Shared learning bulletin

Mental health homicide independent investigation

This document provides an overview of the findings from an independent mental health homicide investigation into the care and treatment of mental health service user Mr M. Following an argument in the street Mr M assaulted a member of the public. The victim died of knife wounds sustained during this assault. A plea of guilty to manslaughter on the grounds of diminished responsibility was accepted by the Crown, and Mr M was detained to hospital under Section37/41 Mental Health Act.

The agencies and teams who might benefit from this learning bulletin include mental health services provided in the community, hospital and prison, and GP services.

Background

Mr M had a diagnosis of paranoid schizophrenia, with a secondary diagnosis of harmful use of cannabis and alcohol. He was initially under the care of mental health services between in 2008 and 2014. During this period, he had two admissions to hospital under the Mental Health Act (MHA). In the community he was initially supported by the Early Intervention in Psychosis team, and then by the community mental health team (CMHT).

Between 2009 and 2014 Mr M was subject to Section 17A MHA Community Treatment Order (CTO). This was intended to support his engagement with services and mitigate against non-compliance with medication.

While under care of community services Mr M was twice prescribed an antipsychotic depot (long lasting medication provided via injections). Mr M was consistently reluctant to accept these, and after periods of compliance would request oral medication, with which he would typically then become non-compliant.

Mr M also had a long history of cannabis use and was unable to connect this with his mental health problems.

Between 2008 and 2017 Mr M was arrested and charged with several offences. These included common assault, threatening behaviour and possession of an offensive weapon in a public place. Mr M's threatening behaviour was often towards members of his family and healthcare professionals.

In June 2017 Mr M was detained under Section 2 MHA following an incident at the family home. On assessment Mr M disclosed that he had not been taking his prescribed anti-psychotic medication for about six months. The plan following this assessment was for an admission to hospital to re-establish him on a depot.

Mr M was discharged after a month to the care of the home treatment team (HTT) and the CMHT. Mr M was homeless, spending some periods of time living with family and friends. He often spent time living more than 30 miles from his GP and the CMHT base.

Until the end of 2017 Mr M attended the CMHT team base monthly for his depot, although he reported side effects to the medication which he found unacceptable. In December 2017 he said he was no longer willing to accept the depot and requested oral medication. The CMHT had no means to compel Mr M to accept a depot, as he was not subject to a CTO, and with the approval of the team consultant psychiatrist prescribed oral medication.

The CMHT registered mental health nurse (RMN) had limited contact with Mr M, meeting with him five times in 2017 and once in 2018 at the discharge meeting. The RMN did not monitor Mr M's compliance with the oral medication, apart from during a phone call on 30 January 2018.

In June 2018 Mr M's family raised concerns about Mr M's compliance with medication with his GP and in September 2018 with the police. The information shared with the GP was not shared with the CMHT. The CMHT were made aware of the concerns raised with the police via a Merlin report, which is s mechanism for reporting concerns about vulnerable people.

Mr M attended a medical review with the RMN and a junior doctor from the CMHT in October 2018. This medical review considered Mr M to be compliant with his medication and he was discharged to the care of his GP.

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In January 2019 Mr M was arrested in the bus station of an airport. He was homeless and had been seeking shelter there. He was searched and found to be carrying a knife. The police charged with him carrying an offensive weapon. He was sentenced to four months in prison, of which he served two.

While in prison Mr M was under the care of the prison mental health team. Mr M was seen several times by a junior doctor and a mental health nurse from the team, who prescribed him medication for his mental health. However, Mr M refused the medication, and his mental state was assessed as stable. The prison mental health team discharged Mr M to the care of his GP when he was released from prison.

Following his release from prison Mr M was homeless. While he was in prison, he had declined support to help him find accommodation for his release.

Mr M continued to collect a prescription for the medication to treat his mental health problems from his GP following his release from prison to the date of the assault.

Key Findings

Community mental health team: In 2017 the CMHT did not identify Mr M's historic pattern of poor engagement with community mental health services and non-compliance with medication.

There was a delay in the CMHT accepting the ward referral for Mr M because a core assessment of Mr M's mental health needs had not been completed. This resulted in Mr M being allocated to a member of the team after his discharge from the ward. The opportunity was lost for the RMN to liaise with the ward and meet Mr M prior to discharge.

Mr M had a long history of care from community mental health services, and we would have expected the team to have taken a more pragmatic approach by accepting the referral and allocating a member of the team while the core assessment was in progress.

