Shared learning bulletin

An independent investigation into the care and treatment of Ms P

Introduction

This document provides an overview of the findings from an independent investigation to identify learning from a patient's care and treatment. Agencies and teams who may benefit from this bulletin include NHS England, Integrated Care Boards (ICBs), adult community mental health services and GP/primary care teams.

Case background

Ms P had a diagnosis of emotionally unstable personality disorder (EUPD). Her mental health problems were significantly exacerbated during periods of stress or when she consumed alcohol to excess. However, she experienced periods of stability when she engaged with support services and reduced her alcohol intake.

Ms P was open to community services and received telephone outpatient appointments (OPA) twice a year with a consultant psychiatrist. She was not under CPA and did not have a care coordinator but was instead managed by the service on a 'duty' basis and received medication via her GP. Ms P's contact with services was usually via the Trust administrative (admin) service which triaged calls and acted as the primary contact for the community service. The admin service would pass on Ms P's messages and requests for a callback to the community team. Ms P contacted the service during periods of crisis, often calling out of hours, but would later decline follow-up (if offered). Ms P's concerns predominantly focused on her social situation and physical health, although she reported periods of low mood and on occasion, hallucinations.

Ms P had criminal convictions for offences usually committed under the influence of alcohol. In the months preceding the incident she had received a Community Order and 20-day Rehabilitation Activity Requirement (RAR) for possession of an offensive weapon. Ms P was arrested roughly three weeks before the incident for assault without injury and racially aggravated harassment, alarm and distress. The probation service spoke to the Trust admin service after this incident, outlining their concerns about Ms P's mental health and alcohol consumption. They described Ms P as 'high risk' and asked that community services contact her, but this did not happen.

A women's charity working with Ms P spoke to the Trust admin service a few days before the incident, detailing their concerns about her mental health. They asked that community services contact Ms P. Ms P also spoke with the admin service around the same time. She said she was not taking her medication and was worried she would hurt someone; the community service were asked to contact Ms P, but this did not happen until three days later and Ms P did not answer. She was arrested on suspicion of murder the next day.

Key Findings

Community services and care planning

The 'duty' model of care provided to Ms P meant there was no central understanding or management of Ms P's mental health, her broader social context and external events. Ms P's management plan was medication-based and did not extend to broader care planning. The community team did not respond to Ms P's care needs or implement longer term care planning to support her. The lack of central oversight meant the team did not promptly respond to P's deteriorating mental health, or indicators of increased risk in the weeks preceding the incident, despite concerns identified by Ms P and other agencies.

Key Findings (cont)

Risk assessment and management

Ms P did not have a comprehensive risk assessment or risk management plan in place at the time of the incident. Ms P's risk assessment was not consistently updated in response to new information and did not accurately reflect her risks. Risk assessment and management were not undertaken in line with Trust policy.

Domestic violence

Ms P was historically a victim of domestic violence. Roughly three months before the incident a multi-agency risk assessment conference (MARAC) was held, which identified Ms P as an alleged perpetrator and victim of domestic violence. The community services response to Ms P's history of domestic violence and threats towards her partner was not managed in line with Trust policy. The community service did not follow up on allegations that Ms P was a victim of domestic violence a few weeks before the incident, nor consider safeguarding for her.

Alcohol misuse

The community service did not refer to the Trust dual diagnosis service or policy as part of its management of Ms P's frequent alcohol use. The service did not explore Ms P's drinking in any depth with her, particularly in the context of broader issues impacting her mental health e.g. physical health concerns and relationships.

Medication

Ms P's medication was appropriate and prescribed in line with expected practice. The exception to this was the absence of documented treatment targets which meant her progress with medication could not be monitored and/or the benefits in treatment identified. Ms P reported significant non-compliance with her medication in the weeks preceding the incident, although she could be inconsistent in her reporting, and had changed her GP earlier in the year to ensure better access to her prescriptions. It is our view that, if Ms P were non-compliant in the weeks leading to the incident, this is unlikely to have been the sole cause of her decline in mental health. There were several contributing factors, none of which the community service explored with her, which included her alcohol use, physical health, difficulties with her neighbours, and relationship difficulties.

Forensic history

Ms P did not meet the criteria for Trust forensic services. However, it would have been helpful for the community service to have sought advice from specialist forensic services in relation to her care planning and risk management, particularly in the eight months preceding the incident, when it was documented that her behaviour had begun to escalate.

Inter-agency working

The community service was aware Ms P was under probation and supported by a women's charity. We did not identify formal or informal working arrangements in place for either agency. There were significant incidents in Ms P's timeline of care when it would have been appropriate for the community service to have engaged with either agency to have worked together to support Ms P. This was a missed opportunity on the part of the community service to develop a better understanding of Ms P's mental health needs, and how to manage these, particularly in response to the concerns raised by the agencies in the days before the incident.

Conclusion

The OPA/duty model was not suited to Ms P's needs. The duty model meant Ms P rarely spoke to the same individual, often only having contact with the admin service, and no one worker was responsible for ensuring her concerns were followed up and/or actions implemented. Ms P was not discussed in a community service multi-disciplinary team (MDT) meeting during the three-year period of review, despite several events that should have prompted a review of her care plan and risk, as guided by Trust policy.

There was a lack of central oversight of her mental health care or treatment in the context of her relationship difficulties, physical health concerns, difficulties with neighbours, or use of alcohol. Ms P's behaviour or significant incidents were rarely explored with her; the absence of central oversight meant there was a lack of care planning or risk assessment in response to these.

Critical Learning Points

1. Every service user should have a primary contact responsible for oversight of their care during periods of crisis. Dependent on the service user's level of need, this should extend to developing a care plan coordinating all aspects of care, management and follow-up of key issues, and liaison with external agencies.
2. Risk assessments for community-based service users should be up to date and subject to regular review. A risk management plan should reflect the detail of the risk assessment.
3. When physical health concerns are identified, a documented plan should be agreed to support the service user to access health services as needed.
4. Trusts need to ensure there are effective communication pathways available to partner agencies and third sector organisations to ensure prompt contact and information sharing for all service users. This should include an agreed central contact pathway for matters requiring escalation.

Learning Quadrant

Individual practice

- Have I reflected the detail of the service user's concerns beyond mental health?
- Do I explore with the service user incidents and events that have occurred since our last contact?
- What steps have I taken to ensure actions agreed with a service user have been taken forward?
- Am I supporting the service user to access other services e.g. primary care?
- Am I in contact with other agencies supporting the service user?
- Am I confident I know how to approach discussions with a service user about domestic violence?

Governance focused learning

- How are we assured that service users can contact community services and have access to support during periods of crisis?
- If we rely on a triage system, how do we know it is working and that calls are being returned and actions followed up?
- What agreements do we have in place to work with partner agencies and third sector, and are these sufficient?
- Are risk assessments, risk management plans and care plans subject to meaningful regular review?

Board assurance

- As a Board member, am I assured that community service users have ready access to community services?
- How am I assured that community services sufficiently support service users without a care coordinator during periods of crisis?
- Is there effective information sharing between Trust services and other agencies/third sector?
- What assurance is provided to the Board that there that risk assessment and care planning are undertaken in line with Trust policy?

System learning points

- What systems are in place to ensure collaborative working with other agencies and the third sector? Are there sufficient escalation pathways?
- How do we ensure all community service users have sufficient access to community services, particularly when relying on a triage call system?
- How do we ensure service users without a care coordinator, still receive effective continuity of care during periods of crisis?