An independent investigation into the care and treatment of M

Learning Summary

July 2024

Executive summary

Incident

1.1 M had been waiting for allocation to a care coordinator since mid-January 2020 after a recommendation for care coordination under the Care Programme Approach (CPA) following a medical review earlier that month.

1.2 The Community Mental Health Team (CMHT) was in an area of the city with higher levels of deprivation and morbidity in the local population. The CMHT was experiencing some challenges with high caseloads, waiting lists for care coordination, recruitment difficulties and staff vacancies, including a team leader vacancy.

1.3 Because of team concerns (M had missed an outpatient appointment in late February with his consultant psychiatrist and that he was still waiting for a care coordinator after a month on the waiting list), the CMHT clinical lead visited M and completed a mental health assessment. They visited M on two further occasions that month and completed a risk assessment. They persuaded M to accept new anti-psychotic medication (aripiprazole) which was prescribed by a new consultant psychiatrist (CP2).

1.4 Later that month the police contacted the clinical lead and informed them that M was a suspect in to the murder of Mrs W, who M knew. M was arrested later that year.

1.5 M was convicted of the manslaughter of Mrs W and ordered to be detained under Section 37/41 of the Mental Health Act 1983 (MHA)[1].

Findings and conclusions

1.6 M had a 20-year history of contact with mental health services. After a GP referral he was seen in outpatient appointments with his first consultant psychiatrist (CP1) for the first 16 years. His diagnosis was recorded as schizoaffective disorder.[2] M also reported a history of quite heavy drug use, predominantly cannabis, from an early age, though reported that he had stopped using cannabis.

1.7 M was removed from his local GP practice under the NHS Special Allocation Scheme[3] due to verbal aggression and placed with another practice in the city. Over the three years before the incident, family members reported M making threats on several occasions and voicing grandiose and paranoid delusions.

1.8 After self-presentation at A&E with paranoid beliefs two years prior to the incident, M spent a week in an adult acute ward where he responded well to a prescription of olanzapine, before being discharged back to the CMHT.

1.9 In the year prior to the incident, M was transferred to the care of a new consultant psychiatrist, CP2, because M was reported to have moved GP practices. There is no evidence that M had changed GP practice. CP2 was then listed as M's care coordinator.

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[1] Section 37/41 of the Mental Health Act 1983 refers to a hospital order with restrictions. This order is made by the Crown Court when a person convicted of an imprisonable offence needs to be treated in hospital for a mental disorder they are suffering from, in the interests of their own health and safety or for the protection of other people. The court might add section 41 restrictions if it thinks that it's necessary for the protection of the public from serious harm. When deciding whether to add section 41 restrictions, the Crown Court must consider the seriousness of the offence committed, any previous offences you may have committed, and the risk of you committing more offences in the future. A section 37/41 lasts until you are discharged by the Mental Health Tribunal or by your responsible clinician. If your responsible clinician thinks you should be discharged, they will need to get permission from the Ministry of Justice. https://www.legislation.gov.uk/ukpga/1983/20

[2] Schizoaffective disorder is a mental health condition characterized by a combination of symptoms of schizophrenia, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania. This diagnosis requires significant mood symptoms and at least a two-week period of psychotic symptoms when a major mood episode is not present.

[3] The Special Allocations Scheme (SAS) was created to address situations where a GP or practice staff has feared for their safety or wellbeing due to an incident involving a patient, resulting in the incident being reported to the police. In such cases, the GP practice can immediately remove the patient from their list. Patients removed from a practice list are registered on the SAS. This allows them to access healthcare services at an alternative, specific GP practice. The goal is to ensure that patients are not denied healthcare following incidents reported to the police.

1.10 M briefly received support from the Home Treatment Team (HTT)[4] after contacting the CMHT duty team with paranoid and suspicious beliefs that the medication was a placebo[5]. He did not demonstrate any insight[6] and an appointment made to see a psychiatrist in early in the New Year (three months before the incident).

1.11 Following his appointment with the psychiatrist M was referred for allocation for a care coordinator under the Care Programme Approach.

1.12 A month later, he changed his name by deed poll. Alongside this the CMHT were concerned that his delusions made him vulnerable to radicalisation, and M was referred to Prevent[7].

1.13 M was discussed in the MDT the following month and noted to be still waiting for a care coordinator. Because of concerns about M's deterioration, the CMHT clinical lead visited M at home the same day. They completed an assessment of his mental state and updated his risk assessment, noting his paranoia and mistrust, and that his risk of harm to other people was deemed to be low.