The CMHT did not review Mr M's allocated zone when there were significant changes in his circumstances or potential risk, for example, when:

- his medication changed from depot to oral medication
- the team received a Merlin report from the police identifying family concerns about medication compliance

The team did not respond appropriately to the Merlin report and seek further information from Mr M and his family about the risks identified by the police.

The records of the CMHT decisions zoning and multi-disciplinary team meetings (MDT) did not meet Trust policy expectations. The record of zoning decisions contained insufficient information about expected level of team contact Mr M. Furthermore, none of the MDT meetings identified that he had not been seen by RMN in the ten months prior to his discharge from the service.

Discharge from the community mental health team: Mr M was discharged by the CMHT ten months after his medication change (from depot to oral medication). This discharge was based on Mr M's self-reported compliance with the prescribed medication, supported by the RMN who considered the transition to oral medication to have been a success. However, Mr M had not had face to face contact with the RMN in the ten months between the change in medication and the discharge appointment.

Mr M's discharge was completed by a junior doctor from the team. The team consultant was not able to demonstrate sufficient oversight of the discharge either through discussion with the junior doctor or the discharge letter to the GP.

When the CMHT became aware that Mr M had been detained to prison, they did not contact the prison mental health team to provide collateral information or establish Mr M's mental state. It was less than three months since his discharge from the CMHT caseload. This could have been considered a 'failed' discharge and the team could have considered re-opening Mr M to the team.

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Care coordination: The care and support provided by the RMN did not meet the expected Trust standard:

- Although two reviews were completed with Mr M, they did not agree a care plan with Mr M
- They did not complete a risk assessment and management plan with Mr M
- There was no plan to monitor his compliance with prescribed medication following the change from depot to oral medication
- They did not have face to face contact with Mr M in the last ten months he was under the care of the team
- The Merlin report is referenced in the CMHT MDT meeting, but the RMN did not respond to it or reference it when they met with Mr M for the discharge meeting
- They did not maintain clinical records in line with Trust policy expectations

Risk assessment and management: The Trust risk assessment tool lacked the structure and rigour needed to support good structured risk assessment. As a result, Mr M's risk assessment was a muddled list of issues and was difficult for the reader to navigate. It is a challenge to determine historical and current risk, and the factors that could escalate Mr M's risk.

Mr M's risk assessment did not identify the impact that substance misuse and alcohol could have on Mr M's mental health.

The last time the risk assessment had been updated was when he was admitted to hospital. There was no up to date risk assessment and management plan in place for Mr M while he was under the care of the CMHT.

Medication compliance: Mr M had a history of non-compliance with oral medication.

The decision to change Mr M from depot to oral medication was reasonable as there was no mechanism available to the community mental health team to compel Mr M to accept the depot medication. The team took the pragmatic decision that oral medication was better than no medication at all. However, no plan was agreed with Mr M to monitor his compliance with the prescribed medication. The RMN made a phone call to Mr M to check his compliance with his medication at the end of January 2019. The RMN's next contact with Mr M was a phone call in the September to arrange the medical review the following month.

The RMN did not seek feedback from the GP about Mr M's compliance. In addition, the GP did not share family concerns about Mr M not taking his medication with the CMHT. The CMHT did not respond to the concerns about Mr M's compliance with medication identified in the Merlin report.

Communication between Trust services: There was missed opportunity for a handover between the ward and the CMHT because of the delay in completing the core assessment and the allocation of a member of the team. Liaison between the ward and the HTT was good, with the HTT completing a joint assessment with the ward and attending ward rounds. There is no evidence of liaison and joint working between the HTT and CMHT.

Communication with other agencies: Mr M had continuity of care from the same GP, despite being homeless and at times living 36 miles from the surgery.

The CMHT's contact with Mr M's GP was limited and restricted to written correspondence. There is no evidence that the RMN made direct contact with the GP to establish their view of Mr M's medication compliance or mental state. Furthermore, the GP was aware that Mr M was supported by the CMHT but did not share family concerns about Mr M's mental health or compliance with medication with the team.

The prison mental health service sought collateral information from Mr M's GP, but there is no evidence that they approached the CMHT for similar. The police made appropriate Merlin referrals following the two contacts they had with Mr M and his family. These reports ensured that other agencies were aware of the concerns about Mr M.

Shared learning bulletin

Key Findings (continued)

Accommodation: Mr M was homeless for the period covered by this investigation, although at times he stayed with family and friends. The RMN did not liaise effectively or consistently with the local authority housing department to address the barriers that prevented Mr M accessing accommodation.

