvement of Mr M and his family

83. Mr M's parents are recorded as attending the discharge CPA in December 2001 but after that there is little if any mention of the family until the consultant's home visit in November 2019. There is also little evidence of Mr M's involvement in his own care because his level of contact with services was limited.

84. Mr M's brother and sister both supported their mother and Mr M, visiting regularly and supporting with shopping etc.

85. There is no record of Mr M's siblings having any formal involvement in his care until they raised concerns through the GP in August 2019 that Mr M's mental health was deteriorating. Mr M's brother and sister were both present at the safeguarding review undertaken on 20 January 2020.

86. Mr M's brother and sister both believed that Mr M cared for his mother and wanted to do the best for her but latterly was increasingly unable to do so because of both his deteriorating mental health and his mothers' increasing care needs.

87. Mr M's brother and sister both believed Mr M was at risk of harming himself and said he would often say he would kill himself if he were separated from his mother or sent to hospital. They also knew that their mother worried about what would happen to Mr M if she and him were separated and this impacted on her decisions, for example, that she only wanted to be rehoused into an easier to manage property if Mr M came too.

88. Both Mr M's brother and sister described how Mr M frequently talked on behalf of his mother or talked over her and often had to be asked to let his mother speak. They did however feel that their mother was able make her views known when she needed to

89. Neither sibling believed that Mr M posed a risk of violence or that he would ever deliberately harm his mother.[12],[13],

90. In the summer of 2019 Mr M's brother and sister were both concerned that Mr M's mental health was deteriorating and that he was struggling in his carer role. They both felt that Mr M needed mental health input and support in caring for their mother. They separately communicated this to the GP practice. They understood correctly that the GP was the access point for all healthcare and that they were best placed to get specialist mental health input for Mr M. Mr M's siblings both felt frustrated that their own and the GP's concerns, although received by health and social care, did not result in any material change in the care or support that Mr M and their mother received.

91. When she visited the home in November 2019 the psychiatrist took the opportunity to speak to Mr M's mother alone whilst Mr M was upstairs, she asked her if she felt safe and she said she did. This appears to be the only occasion on which any clinician spoke to Mr M's mother alone.

92. A carers assessment was offered to Mr M for the first time when the Social Worker visited the home on 20 January, however he declined. The local authority investigation found there to have been no further exploration with Mr M on his own regarding his mental health and that he was not coping in caring for his mother who also confirmed that he was struggling.

[12] Telephone call with Mr M's brother 9/2/21
[13] Telephone call with Mr M's sister 9/2/21

Recommendation 12

93. This investigation fully supports the recommendation from the EPUT investigation that Community Mental Health teams have a scenario-based learning session on safeguarding issues. This should include the importance of considering the needs of patients who are carers and additional support required including respite care.

The appropriateness of the treatment of Mr M in light of any identified health needs/treatment pathway

94. Mr M was correctly diagnosed to be suffering from Schizophrenia; he also had comorbid dependent use of alcohol and benzodiazepines which services noted.

95. Services did not always pay sufficient regard to the role that alcohol played in Mr M's presentation.

96. The most stable period in Mr M's treatment history appears to be the decade following his first admission when he was in regular contact with a consultant psychiatrist and a Community Psychiatric Nurse (CPN), both of whom addressed his use of alcohol and benzodiazepines in addition to his mental illness.

97. Mr M responded positively in 2016 to the interventions from a support worker to help him in leaving the house[14],[15].

98. From September 2017 onwards Mr M's treatment was, in real terms, managed entirely by the GP practice. This was not appropriate; Mr M should have remained under the care of a community mental health team and been subject to CPA which would have assisted in bringing all involved agencies together to coordinate Mr M's care.

99. It cannot be said with certainty to what extent Mr M's mental state was stable during these years, as there are no formal examinations of his mental state until November 2019 when he appeared '*sensitive and slightly paranoid*'.

100. It is unknown what was his compliance with prescribed medication, and it is unknown what was the interplay with benzodiazepines and alcohol use and his schizophrenia.

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[14] Interview with Dr I, 24/3/21

[15] Telephone conversation with Mr M's sister

101. Given these unknowns in a man with this complex history of mental disorder, it is likely that his deteriorating mental state was highly relevant to and contributed to the violent attack on his mother, behaviour that was by all accounts completely out of character.

102. Due to the investigation team being unable to conduct a mental state examination on Mr M we are unable to comment on his medication regime.