Key findings

Patient factors

1.14 Despite his chaotic lifestyle and entrenched, paranoid and grandiose beliefs, M presented as someone with a high degree of independent functioning. M was consistently diagnosed with schizoaffective disorder exacerbated by cannabis use, although he reported that he had stopped smoking cannabis three years prior to the incident in order to get his driving licence back. His reluctance to take anti-psychotic medication and infrequent contact with his consultant psychiatrist combined with his high degree of functioning appears to have contributed to his remaining on standard care.

1.15 M engaged well with the Home Treatment Team (HTT) and with the wider members of the CMHT, including often meeting the duty team when seeking out further support.

1.16 Risk assessments completed by the CMHT clinical lead were thorough and considered presenting risks. They noted no recent history of violence and M was assessed as no risk of harm to himself or others. Historic risks had focussed on threats to his wider family but there was no evidence that these had ever escalated into action.

In patient care

1.17 M was briefly admitted to hospital as an informal patient in November 2018 and discharged a week later to the care of the HTT.

1.18 During the week as an in-patient, we found that his risk assessments had been updated appropriately in line with policy. There was evidence of care planning and observation levels on admission and then management of risk through use of leave before discharge.

1.19 We were not able to identify any evidence of liaison and communication between the ward and his consultant psychiatrist and the CMHT regarding his discharge, other than a discharge summary in the clinical record. This was not in line with best practice guidance.

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[4] The Acute Home Treatment service provides support to people with acute mental health problems who are experiencing severe difficulties when the stability of their mental health has been interrupted by crisis, and home treatment can avoid an admission.

[5] A placebo is a substance that is given to someone who is told that it is a particular medicine, either to make that person feel as if they are getting better or to compare the effect of the particular medicine when given to others. It is usually pharmacologically inert and is prescribed more for the mental relief of the patient than for its actual effect on a disorder. https://dictionary.cambridge.org/dictionary/english/placebo

[6] 'insight' refers to a person's awareness and understanding of their own mental illness. It encompasses a complex concept which should not be considered as an isolated symptom which is present or absent. Instead, it may be more appropriate to think of insight as a continuum of thinking and feeling, affected by numerous internal and external variables. A patient who is aware that they are suffering from a mental disorder and is able to articulate their condition in the language of symptoms is often described as "having insight". Conversely, a patient who is unwell but unaware of their own illness may be described as "lacking insight" or "having impaired insight". See Thirioux B, Harika-Germaneau G, Langbour N and Jaafari N (2020) The Relation Between Empathy and Insight in Psychiatric Disorders: Phenomenological, Etiological, and Neuro-Functional Mechanisms. Front. Psychiatry 10:966. doi: 10.3389/fpsyt.2019.0096 https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2019.00966/full

[7] Prevent is the UK government initiative to stop people from becoming terrorists or supporting terrorism.

Delivery of the Care Programme Approach (CPA)

1.20 The Trust's Care Management Policy defines the role and expectation of care coordination. We found that the care management provided did not meet the expectations of this policy. When it was identified that he needed a higher standard of care we found a lack of documented rationale for escalating M's care and allocating a non-medical care coordinator (who would have been in a better position to work more intensively with M).

1.21 M was retained on standard care[8] with a consultant psychiatrist acting as care coordinator. This allocation was an automatic function of the Trust Electronic Patient Record, not a considered decision, and the care coordination role or function was not undertaken as anticipated. Most documentation relating to M's care was completed by non-medical staff who were not care coordinators for M.

1.22 M was referred by his consultant psychiatrist for care under CPA with a care coordinator in the CMHT MDT meeting a month prior to the incident. However, due to a shortage of staff, high caseloads and a waiting list for care coordination this did not happen. However, the clinical lead of the team was concerned that M was not receiving care under CPA with a care coordinator. They visited M on several home visits and undertook comprehensive assessments of M's mental state and healthcare needs prior to the incident. We could not identify any Trust policy guidance on what CMHTs are expected to do when there are service users waiting for allocation to CPA and a care coordinator.

Transfer of care

1.23 Three months prior to the incident M was discharged from the HTT and his care transferred back to the CMHT without discussion with the CMHT.

1.24 M's care transferred from his first consultant psychiatrist to the care of a second psychiatrist, without handover or discussion and information sharing in particular with regard to the need for care coordination.