GP services: The GP provided support to Mr M's family when they had concerns about Mr M's mental health and compliance with medication. However, they did not share these concerns with the CMHT.

Prison mental health services: The prison mental health team was sufficiently concerned about Mr M's mental health to keep him open to the team while in prison. Mr M's mental health was stable, and he remained medication free. However, when he was released from prison the team should have considered the original plan to refer him back to the community team.

The prison mental health team did not seek collateral information about Mr M from the community mental health team.

The prison mental health team discharge summary sent to the GP was in list form. It lacked detail or any information about the assessments completed by the team, or the team view of Mr M's presentation or risk. It is unclear from the discharge letter if the GP was required to prescribe medication for Mr M.

The risk assessment completed by the prison mental health services did not meet policy requirements for the team. It does not identify any of Mr M's known risks or have a case formulation /summary of risk.

Contact with Mr M's family: While Mr M was under the care of the Trust mental health services there was limited contact with Mr M's family. The HTT liaised with the family when Mr M was on leave from the ward. However, the CMHT and RMN did not have contact with the family while Mr M was under their care. Family involvement in assessment and care planning is a requirement of Trust policy.

Critical learning points

1. Patients with a history of non-compliance with medication must have a robust plans in place to monitor their compliance when medication is change from depot to oral medication. These plans should include liaising with the patient's GP, if they are responsible for prescribing.
2. Discharge from CMHTs must be based on up-to-date, reliable information about the patient's compliance with medication and their mental state. Teams must ensure that there is adequate oversight of discharges by the MDT and senior medical staff.
3. CMHT's must have procedures in place to monitor the contact that team members have with patients on their caseload.
4. Prison mental health teams must liaise with CMHTs when they are aware that a patient has recently been discharged by a team.
5. CMHTs must ensure appropriate action is taken when they receive a Merlin report which contains family concerns about a patient's mental state and compliance with medication.
6. The family of a patient must be involved in their assessment and care planning.

Shared learning bulletin

Recommendations

The independent investigation made a total of 12 recommendations. Of these recommendations 8 are for the Trust, 3 for the prison mental health service and 1 for GP services.

Recommendations for the Trust

Recommendation 1: Medication history at admission to an inpatient ward

The ward did not complete a comprehensive history or medication review for Mr M when he was admitted

The Trust must provide assurance that when patients are admitted to a ward a comprehensive history is completed that includes:

- information about previous admissions
- a medication review, that identifies any patterns in the patient compliance with medication.

Recommendation 2: Monitoring medication compliance in the community

The community mental health team did not identify Mr M's pattern of non-compliance with oral medication.

The Trust must:

- provide advice and guidance to staff about monitoring compliance with medication
- require a risk assessment to be completed when a patient's medication is changed from depot to oral. This must identify how compliance with medication will be monitored and actions to be taken should the patient be non-compliant. And,
- the risk assessment must be shared with the GP.

Enquiry about risks of domestic abuse or safety at home by general practice staff should be routine practice.

Recommendation 3: Community mental health team contacts

The RMN did not have face to face contact with Mr M between December 2018 and October 2019

The Trust community mental health teams must put a process in place that monitor team member's contact with the patients on their caseload. This information must be available when supervision is completed and non-contact with patients must be addressed.

Recommendation 4: The community mental health team response to police concerns about Mr M

When the community mental health team received a Merlin report that identified concerns about Mr M, the team discussion and plan to address the identified issues was not recorded in sufficient detail

The Trust must clearly define its expectations about how services respond to a Merlin report and how this is recorded in the clinical record.

Shared learning bulletin

Recommendations (continued)

Recommendation 5: Community mental health team discharge practices

The community mental health team discharge in October 2018 was based on inaccurate information

The Trust must provide assurance that all discharges from community mental health teams are based on all the relevant information available to the team about the patient. Discharges must be discussed in the team MDT and the CMHT team member responsible for the patient must provide clear evidence that the patient meets the team discharge criteria.

In addition, all discharges from community mental health teams completed by a junior doctor must be countersigned by a consultant psychiatrist.

Recommendation 6:The Trust Risk Assessment Policy

The Trust Risk Assessment Policy does not reflect good practice in risk assessment and formulation.

The Trust must review the Clinical Risk Assessment Policy and CPA policy (or whatever policy is currentlyy in place to support care planning) and ensure that they contain reference to the expectation of the development of a risk formulation.