103. Considering the assessments of Mr M's mental state immediately after the incident there is every indication that Mr M was floridly psychotic at the time that he killed his mother[16].

104. There are no recommendations for this ToR

Working alongside the Domestic Homicide Review panel

105. Lisa Dakin, the lead investigator for this report was a member of the joint Domestic Homicide and Safeguarding Adults review panel and attended all meetings.

106. The DHR panel Chair and Lisa spoke with Mr M's brother and sister on 9 February 2021. Due to restrictions in place for the Covid 19 pandemic these conversations unfortunately had to be on the telephone rather than face to face.

107. There are no recommendations for this ToR

SUMMARY OF FINDINGS

Best Practice

108. The general practitioners were diligent in their endeavors to meet Mr M and his family's needs. When concerns were raised, they were regularly triangulated by a home visit and consistently followed up with secondary care.

109. In 2016 Mr M was supported to leave his house by a care worker for a period of time. This was a significant intervention which was viewed as helpful by Mr M's family and his GP, though it was unfortunately time limited.

[16] Contemporaneous psychiatric assessment

Opportunities for Learning

110. In addition to the recommendations made, this incident highlights inherent risks every time a patient's care transitions and the need for services to work collaboratively to ensure that transitions are avoided where possible, information is not missed, and the patient's needs continue to be met.

111. This incident also highlights the difficulty of delivering services to people with complex mental health needs who may - by the very nature of their illness or social circumstances - find engaging with services difficult, and who therefore need additional support or modification of services to do so.

Conclusions

112. Mr M did not have a history of violence to others and both his family and professionals who knew him never saw any indication that he may act violently towards his mother. We therefore conclude that the attack on Mr M's mother could not have been predicted.

113. Mr M had a complex mental health presentation with a diagnosis of schizophrenia, alcohol dependence, misuse of prescribed medication and anxiety.

114. Following an initial period of good care, from 2016 onwards Mr M's care was characterized by failure to follow policies and procedures in relation to CPA and disengaging patients, inadequate risk assessments and limited and unrealistic care planning, with insufficient family engagement.

115. The transitions of Mr M's care from CPFT to EPUT, from GP care to secondary mental health services and then from the Access and Assessment Team to the Psychosis Team were not managed appropriately.

116. Tragically for Mr M and his family these cumulative failures left him without the ongoing secondary mental health care he needed for more than a year. Had he received that care in a timely manner it may well have been possible to prevent the deterioration in his mental state and ultimately, even though it could not have been predicted, he may have still been prevented from attacking his mother due to preventing his relapse into psychosis.

Recommendations

1. EPUT should go back and review the care of all patients whose psychiatric care was transferred from CPFT to EPUT in 2017 (approx. 100 patients) to ensure that their care and treatment has not been adversely affected by inadequate handover of care

2. This investigation fully supports the recommendation from the EPUT investigation that the Trust should ensure that all transfers of care for patients subject to CPA should be in accordance with the CPA Policy and should ensure that a robust hand over from Care Coordinator to Care Coordinator take place

3. EPUT should undertake an audit of referrals within services for working age adults to explore the current time periods from receipt of the referral to providing a service which addresses the concerns of the referrer. This audit should include referrals both from colleagues in secondary care and primary care.
4. EPUT should embed a process to ensure that when a referral is accepted to their community mental health teams the care coordinator or other relevant professional working with that patient makes contact with the patient's family/carers at the earliest opportunity to provide a point of contact for the family and to listen to the families' views on the care the patient needs.
5. In relation to patients who transition between primary and secondary care; EPUT Mental Health, Primary Care and Social Services should work together to produce collaborative processes and consider joint training which would also enable staff to build their networks of professionals to contact when support is required.
6. EPUT should ensure that communication with mental health patients about prospective or missed appointments takes into account the potential that the patient may be vulnerable due to mental disorder and may have difficulty in engaging and forming relationships with service providers and as a result may need more assistance/support to ensure that they attend.
7. This investigation fully supports the recommendation from the EPUT investigation that the Trust should ensure all failed urgent home visits are communicated to a team leader or equivalent to agree an appropriate plan of action including, if necessary, the use of out of hours services.
8. This investigation fully supports the recommendation from the EPUT investigation that they should ensure any significant concerns from the GP regarding a patient's health must be brought to the attention of the patient's consultant Psychiatrist.
9. EPUT should ensure that their own policy in relation to placing patients with multiple needs and serious risk on CPA is robustly implemented.
10. EPUT should ensure that their own policy in relation to discharging patients in their absence due to non-engagement is robustly implemented.
11. EPUT should ensure that their own policy in relation to patients who disengage with services is robustly implemented.
12. This investigation fully supports the recommendation from the EPUT investigation that Community Mental Health teams have a scenario-based learning session on safeguarding issues. This should include the importance

of considering the needs of patients who are carers and additional support required including respite care.