1.25 We found that there is no Trust policy or guidance on the transfer of care between clinicians, professionals or teams including handover of a patient under care coordination.

DNA appointments

1.26 Although he did attend some appointments with non-medical staff, M would frequently not attend his OPAs with medical staff. After failing to attend appointments (DNA) twice in a row he was discharged on two separate occasions in the three years prior to the incident. We found that the Trust has no guidance on managing DNAs and discharging patients for failing to attend appointments, including the rationale for the decision to discharge or to escalate any concerns.

Risk assessment

1.27 In general, M's risks were frequently assessed and reviewed as required by Trust policy, and the assessment completed by the clinical lead prior to the incident was particularly detailed.

1.28 However, we found that previous key events, when he had made threats to family members and also his earlier contact with the police and with the criminal justice system were not included in updated risk assessments at that time, or since, nor considered as key events to indicate risk to others. Risk assessments would have been improved with inclusion and consideration of this additional information.

1.29 It was frequently reported that M had stated that he been arrested for actual bodily harm (ABH) but not charged and that he had a significant forensic history and convictions for grievous bodily harm (GBH)

[8] Standard care is described as "*Where a service user has straightforward needs and has contact with only one agency then an appropriate professional in that agency will be the person responsible for facilitating their care. Formal designated paperwork for care planning and the review process for these service users is not required. However a statement of care agreed with the service user should be recorded. This could be done in any clinical or practice no*tes, or in a letter, and this documentation will constitute the care plan. It is not necessary to engage in further bureaucracy for these individuals." Department of Health; "Refocusing the Care Programme Approach" March 2008

which is a more serious offence. Corroborating information on his criminal record was not sought from the police although this was available and a policy expectation.

Carers assessment and involvement

1.30 On one occasion M's son was identified as his carer, and frequently documented as living at his home. However, there is no documented evidence that he was formally considered a carer and offered a carers assessment in line with the requirements of the Care Act 2014.

1.31 Similarly, staff latterly did not consult with any family members, especially M's son, to corroborate their version of events and his mental state when M's mental state deteriorated, and the family had reported incidents to the CMHT.

GP registration

1.32 M had been removed from his regular GP practice three years earlier after an altercation and threats made to a GP, and he was then placed on the NHS Special Allocation Scheme. We found that at least three different GP practices were identified as his GP and that on only one occasion was his registration checked.

1.33 There was an increased risk with his GP practice not being fully informed of the care provided and then not being able to identify deterioration and potentially escalate M back into services.

Use of the Mental Health Act (1983)

1.34 The Home Treatment Team had documented that although there was a risk of further deterioration, M could be managed in the community and that assessment under the MHA would not be initiated.

1.35 M had attended a medical review three months prior to the incident and been assessed by a psychiatrist, and M was subsequently accepting visits from the CMHT clinical lead. After the last home visit M had agreed to take antipsychotic medication. The clinical lead noted M's psychosis and also his high degree of functioning, that he was able to process information logically and cohesively, that risks of self-harm or aggression to others was low and there was no justification for detention under the MHA.

1.36 Because of the 'the least restrictive principle' in the MHA Code of Practice, we found that it was unlikely that M would have been assessed and detained under the MHA at that time.

Mental capacity

1.37 The assessment of mental capacity did not fully follow the recommended steps required by the Mental Capacity Act 2005 (MCA) and the MCA Code of Practice. We found that staff routinely documented that M had mental capacity but rarely documented the rationale behind this assertion. The first principle of the MCA is to assume capacity. If staff determine that a capacity assessment is required it must be documented and the steps required followed, e.g. rationale for the decision, and the aspects of that assessment. There was in fact no clear need to assess his capacity and we found no evidence to indicate why an assessment was needed.

1.38 It is this investigation's view that in the absence of a properly documented test of mental capacity it would be better not to document any assumptions, in line with the first principle of the MCA.

Other issues identified in the course of this investigation

1.39 The CMHT is based in an area of a city with high morbidity and demand for mental health services. This resulted in higher caseloads with service users who had higher needs and acuity.

1.40 We identified that during the year prior to the incident the CMHT had been undergoing a programme of change. For three years the CMHT had been on the Trust Risk Register as a concern, with a risk score of 12, (i.e., deemed 'significant risk'). There had been high turnover and a shortage of staff and a waiting list for care coordination.

1.41 At the time of the incident there still remained concerns, although shortly after that the CMHT had stabilised, and the Trust had successfully recruited a new team leader.