Recommendation 7: Involvement of family in care

The community mental health team did not involve Mr M's family in his care planning or risk assessment. There is an expectation that family will be involved in care planning and especially when a patient is being discharged from CPA. This expectation is described both in the CPA Policy and the service Standard Operating Policy.

The Trust provides assurance that every endeavour is taken to involved families in the care and treatment of all patients.

Recommendation 8: Engagement with local authority housing

A service reconfiguration has been completed since this incident. The reconfigured service is committed to work closely with other agencies, including housing, to meet the needs of patients. Mr M's main area of need was housing.

The Trust must ensure that an evaluation of the new community mental health service addresses recommendations in this report. In addition, the evaluation reviews how the team works with local authority housing department to address the housing needs of patients on the team caseload.

Shared learning bulletin

Recommendations (continued)

Recommendations for prison mental health services

Recommendation 9: Standards for discharge letters to GPs by prison mental health services

The prison mental health service letter to the GP was scant and lacked clarity on the teams' expectations of the GP with regard to ongoing prescribing

The prions mental health service must ensure that discharge letters provide clear clinical information to GPs and give accurate information about a patient's risk and ongoing care needs, including prescribing.

Recommendation 10: Discharge planning by the prison mental health service

The prison mental health service had a clear plan when Mr M was accepted onto the team caseload to discharge Mr M to the care of the CMHT when he was released from prison. They were unable to explain why they deviated from this. Their concerns about Mr M's mental health were consistent during his detention and they continued to prescribed medication which he did not take

The prison mental health service must provide assurance that there is a process in place that requires any changes to a discharge plan and the rationale for the change to be documented in the clinical record.

Recommendation 11: Action plans following the SI report

The 72-hour Health in Justice Significant Incident report completed in January 2020 identified the following immediate actions:

- **Patients to be allocated to a CPN if accepted onto caseload, irrespective of whether collateral information has been obtained or not.**
- **To arrange for a regular monthly supervision spot checks on notes and audit processes in line with the Trust Standards of practice.**
- **Full documentation audits looking specifically at ensuring Zone is documented and plan for next review forms part of each entry and mental health review.**
- **Full Case Load scrutiny conducted every 3 months.**
- **Liaise with Court Teams to ensure that any concerns over risk and self-harm are documented and shared.**
- **Assessment to mental health inreach team email address.**
- **Mental Health Team to meet with each patient prior to release/transfer/discharge as it is recognised that this period can increase levels of anxiety**

The Trust responsible for the prison mental health service must provide assurance that these immediate actions have been completed and embedded into practice.

Recommendations (continued)

Recommendations for the GP

Recommendation 12: GP sharing information about concerns with the Trust

The GP did not contact the community mental health team or any other Trust service when they became aware of concerns about Mr M's compliance with medication.

The GP practice and Trust must work together to improve communication and the sharing of information about patients under the care of the Trust. This must include what information it would be reasonable to expect a GP to share with mental health services, e.g., non-compliance with medication, signs of relapsing mental health.

Learning Quadrant

Individual practice reflections

- Do all the patients on my caseload have up to date care plans and risk assessments?
- Is my contact with patients on my caseload in line with their care plan?
- Do I understand historic risk of non-engagement and non-compliance?
- Is there an effective plan in place to monitor compliance with prescribed medication?
- Do I liaise sufficiently with other professionals such as the GP, who may have important information about patients' mental state and compliance with medication?
- Have I involved the patient's family in assessment and care planning?

Governance focused learning

- Do you have arrangements in place for the management and supervision of CMHT staff that is in line with national standards?
- Are your operational policies reflective of current good practice and guidance?
- Do you know if your clinical pathways are fit for purpose and reviewed regularly?

Organisational assurance questions

- Are there mechanisms in place to monitor the contact that practitioners have with the patients on their caseload?
- Are there mechanisms in place to monitor compliance with the Trust requirements around care plans, risk assessment and risk management?
- Are we assured that there are processes in place to ensure that all discharges from services are safe?
- Are we assured that there are robust processes in place to respond to issues identified in Merlin reports?

System learning points

- Does the system have multi-agency processes to support complex and challenging individuals in the community? What would improve this?
- Is the system providing enough support for complex individuals living in the community? Are the resources properly skilled and competent to deal with this behaviour?
- Does the system support mental health patients who are homeless to secure accommodation?