APPENDIX 1

Our Ethos and Our Team

Psychological Approaches CIC is a not-for-profit community interest company focused on work with individuals with complex mental health needs – often associated with a history of offending and social exclusion. Our ethos is one of collaboration and partnership with other organisations to review and evaluate services to achieve better outcomes. Our independent serious incident investigation team comprises five senior practitioners from a multi-disciplinary background with many decades of experience in forensic mental health services, and clinical governance. We adopt a whole team approach to independent serious incident investigations, with an emphasis on peer review and ratification of findings.

Investigators

This investigation was led by Lisa Dakin assisted by Dr Deborah Brooke. Lisa is a Mental Health & Learning Disability Nurse Consultant and specialist in secure inpatient and prison healthcare, with over 30 years, experience working as a nurse leader in forensic & prison mental health and learning disability services. Formerly Head of Nursing and Associate Clinical Director for Forensic & Prison services in a large NHS Trust, and with considerable experience of incident investigations in prisons and hospital. MSc in forensic mental health; post graduate training in leading & managing partnership working. A special interest in learning from lower harm incidents. Deborah is a consultant psychiatrist who brings expertise in co-morbid substance misuse & many years' experience of delivering community mental health care.

APPENDIX 2

Chronology

Date	
Jan 1971	Year of birth
teenager	Compulsive hand washing for several months. Did not see psychiatric services
School leaver	Printing company apprentice
Age 23	Moved to London to undertake a degree Living in room in shared house
1995, age 24	First contact with Mental Health services - cut wrists. Left degree Subsequently worked for a security company
2001	Psychotic & affective symptoms developed over eight or nine months. Formed the belief that his flat mates were poisoning him. Had been spending £20 /week on cannabis. Continued to work as a printer
24 Sep 2001	First admission. Attended A&E after cutting his wrist with a razor blade. Tried to strangle himself with a belt on the ward. Detained under Sec 2 then Sec 3 MHA
19 Dec 01	Pre discharge CPA meeting attended by both parents
30 Jan 02	Discharged on olanzapine 30mg and sertraline 100mg. Subsequently under care of CMHT local to his mother's home having moved back there from London
22 Feb 02	O/P appt - would like to reduce olanzapine from 30mg. Is planning on taking a course
15 May 02	Seen by consultant with CPN - sheltered accommodation worked out well
12 Jul 02	Outpatient (O/P) appt - reports low mood, sleeping in day, weight gain - has put on four stone since starting olanzapine
27 Sep 02	O/P appt - started a course, sharing a house. Try reducing olanzapine from 30mg to 25mg. Continue sertraline 100mg
13 Dec 02	It seems that he did not attend O/P appt
24 Jan 03	It seems that he did not attend O/P appt
28 Feb 03	O/P appt - small reduction in olanzapine caused disturbed sleep so dose returned to 30mg
14 Mar 03	O/P appt - feeling anxious, started drinking
28 Mar 03	O/P appt - improved, reduced drinking
13 Jun 03	O/P appt Mood low. Sertraline 150mg not helpful; try mirtazapine 30mg
27 Jul 03	O/P appt
24 Oct 03	O/P appt Mirtazapine 30mg, Olanzapine 20mg, alcohol 16U/week
2004	First six months of 2004 - mood dipped, alcohol increased
23 Jan 04	O/P appt - 'Doing well', 'beer 3 pints 3 times per week'
23 Apr 04	DNA O/P appt
14 May 04	DNA O/P appt
1 Jun 04	DNA O/P appt