Recommendations

1.42 Our recommendations are focused on how the Trust can identify and support patients who do not readily engage with deteriorating psychotic symptoms but who otherwise appear to be able to function independently. We made seven recommendations:

Recommendation 1: Delivery of the Care Programme Approach

The documentation of care decisions made, and actions taken did not match the policy expectations of the Trust Care Management policy. While the decision appears appropriate, the rationale for escalating M's care to CPA was not documented. Most documentation was completed by non-medical staff, although for three years M's care coordinator had been identified as a consultant psychiatrist whilst he was on standard care. The role of care coordinator of people on standard care for medical staff needs clarification.

- The Trust should revise the Care Management policy in light of the findings of this investigation. This revision should clarify the rationale for the allocation of care coordination to medical staff and the expectations of medical staff when they are identified as care coordinators.
- When patients are escalated to care coordination under the Care Programme Approach or its successor framework the Trust should ensure that staff document the rationale for this. Consultation with staff on why this is not happening or any challenges they face would inform any revisions to the Care Management policy.
- The Trust should develop guidelines to inform staff about what to do when a patient is in need of care coordination under the CPA and is waiting for a care coordinator.

Recommendation 2: Transfer of care

In December 2019 M was discharged from the Home Treatment Team to the care of the CMHT without discussion with the CMHT. Similarly, M's care was transferred between two consultant psychiatrists with no handover between them in 2019. There is no Trust policy on the handover of service users either between individual teams or individual professionals/clinicians.

- The Trust should develop and issue guidance on the correct way to transfer care between distinct mental health teams and services within the Trust.
- Guidance to professionals/clinicians to follow when handover is required between clinicians (in particular Consultant Psychiatrists) including key information required should be developed. This should be developed in consultation with Consultant Psychiatrists to support engagement for future handovers.
- An audit of handovers should be conducted 12 months following the introduction of the guidance and appropriate revisions made (if required).

Recommendation 3: DNA appointments

Between 2017 and 2020 M attended one OPA out of seven with medical staff. He was discharged twice (in 2017 and 2019) for not attending appointments. There is no Trust policy or guidance on how to manage patients who do not attend.

- The Trust should explore best practice in the management of non-engagement from across other similar Trusts.
- The Trust should then develop a policy with associated guidance on how to manage patients who do not attend.
- This should include:
  - documenting the rationale for discharge, and
  - when and how to escalate any concerns about frequent non-attenders.

Recommendation 4: Risk assessments

M's risks were frequently assessed and reviewed. However. key information such as criminal convictions, police contact, and threats to family members were not included, and the corroboration of his mental state by family was not undertaken, including when they had been identified as carers.

- The Trust should ensure that staff seek corroborating information from all relevant stakeholders in a patient's care where there are threats of violence and risks of harm to others. This should include contacting the police for confirmation of contact with criminal justice services.
- The Trust should establish if there are any barriers to contacting key agencies in seeking information from stakeholders by consulting with staff and build any improvements into operational policies.
- In addition, when family members contact a CMHT with concerns, the Trust should ensure that steps are taken to:
  - rapidly respond to these concerns,
  - the concerns are used to inform care planning and risk assessments, and
  - family members are not solely advised to contact the police if they have further concerns.

Recommendation 5: Carers assessments

M's son had been identified as his carer in 2017 and was also noted to be living with or visiting him frequently. However, he was not offered a carers assessment in line with the expectation of the Care Act 2014.

- The Trust should ensure that all community staff are aware of the requirements of the need for carers assessments under the Care Act 2014, and work with the relevant local authorities to develop good practice and guidance for staff to ensure that carers are appropriately offered assessments.
- Monitoring the number of carer assessments within the caseloads of CMHT's may provide a means to standardise practice.

Recommendation 6: GP registration

M had been removed from his GP practice and placed on the NHS Special Allocation Scheme in 2016 after an altercation on their premises. However, three different GP practices were identified in his records and key information, such as discharge letters and transfers of care, were not passed on as a result.

The Trust should take steps to ensure that a patient's reported GP practice is checked and reconciled with the correct list or registration, to ensure that appropriate information is shared with the correct GP.

Recommendation 7: Mental capacity assessment

It was frequently recorded that M had mental capacity to make decisions about his care and treatment. However, there were few documented assessments, and none of these documented the full steps required by the MCA and MCA Code of Practice to conclude on his capacity in specific instances.

Trust documentation does not follow the first principle of the MCA which is the presumption of capacity.