19 Jul 04	Admitted informally at request of CPN. Liver function tests (LFTs) abnormal.
28 Jul 04	Discharged on olanzapine 30mg, mirtazapine 45mg.
13 Aug 04	Outpatient review - well. Discussed alcohol consumption - ‘about a pint a day’
8 Oct 04	Outpatient review - back at work. Olanzapine 30mg, mirtazapine 45mg
14 Jan 05	DNA O/P appt
11 Feb 05	DNA O/P appt
23 Nov 05	Admitted informally due to increasing ideas of persecution - had stopped meds because of nausea and vomiting Also had escalated his drinking - up to 70U/week - and cannabis use
29 Nov 05	Liver Function Tests show raised ALT and GGT (abnormal)
9 Dec 05	Discharged on olanzapine 30mg, mirtazapine 60mg lansoprazole 30mg
20 Jul 07	CPN referred to Drug & Alcohol Services; “M feels his drinking is out of control’
20 Aug 07	Admitted, diagnosis depression with psychosis. Blood tests showed a macrocytosis (enlarged red cells), which can be a marker for alcohol misuse but there did not seem to be a record of LFTs in the notes for this admission
24 Oct 07	Discharged to Home Treatment. Revised diagnosis paranoid schizophrenia. Referred to Drug & Alcohol Team
14 Nov 07	Outpatient appointment
23 Nov 07	Missed clinic appt
9 Jan 08	Outpatient appointment - doing well, not drinking much, mood improved, duloxetine (an antidepressant) 90mg
3 Mar 08	Referred to CDAT by CPN for help to reduce alcohol use
14 Mar 08	DNA
28 Mar 08	DNA
9 May 08	Outpatient appointment - diagnosis paranoid schizophrenia, risperidone 8mg per day and occasional glass of wine
8 Aug 08	Outpatient appointment
1 Sep 08	Vomiting, probably anxiety-related. Consultant suggested a short course of diazepam, 2 - 5mg daily
28 Sept 08	Outpatient appointment. Finds 2mg diazepam helpful in stopping vomiting. Back at work
14 Nov 08	Outpatient appointment - discussed diagnosis of paranoid schizophrenia, on diazepam 4mg, risperidone 6mg and duloxetine 120mg
16 Jan 09	Outpatient appointment - has reduced drinking, diazepam 4mg, risperidone 6mg, plus duloxetine. Seeing counsellor from ADAS
27 Mar 09	Outpatient appointment - 10U/week, risperidone 6mg
26 Jun 09	Outpatient appointment - drinking more than a bottle of wine at night, some increase in anxiety
29 Jun 09	Letter from Clinical Psychology services in response to referral by CPN - “please complete this form telling us how you see your difficulties…”

24 Jul 09	Outpatient appointment - back at work, drinking at a 'moderate' level on diazepam 6mg Same date: letter from Clinical Psychology offering appt on 6 Aug 09
13 Nov 09	Outpatient appointment - abstaining from drink because of Barratt's oesophagus, diazepam 6mg daily
Nov 09	Last job ended (document imaging company)
12 Feb 10	Outpatient appointment - drinking and using diazepam. Declined admission
14 May 10	Did not attend, reviewed by phone
28 May 10	DNA
11 Jun 10	DNA
25 Jun 10	Phone conversation with Staff Grade doctor - paranoid & anxious, 'self-medicating' with alcohol (up to 18U /day) and diazepam. Declined admission
28 Jun 10	Assessed by CDAT - 10-year history of alcohol misuse, currently up to 27U/day. Treatment goal = social drinking. Risk assessment completed
8 Jul 10	S/B consultant & CPN - alcohol 15U/day, 5mg diazepam. Seeing CDAT
10 Sep 10	Letter from consultant asking Mr M to arrange review appt with his CPN and consultant
11 May 11	Outpatient appointment
13 May 2011	Letter from consultant: risperidone 6mg fluoxetine 20mg diazepam 5mg plus 20U/week
22 Apr 13	GP requested review - concerns about codeine and diazepam use
24 May 13	DNA - consultant asked him to call and make another appointment
6 Aug 15	Letter from GP to consultant, re-referring: "He has not been seen for five years…his mood is low, anxious and paranoid"
9 Sept 2015	Outpatient review at GP's request - increase in paranoid ideation. Had used cannabis and alcohol
16 Oct 15	Better with addition of quetiapine to risperidone. On diazepam 10mg/day. Discussed reducing to occasional use only. It seems that his consultant told him he would not be covering the patients in that area from the New Year
3 Nov 15	Letter asking Mr M to contact services because "the contact numbers we have for you do not seem to be working". (Mr M did not pick up calls if the number had been withheld.)
9 Dec 15	Risk assessment by West Specialist MH Recovery Team
9 Feb 16	Letter offering help with anxiety related to leaving the house, proposing home visit on 22 Feb 16
9 Mar 16	Non-CPA care review at home by W Specialist MH Recovery Team
30 Mar 16	Carer's assessment of Mr M's mother at their home by W Specialist MH Recovery Team. No unmet needs identified
13 Apr 16	Seen in clinic by consultant with support worker who was helping Mr M in getting out of the house
22 Apr 16	Care plan agreed for support with leaving the house
16 Jun 16	Risk assessment by W Specialist MH Recovery Team

6 Sep 16	Letter to GP: "Has not attended any appointments offered, or replied to letters sent on 3 Nov 15, or 14 July and 30 Aug 16…we have therefore discharged Mr M from our services"
22 Sep 16	Risk assessment by W Specialist MH Recovery Team. 'Care review' recorded on the same date, but it is not clear where the information came from, especially for the subjective boxes, all of which have been endorsed 'often'. Mr M is recorded as not being eligible for Sec 117. The plan is for weekly phone contact and monthly face to face
23 Sep 16	Phone call with consultant - anxious on higher dose of fluoxetine (30mg)
30 Nov 16	DNA psychiatric follow-up appointment
8 Aug 17	Letter from GP - concerned about agitation and disturbed sleep
16 Aug 17	Letter offering appt on 23 Aug 17
November 2017	Transition to EPUT. Mr M was offered an appointment on 20 Nov for assessment of his mental health in a letter dated 10 Nov 17
20 Nov 17	DNA this appointment
23 Nov 17	Discharge from EPUT services because he did not attend his appointment on 20 Nov 17
20 Nov 18	Referred to Access and Assessment Service by his GP, following concerns that his mental health was deteriorating
1 Dec 18	Letter from EPUT asking Mr M to contact the service in response to the GP's referral
24 Dec 18	Letter from EPUT offering appt at CMHT on 20 Mar 19
8 Apr 19	Letter from EPUT offering appt at home on 3 May 19
9 May 19	Letter from EPUT asking Mr M to get in touch as a planned home assessment had been cancelled by him
30 May 19	Letter from Access and Assessment Service re home visit on 2 Jul 19
6 Sep 19	Mr M's mother first became known to Essex Adult Social Care through a telephone referral from her GP to the Early Intervention Single Point of Access Team. This contact raised concerns that her son, Mr M, was struggling to cope with meeting his mother's needs. When contact was made with Mr M's mother and Mr M it was established during a telephone conversation that they required support with gardening and housework. A referral was made to Community agents to support with their request. No home visit was undertaken, nor any follow up contact with Mr M's mother, Mr M or the provider to ensure that the Community agents met their needs
18 Sep 19	Letter from Access and Assessment Service re home visit on 15 Oct 19
25 Oct 19	Letter from Access and Assessment Service re home visit on 14 Nov 19
12 Nov 19	Assessed at home by consultant (CP2) - subsequent letter to GP dated 10 Jan 20. The plan was: swop hypnotic; refer to pathway for ongoing support; GP was asked to consider referring mother to social care
21 Nov 19	Initial Assessment form completed by CP2 who noted that Mr M had difficulties caring for his mother, who had disabilities. The consultant noted that Mr M would like some support to go out of the house more and had found support provided in the past to be helpful. He also indicated that he would like some support with his mother.