- The Trust should take steps to ensure that the principles of the Mental Capacity Act are followed and that if statements of mental capacity are documented, they must be supported by a full and thorough test of mental capacity in line with the law.
- Trust documentation must be reviewed as a matter of priority to ensure that the documentation being used by staff is appropriate and consistent with lawful practice.

Observation for information: Patient changing names

M changed his name by deed poll – there is a risk that in these circumstances a patient may be missed in Trust electronic systems, and also, whilst M was entitled to change his name, it may also have indicated a worsening of his mental health condition and paranoia.

- The Trust should check arrangements are in place to ensure patient name changes are well documented and linked on Trust systems.
- The Trust should also take steps to ensure that when a patient changes their name that staff are reminded to be professionally curious to establish the rationale and any underlying reasons for this name change to exclude any worsening of mental health conditions

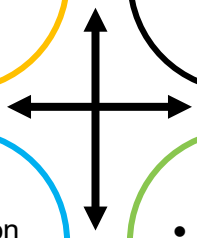
Learning quadrant

Individual practice

- Have I involved the families and carers in risk assessment and care planning?
- Have we triangulated information with family members to get a clearer understanding of risk?
- Does the risk assessment completed reflect the full range of information?
- If a service user reports a forensic history of violence, have I checked with the police any records of violent offences?
- Have I offered a carers assessment when appropriate?
- If a family member raises concerns, have I responded appropriately?

Governance focused learning

- Are we compliant with Trust policy when completing risk assessments?
- Is the allocation of care coordinators in line with best practice?
- When service users are transferred between teams how are we assured that there is a proper handover and transfer of relevant information?
- Do our teams offer carers' assessments appropriately?



Board assurance

- How do we know appropriate information is shared when service users transfer between teams and professionals?
- Are we assured of the quality of risks assessments not just the timeliness?
- Do audit and quality monitoring measures include a focus on relevance and quality as a standard expectation?
- Are we sighted on all the risks facing our teams with high demands and a shortage of key staff and confident in the actions being taken to mitigate?

System learning points

- How do we make sure we have identified the correct GP practice when sending important letters?
- Are there clear guidelines on what CMHTs should do when there is a wating list for care coordination?
- Do staff really understand the Mental Capacity Act (2005)?
- Are mental capacity assessments truly in line with best practice guidance and the law?

Appendix A – Terms of Reference

Independent Investigation into the Mental Health Care and Treatment received by M (2020/6329)

Background to the Independent Investigation

In March 2020 M killed an elderly woman he was working for. M fled the country and was extradited back to the UK. M has pleaded guilty to manslaughter by reason of diminished responsibility and has been detained in a secure mental health facility.

Purpose of the Independent Investigation

- To independently assess the quality of the NHS care and treatment provided to M against best practice, national guidance and Trust Policy.
- To identify opportunities for learning that may be applicable on a local, regional or national basis.

Terms of Reference (updated August 2023)

The following Terms of Reference are final following review at the start up meeting and agreement with the families concerned.

- Compile a full chronology of M's contact with Mental Health and Primary Health Care from 2017 to determine if his healthcare needs and risks were fully understood
- Review the interactions with services including risk assessment and management plans in line with Guidance, National Policy and best practice,
- Review the adequacy of risk assessments and risk management processes and what plans were put in place to mitigate those risks.
- Determine whether there were any missed opportunities to engage, listen to and support M and his family.
- Involve the families to the extent of the families wishes, in liaison with NHS England and other identified support organisations.
- Provide a written report to NHS England that includes measurable (SMART) and sustainable recommendations that have been co-produced with the affected organisations
- Produces a learning document, suitable for sharing with other providers both regionally and nationally on the key learning from the investigation

Timescale

The independent investigation process starts when the investigator receives the Trust documents and the investigation should be completed within 3-6 months thereafter.

Initial steps and stages
NHS England will:

- Ensure that the relevant families are informed about the investigation process and understand how they can be involved including influencing the terms of reference
- Arrange a start-up meeting between the trust, commissioners, investigator and other agencies who are involved in this investigation

Outputs

- NHS England will require monthly updates which will be shared with the relevant ICB and other involved organisations.
- A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proofread and shared and agreed with participating organisations and families (NHS England style guide to be followed)
- At the end of the investigation, to meet the families to explain the findings of the review.
- To participate in meetings to explain the findings of the report to the involved organisations and support the publication of the report.

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