	It is recorded that Mr M was on CPA between March 04 and Oct 15 and 'Non-CPA' between Oct 15 and Dec 16 when he was discharged. Referral made to Psychosis Pathway (West Essex Specialist Psychosis Team) by CP2
2 Dec 19	Associate Practitioner allocated the case. He was asked to assess Mr M's needs. He telephoned Mr M and offered to visit but Mr M unwilling to engage and requested telephone contact with the consultant who visited his home on 12 Nov 19. Mr M said he would rather work with the support worker who helped him leave the house in 2016
12 Dec 19	MDT meeting: Mr M was not engaging with the Associate Practitioner and 'awaiting contact from CP2'. It is unclear why this was as the patient was no longer under the care of the access and assessment team
9 Jan 20	Appointment letter for medication review in outpatients on 7 Feb: "If you fail to attend and do not contact us to re-schedule, your file will be closed to the West Specialist Psychosis Service"
14 Jan 20	Safeguarding referral made by Mr M's GP in respect of the victim; the concerns were that both Mr M and his mother were refusing help, however Mr M was neglecting her needs and refusing entry to professionals. A social worker made contact with the victim's other son, the GP and Mr M on 14 January 2020. A home visit was undertaken on 20 January 2020
20 Jan 20	Home visit by social worker, attended by Mr M's brother and sister. Mr M's mother was assessed as having capacity and insight into the concerns, however, did not want the safeguarding concern progressed to an enquiry. She did agree to a Care Act Assessment and an Occupational Therapy assessment. Due to high caseloads, this was scheduled for 4 March
7 Feb 20	Mr M did not attend the appointment at the outpatient centre. Appointment letter for 28 Apr 20 at W Specialist Psychosis outpatient centre.
18 Feb 20	GP letter to consultant asking for a home review because Mr M has severe agoraphobia so cannot get to the outpatient centre. GP concern re use of hypnotics and lorazepam
24 Feb 20	Urgent request from GP because increasing paranoia. GP had made safeguarding referral for Mr M's mother
27 Feb 20	Associate Practitioner phoned Mr M to arrange a home visit following concerns communicated by his family to CP2 that Mr M was self-medicating and deteriorating in his mental state. There was no reply
28 Feb 20	Home visit attempted but CPN went to the wrong address
	During the independent investigation, the investigators heard that the consultant who did the home visit in November was concerned that Mr M may be becoming unwell and emailed and visited the W Specialist Psychosis team requesting contact with him. Despite her requests no effective contact was made with Mr M.

Mar 20	Mr M killed his mother and was arrested
Sep 20	Mr M was convicted of the murder of his mother and sentenced to life imprisonment.

APPENDIX 3

Glossary of Terms

Below is a glossary to help with understanding the various acronyms or terms that are used throughout this report.

Acronyms/Terms Used in the Report	
Affective disorder	Affective disorders are a set of psychiatric disorders, also called mood disorders. The main types of affective disorders are depression and bipolar disorder. Symptoms vary by individual and can range from mild to severe.
Agoraphobia	Agoraphobia is a fear of being in situations where escape might be difficult or that help wouldn't be available if things go wrong.
AP	Associate Practitioner a nursing assistant role junior to a registered nurse.
Care act	The Care Act gives carers the right to receive support from their local authority if they have eligible needs. You can get this support through a carer's assessment.
CDAT	Community Drug and Alcohol Team
CMHT	Community Mental Health team
COD	Cause of Death
CP	Consultant Psychiatrist
CPA	Care Programme Approach is a package of care that is used by secondary mental health services. Patients will have a care plan and someone to coordinate their care if they are under CPA. All care plans must include a crisis plan.
CPN	Community Psychiatric Nurse
Diazepam	Is used to treat anxiety disorders, alcohol withdrawal symptoms, or muscle spasms and stiffness.
DNA	Did not attend
Dr	Doctor
EPUT	Essex Partnership University NHS Foundation Trust
FLO	Family Liaison Officer
FTA	Failed to attend
GP	General Practitioner
Hypnotics	Anxiolytics, sedatives and hypnotics are medicines that work on the central nervous system to relieve anxiety, aid sleep, or have a calming effect.
Lorazepam	Lorazepam is used to treat anxiety and sleeping problems that are related to anxiety.
MDT	Multi-Disciplinary Team
Mirtazapine	Mirtazapine is an antidepressant medicine. It's used to treat depression and sometimes obsessive compulsive disorder and anxiety disorders.
NHS	National Health Service

Olanzapine	Olanzapine is an antipsychotic medication that is used to treat psychotic conditions such as schizophrenia and bipolar disorder (manic depression).
O/P	Outpatient appointment
Psychosis	Psychosis (also called a 'psychotic experience' or 'psychotic episode') is when you perceive or interpret reality in a very different way from people around you. You might be said to 'lose touch' with reality. The most common types of psychotic experiences are hallucinations, delusions and disorganised thinking and speech.
RCA	Root Cause Analysis is a type of investigation process used to aid learning from incidents
Risperidone	Risperidone is an antipsychotic medicine that works by changing the effects of chemicals in the brain. Risperidone is used to treat schizophrenia.
Safeguarding	Safeguarding means protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care.
Section 3 MHA	A section 3 is used if you have had your mental health assessed before and are already getting mental health treatment. For example, you already have a mental health diagnosis or are receiving support from a psychiatrist or community mental health team.
Section 2 MHA	You can be detained under section 2 if: you have a mental disorder you need to be detained for a short time for assessment and possibly medical treatment, and it is necessary for your own health or safety or for the protection of other people.
S/B	Seen by
SMART	Specific Measurable Achievable Realistic Timely
SSW	Senior Social Worker

APPENDIX 4

Terms of Reference

This investigation will examine the NHS contribution into the care and treatment of Mr M from his first contact with specialist mental health services up until the date of the incident.

1. Critically examine and quality assure the NHS contributions to the Domestic Homicide Review
2. Examine the referral arrangements, communication, and discharge procedures of the different parts of the NHS that had contact with the service user
3. Review and assess compliance with local policies, national guidance, and relevant statutory obligation
4. Examine the effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and his family
5. Review the appropriateness of the treatment of the service user in light of any identified health needs/treatment pathway
6. To work alongside the Domestic Homicide Review panel and Chair to complete the review and liaise with affected families

APPENDIX 5

Suggested Action Plan

No.	Recommendation	Responsible person	Date to be completed	Acceptable evidence	Monitoring arrangements	Date closed/progress With evidence
1.	EPUT should go back and review the care of all patients whose psychiatric care was transferred from CPFT to EPUT in September 2017 (approx. 100 patients) to ensure that their care and treatment has not been adversely affected by inadequate handover of care	CEO EPUT		a) A one-off written review with accompanying action plan if indicated	Signed off by the Trust board	
2.	EPUT should ensure that all transfers of care for patients subject to CPA are in accordance with the CPA policy and should ensure that a robust hand over from Care Coordinator to Care Coordinator takes place.	CEO EPUT		b) A routine audit of the implementation of CPA transfers within the Trust and between the Trust and other organisations	Annual monitoring by EPUT patient safety lead	
3.	EPUT should undertake an audit of referrals within services for working age adults to explore the current time periods from receipt of the referral to providing a service which addresses the	CEO EPUT		c) A one-off audit sowing time from receipt of referral to providing a service with accompanying action plan if indicated	Signed off by the Trust board	

	concerns of the referrer. This audit should include referrals both from colleagues in secondary care and primary care					
4.	EPUT should embed a process to ensure that when a referral is accepted to their community mental health teams the care coordinator or other relevant professional working with that patient makes contact with the patient's family/carers at the earliest opportunity to provide a point of contact for the family and to listen to the families' views on the care the patient needs	CEO EPUT		d) Policy document e) Feedback from carers demonstrating evidence of policy implementation	Signed off by the Trust board	
5.	EPUT Mental Health, should work together with local Primary Care and Social Services to produce collaborative processes and consider joint training which would also enable staff to build their networks of professionals to contact when support is required	Lead by EPUT CEO in conjunction with local primary care and social services leads		f) Evidence of collaborative events, strategy documents or training	Signed off by the Trust board	
6.	EPUT should ensure that communication with mental health patients about prospective or missed appointments takes into account the potential that the patient may be vulnerable due to	CEO EPUT		g) Revised policy document on disengaged patients h) Review of communication process for outpatient appointments incorporating feedback	Signed off by the Trust board	

	mental disorder and may have difficulty in engaging and forming relationships with service providers and as a result may need more assistance/support to ensure that they attend.			from patients and carers to maximize attendance		
7.	EPUT should ensure all failed urgent home visits are communicated to a team leader or equivalent to agree an appropriate plan of action including, if necessary, the use of out of hours services	CEO EPUT		i) Revised policy document	Signed off by the Trust board	
8.	EPUT should ensure any significant concerns from the GP regarding a patient's health must be brought to the attention of the patient's consultant Psychiatrist	CEO EPUT		j) Revised policy document	Signed off by the Trust board	
9.	EPUT should ensure that their own policy in relation to placing patients with multiple needs and serious risk on CPA is robustly implemented	CEO EPUT		k) Written audit of policy implementation	Signed off by the Trust board	
10.	EPUT should ensure that their own policy in relation to discharging patients in their absence due to non-engagement is robustly implemented	CEO EPUT		l) Written audit of policy implementation	Signed off by the Trust board	
11.	EPUT should ensure that their own policy in relation to patients	CEO EPUT		j) Written audit of policy implementation	Signed off by the Trust board	

	who disengage with services is robustly implemented					
12.	EPUT Community Mental Health Teams have a scenario-based learning session on safeguarding issues. This should include the importance of considering the needs of patients who are carers and additional support required including respite care	CEO EPUT		k) Lesson plan l) Attendance data	Signed off by CMHT managers	